

# APPLICATION FORM

## General Question

Proposed Insured Name:

(please use capital letters)

Birthday:-  ☐ GENDER:- ☐ Male ☐ Female

Address:-  Email:-

Id Number:-  Social Security Number:-

Status:- ☐ single ☐ married ☐ divorce ☐ couple

occupation:-  Are you retire? ☐ yes ☐ no

## B.Type of health Coverage

Empolyee:- ☐ yes ☐ no

plan of choice

Spouse:- ☐ yes ☐ no

plan of choice

children:- ☐ yes ☐ no

plan of choice

complete if Spouce/children are prosped for issurance

name	ssno	relationship to proposed insurance	date of birth	age	sex
ibrahim	1211	no	16-4-1999	21	male
fatima	1211	no	16-4-1999	21	male
naina	1211	no	16-4-1999	21	male

## C.Policy

units:  ANNUAL PREMIUM:-

payment mode:- ☐ annual ☐ semi-annual ☐ monthly pat(complete pat-card)

cash with application:- \$

planned model premim:- \$

signature

Date:-  ☐