



JIBAN BIMA CORPORATION

(Only State-owned Life Insurance Corporation)

Head Office : Phone : 9551096, PABX : 9551414, 9551423-24, 9552047-49, 9559951-2

Fax : 88-02-9561825, E-mail : infotejbc.gov.bd, Web Site : www.av.jbc.gov.bd

PROPOSAL FORM FOR OVERSEAS MEDICLAIM POLICY (EMPLOYMENT & STUDIES)

(To be submitted in original with two copies)

(Available to persons in the age group of 18 to 59 years)

ELIGIBILITY :

This Insurance is specially designed for you if you are a Bangladeshi Citizen residing or will be proceeding shortly temporarily outside Bangladesh solely for the purpose of either

1. Furthering your education; OR
2. Engaging in research activities; OR
3. Temporary posting in a sedentary non-manual work, provided you are a holder of an appropriate and valid visa for the same purpose issued by the authorities in Bangladesh.

IMPORTANT NOTES :

If a spouse or a child accompanying you is / are also to be covered, a separate Proposal Form should be completed by each accompanying person.

You must complete and sign a Proposal Form to the best of your knowledge and belief and all material facts* must be disclosed. An adult may complete and sign on behalf of his child aged 18 years or less.

* A material fact is one that is likely to influence the acceptance or assessment of the Proposal. You should consult the Corporation/ Company if you are in any doubt as to what constitutes a material fact.

1.0 PERSONAL DETAILS :

1.1. Name (Mr. / Mrs. / Miss/ Master) _____
(BLOCK LETTER)

1.2. Sex : Male / Female

1.3. Date of Birth : ____/____/____ Age : _____
 DD MM YY

1.4. Height _____ ft _____ inch (_____ cms) Weight: _____ lbs _____ (kgs)

1.5. Passport No. : _____

1.6. Date of Issue : _____

1.7. Type of Visa held : _____ other _____

1.8. State Type : _____

1.9. Is the Proposed Person a spouse or child of an Insured Person (participant), if so, state Policy No. _____
of Insured Person and Passport No. _____ of Participant.

2.0 Your address in Bangladesh : _____
_____ Tel. No. _____

2.1 Your next of kin (Mr. / Mrs. / Miss.) _____

2.2 Relationship : _____

2.3 Address : _____
_____ Tel. No. _____

3.0 Your Country of Visit : _____

3.1 Country of Studying of Posting : _____

- 3.2 Address in Country of Studying or posting : _____
 _____ Tel. No. _____
- 3.3 Name and Address of School / Work place you are attending :

 _____ Tel. No. _____
- 3.4 Brief details of nature of future studies/ research and activities/ or employment/ employment to be undertaken

 _____ from _____ / _____ to _____ / _____
 MM YY MM YY
- 4.1 Name and Address of Bangladeshi Sponsor : _____

 _____ Relationship _____
- 5.0 Period of Insurance required : _____
- 5.1 Commencement Date : _____ / _____ / _____
 DD MM YY
- 5.2 Total period of months that you are intending to study / work in the country of study / posting _____ months
- 6.0 **YOUR MEDICAL HISTORY :**
PLEASE ANSWER THE FOLLOWING QUESTIONS IN YES OR NO (A DASH IS NOT SUFFICIENT)
- 6.1 Are you in good health and free from physical defect or infirmity ? _____
- 6.2 Do you ordinarily enjoy good health ? _____
- 6.3 Have you ever suffered from : _____
- a) Any nervous or mental condition, fainting episode, blackout, fit or paralysis of any kind ? _____
- b) High blood pressure, a heart condition, haemorrhoids, varicose veins, or other circulatory disorder, rheumatic fever or diabetes? _____
- c) A "slipped disc" or other spinal disorder, a hernia, or any rheumatic or arthritic condition? _____
- d) Any respiratory, urinary or allergic condition, or any disorder of the stomach or bowels? _____
- e) Any other condition requiring specialist consultation or surgical or hospital treatment? _____
- f) Any symptom or tendency that might necessitate such consultation or treatment in the future? _____
- 6.4 Have you any intention of engaging in winter sports or any other sports or pastimes rendering you liable to personal injury?

- 6.5 Are there any additional facts affecting the proposed insurance which should be disclosed to Insurers?

NOTE: - If the Proposer / Spouse

- a) Is travelling to North America and is above 40 years; Or
 b) Is travelling to any other countries and is above 50 years; Or
 c) Answer to questions 6.00 to 6.5 reveal that the proposer has suffered any time in the past or is suffering from any disease/ illness.

The Proposal Form should be accompanied with ECG and Urine Strip Test Report etc. alongwith the attached questionnaire 7.1 to 7.2 to be completed and signed by the Doctor conducting the test. In the absence of such medical tests and reports due to a shortage of time before travel cover may still be granted subject to a satisfactory proposal form but the sum insured under policy, in respect of expenses incurred for the treatment of illness or diseases shall be restricted to US \$ 10,000/- only. However, the limit of cover for visiting EEC countries and Schengen States is Euro 30,000 (or US\$ equivalent) **for accident and illness** without medical examination subject to:-

- a) Satisfactory proposal
 b) Full unlimited pre-existing exclusions
 c) Age of proposer not to exceed 40 years travelling to North America or 50 years for travel to any other country.

MEDICAL EXAMINATION: (TO BE COMPLETED BY A DOCTOR WHO HOLDS ATLEAST AN M.B.B.S. DEGREE)

- 7.1 a. History :
- b. Any past history of disease, operation, accidents, investigations etc. :
- c. General Examination :
- d. Systematic Examination :

7.2 Electrocardiography :

- a. Does the attached Electrocardiogram in your professional opinion show any abnormalities and if so, please describe :
- b. Does the abnormality represent a current illness or disease which may possibly be expected to require medical treatment during proposer's forthcoming trip? :
- c. Does the proposer now or did he/ she in the past require medication for this abnormality? :
- d. Please describe any treatment taken by the proposer in the past or being taken at present :
- e. Do you consider that the proposer is fit to travel anywhere abroad, due account being taken of the stress of air travel adversely affecting his/ her medical condition? :
- f. Does the Fasting Blood/ Urine Strip Test show any Sugar? :

Signature of Doctor: _____

Name of Doctor: _____

Qualifications: _____

Address: _____

_____ Tele. No. _____

8.0 Name and address of usual medical physician in Bangladesh

_____ Tele No. _____

9.1 Please attach a copy of your medical report, if any, which was required for Entry Visa or Application to study

9.2 If you answer YES to any questions (c) to (f) _____
please give full details with dates _____

10.0 DECLARATION :

Please read IMPORTANT NOTES above before your signing.

I hereby declare and warrant that the above statements are true and complete. I consent to the Corporation / Company and /or their appointed Claims Administrator seeking medical information from any Doctor who has at any time attended concerning anything which affects my physical or mental health, and I authorize the giving of such information. I agree that this Proposal shall form the basis of the contract of Insurance.

I am willing to accept the Policy, subject to the terms, exceptions and conditions prescribed by the Corporation/ Company therein.

Date : _____ / _____ / _____
 DD MM YY

Signature : _____

Place : _____

11.0 STUDY :

If you are under 18 years old and / or residing with your parent(s), one of your parents must confirm the accuracy of the information provided in this proposal by signing below :-

Signature of Parent (or Guardian) _____

Date : _____ / _____ / _____
 DD MM YY

Place : _____

12.0 EMPLOYMENT :

If you are being posted overseas by a Bangladeshi Employer, the competent official of your Company must confirm the accuracy of the information provided in this proposal by signing below:-

Employer's competent official's signature : _____

Date : _____ / _____ / _____
 DD MM YY

Place : _____

I M P O R T A N T

IF YOU ARE NOT ABLE TO SIGN THIS DECLARATION AND WARRANTY AT THE TIME OF PROPOSAL OR HAVING SIGNED THE DECLARATION AND THEREAFTER CIRCUMSTANCES CHANGE BEFORE THE FIRST DAY OF INSURANCE WHEREBY THE DECLARATION IS RENDERED INVALID, YOU MUST INFORM CORPORATION/ COMPANY FOR FURTHER ADVICES.

U N D E R T A K I N G

I, Mr. / Mrs. / Miss / Master _____ do hereby agree and undertake to refund to Corporation/ Company providing the insurance (hereinafter referred to as the Insurers) all medical related expenses, made by insurer's Claims Administrators on my behalf which expenses are found to be not payable as per terms and conditions of the Policy and which expenses are required to be reimbursed by the Insurers to the Claims Administrator under the agreement made between the Insurers and their Claims Administrator. Such payments would be refunded by me to the insurers in Bangladesh TAKA immediately

Date : _____ / _____ / _____
 DD MM YY

Signature of Proposer : _____

Place : _____