NAGICO INSURANCES

Official Use Only
Policy #: _____
Effective Date: _____
Agent: _____

NAGICARE INDIVIDUAL HEALTH INSURANCE APPLICATION

Note: It is essential that all questions are fully answered.

SECTION I - APPLICANT'S DETAILS

1. Applicant's name in full: _____ (First Name) _____ (Middle Name) _____ (Surname)
2. Applicant's occupation: _____
3. Date of birth: _____ (DD/MM/YYYY) Gender: ◯ Male ◯ Female
4. Marital status: ◯ Single ◯ Married ◯ Divorced ◯ Widow(er) ◯ Separated
5. Tel. #: _____ Fax #: _____ Email: _____
6. Mailing address: _____

SECTION II – COVERAGE DESIRED

7. Premium payment mode: ◯ Annual ◯ Semi-Annual ◯ Quarterly ◯ Monthly
8. I desire insurance on my eligible dependents: ◯ Yes ◯ No If yes, fill the table in no. 10
9. Select the type of coverage required by placing a checkmark in the appropriate check box:
   ◯ Turquoise ◯ Emerald ◯ Gold ◯ Platinum
   ◯ Dental & Vision Care
   Deductible Selected: _____
   Hospitalization Class: ◯ Private room ◯ Semi private room ◯ General ward

SECTION III – DEPENDENT INFORMATION

10. List the dependents in order of age, with oldest first. *(Please provide original or certified copies of birth certificates for all dependents & marriage certificate or common law declaration for dependent spouse. For additional dependents, please list on a separate sheet of paper & attach to the form)*

Full Name of applicant & other members of family	Nationality	Passport no.	Relationship to applicant	Date of birth			Age	Height		Weight
				DD	MM	YY		FT	IN	
1.			◯ Self							
2.			◯ Husband ◯ Wife							
3.			◯ Son ◯ Daughter							
4.			◯ Son ◯ Daughter							
5.			◯ Son ◯ Daughter							
6.			◯ Son ◯ Daughter							
7.			◯ Son ◯ Daughter							
8.			◯ Son ◯ Daughter							

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SECTION IV – OTHER INSURANCE INFORMATION

11. Are you or any family members covered by any other Health Insurance? ◯ Yes ◯ No If yes, state who is covered _____
    ◯ Yourself ◯ Spouse ◯ Dependent children
    State the name of the insurance company _____
    Address where claims are usually submitted _____
    Is the insurance through an employer? ◯ Yes ◯ No If yes, state name of employer _____
12. Is the insurance being applied for herein to replace another Sickness and Accident or other Health Insurance policy that you presently have in effect? ◯ Yes ◯ No If yes, give details _____
13. Have any of the applicants ever engaged in flying as a pilot or crew member, mountain climbing, vehicle racing, scuba diving, skiing, sky diving or any other hazardous activities? ◯ Yes ◯ No If yes, give details _____
14. Have you ever filed a claim for benefits under an insurance policy for yourself or any family member proposed for coverage? ◯ Yes ◯ No If yes, give details _____
15. Has any Insurance Company declined to issue or reinstate or renew, cancelled or modified any Life or Health Insurance on your Life or any family member proposed for coverage? ◯ Yes ◯ No If yes, give details _____
16. To the best of your knowledge, are all the applicants in good health? ◯ Yes ◯ No If no, give details _____
17. In addition to the conditions listed above and to the best of your knowledge and belief, has any person named in this application, within the last five (5) years;
    a. Consulted a physician or other provider for medical or surgical treatment or advice for any condition not listed above? ◯ Yes ◯ No
       If yes, give details _____
    b. Had any departure from good health or symptoms not previously mentioned anywhere above for which they have or have not consulted a physician or other provider? ◯ Yes ◯ No If yes, give details _____
    c. Had a physical examination? ◯ Yes ◯ No If yes, give details _____

If you have checked "Yes" to any question above, please provide complete information below including a copy of a medical report.

Applicant's name	Diagnosis	Treatment	Date	Physician's/hospital's name & address

PLEASE READ CAREFULLY – This section must be dated and signed

It is understood and agreed that:

a. The coverage will become effective upon approval of the application by NAGICO INSURANCES hereafter called 'The Company'. The Company reserves the right to reject or accept any enrollment application. Coverage provided by the Company is not effective until approval of the application and receipt of full payment of applicable premium by the Company.

b. The statements and answers made herein are complete and correct and to the best of my knowledge and belief. Should any statements or answers contained in this application be untrue (if such statements are fraudulent or material to the acceptance of this application) then the contract(s) may be cancelled by the Company and their obligation shall consist only of the return of any subscription charges actually paid, less the amount of any benefits paid under the contract.

c. The Subscriber shall repay to the Company the amount of any payment made in error to the Subscriber on behalf of the Subscriber or any covered family member as the result of a claim.

d. Upon presentation of the original or a photo-copy of this signed questionnaire, I authorize any medical professional, hospital, clinic, other medical or medically related facility, governmental agency or other person or firm to provide the Company information including copies of records concerning advice, care or treatment provided to me and/or my dependents including without limitation, information related to mental illness or use of drugs or alcohol.

Applied for this _____ day of _____ 20 _____

_____ **Applicant's signature**
(on behalf of himself and all others applying for coverage)

_____ **Agent's name & signature**

Important: Please verify that all the questions on this application are answered. All applications with incomplete questions will be returned to the applicant for more information. This will cause a delay in the process of enrollment.