AXA MANSARD HEALTH CORPORATE PROPOSAL FORM (2017)

Main Member Passport

"AN INDIVIDUAL WHO ASSISTS AN APPLICANT TO COMPLETE THIS PROPOSAL FORM FOR INSURANCE SHALL BE DEEMED TO HAVE DONE SO AS THE AGENT OF THE APPLICANT"

PRIMERA MFB
...your partner for growth.

AXA MANSARD

Company Name _____ Staff ID/Number _____

Enrollee name (Surname, Other names) _____

Birth Date (DD/MM/YYYY) _____ Religion: _____ Marital Status: _____ Sex: _____

Job Title: _____ Mobile No: _____

Address: _____

Email: _____Health Plan type: _____Genotype& Blood Group_____

Choice of Hospital (Primary) _____

Alternate Hospital (Secondary) _____

State any Pre-Existing Medical Condition (Diabetes, hypertension, Sickle cell, Cancer, Kidney Issue, others….) _____

Dependents Details

SPOUSE

Full Name _____

Birth Date (DD/MM/YYYY) _____Sex_____

Primary Hospital _____

Secondary Hospital _____

Pre-existing Conditions _____

Occupation _____

Telephone No _____

Email _____

CHILD 1

Full Name _____

Birth Date (DD/MM/YYYY) _____ Sex_____

Primary Hospital _____

Secondary Hospital _____

Pre-existing conditions _____

Telephone No _____

CHILD 2

Full Name _____

Birth Date (DD/MM/YYYY) _____Sex_____

Primary Hospital _____

Secondary Hospital _____

Pre-existing Conditions _____

Telephone No _____

CHILD 3

Full Name _____

Birth Date (DD/MM/YYYY) _____ Sex_____

Primary Hospital _____

Secondary Hospital _____

Pre-existing conditions _____

Telephone No _____

CHILD 4

Full Name _____

Birth Date (DD/MM/YYYY) _____Sex_____

Primary Hospital _____

Secondary Hospital _____

Pre-existing Conditions _____

Telephone No _____

DECLARATION

I,……. the assured, do hereby declare that all the foregoing answers are true, that I have not concealed nor withheld anything with which the assurer should be acquainted with in order to assess my eligibility for health insurance. Are there any additional facts affecting the risk of assurance on your health of which the company should be made aware? Yes ____ No____ If Yes, State details:
.....

Pre-existing/Chronic medical condition is defined as an injury, illness, sickness, disease or other physical, medical, mental or nervous condition, disorder or ailment that with reasonable medical certainty existed at the time of purchase of the policy or prior to the purchase of the policy. In a case of non-disclosure, we reserve the right not to treat or to terminate this policy.

I agree that these and all statements I have made or shall make to the assurer or to its medical examiner(s) in connection with this or previous proposal(s) shall be the basis of this contract.

Client Signature _____ Date _____

Spouse's Passport	Child 1 Passport	Child 2 Passport	Child 3 Passport	Child 4 Passport

NOTE: Please affix recent photographs, following sequence as stated. Kindly keep staple pin off faces.