Proposal Form
Term Life Insurance

Please complete this form using black or blue ink. Write in BLOCK LETTERS and tick the relevant items. If your application is incomplete it might cause a delay. Kindly ensure that you submit a fully filled form together with the signed illustration. The proposed life assured and policy owner are required to disclose all information requested. Please retain a copy of this proposal form and other correspondences with us for your future reference.

1.	**Details of Proposed Life Assured**				
A.	Name First Name:			Ms. ☐ Mrs. ☐ Mr. ☐	
	Family Name:			Male ☐ Female ☐	
B.	Nationality		Place of Birth		
C.	Date of Birth				
D.	Marital Status	Single ☐	Married ☐	Widow ☐	Divorced ☐
E.	Email				
	Address				
F.	Residential	Building:			
		Street:			
		PO Box:	City:	Country:	
	Mobile		Telephone		
G.	Office	Building:			
		Street:			
		PO Box:	City:	Country:	
	Mobile		Telephone		
H.	Home Country	Building:			
		Street:			
		PO Box:	City:	Country:	
	Mobile		Telephone		
I.	Correspondence Address	Residential ☐	Office ☐		
J.	**Occupation**	Salaried ☐	Self-Employed ☐	Other ☐	
K.	Job Title				
L.	Company Name				
M.	Nature of Business				
N.	Monthly Income	AED			
O.	Are you a Politically Exposed Person*?	Yes	☐	No	☐

* A Politically Exposed Person is a natural person, who is currently in public office or who left public office within the last two years, such as, heads of state or government; senior government, judicial, legislative or military officials; senior executives of state owned corporations; high ranking politicians; and important political officials at the national level.

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2.	Details of Policy Owner (if other than the Proposed Life Assured)				
A.	Name First Name:				Ms. ☐ Mrs. ☐ Mr. ☐
	Family Name:				Male ☐ Female ☐
B.	Nationality		Place of Birth		
C.	Date of Birth				
D.	Marital Status	Single ☐	Married ☐	Widow ☐	Divorced ☐
E.	Email				
	Address				
F.	Residential	Building:			
		Street:			
		PO Box:	City:	Country:	
	Mobile		Telephone		
G.	Office	Building:			
		Street:			
		PO Box:	City:	Country:	
	Mobile		Telephone		
H.	Home Country	Building:			
		Street:			
		PO Box:	City:	Country:	
	Mobile		Telephone		
I.	Correspondence Address	Residential ☐	Office ☐		
J.	**Occupation**	Salaried ☐	Self-Employed ☐	Other ☐	
K.	Job Title				
L.	Company Name				
M.	Nature of Business				
N.	Monthly Income	AED			
O.	Are you a Politically Exposed Person*?	Yes ☐	No ☐		

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3. Cover Details

A.	Product	Protect ☐		MortPro ☐		Life Guard ☐	
B.	Sum Assured			Currency	AED ☐	USD ☐	
C.	Policy Term		Years	Payment Term		Years	
	Additional Benefits						
D.	Accidental Death Benefit	☐		Term (years)		Amount	
E.	Permanent Total Disability						
	Accident Only ☐	Accident & Sickness ☐		Term (years)		Amount	
F.	Hospital Income Benefit	☐		Term (years)		Amount	
G.	Family Income Benefit	☐		Term (years)		Amount	
H.	Critical Illness Cover						
I.	Additional Cover ☐	Accelerated Cover ☐		Term (years)		Amount	
J.	Waiver of Premium due to disability (mandatory if E is selected)	☐		Term (years)		Amount	
K.	Passive War Risk	☐		Term (years)		Amount	

L. Please confirm the purpose of this insurance application
(i.e. personal cover, family protection, mortgage cover, keyman insurance, partnership protection, etc).

M. Do you have any existing life, disability or critical illness cover already in force with Oman Insurance or any other insurance company? Yes ☐ No ☐

Insurer	Policy Number	Sum Insured	Start Date	Benefits	Policy Term

N. Are you intending to replace any of the above covers with this application? Yes ☐ No ☐

If Yes, please specify the cover to be replaced.

O. Have you applied for concurrent life cover with other insurance companies? Yes ☐ No ☐

If Yes, please provide below details

Insurer	Sum Insured	Benefits	Policy Term

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4. Beneficiaries (shared equally unless otherwise stated)

A. **Primary Beneficiaries**

Name	M/F/Legal Entity	Age	% Share	Relation

B. **Contingency Beneficiaries**

Name	M/F/Legal Entity	Age	% Share	Relation

5. Health and Lifestyle Questionnaire

A. What is your height? cm Weight kg

B. Do you consume alcohol? Yes ☐ No ☐

If 'Yes' please provide the number of units* consumed each week.
*1 unit = single measure of spirits or 125ml glass of wine or 250ml of beer.

C. Do you smoke? Yes ☐ No ☐

We may ask you to undergo a test to validate your answer.

If you have smoked or used any form of tobacco or nicotine products in the last 12 months, please provide type, frequency and quantity (e.g. 20 cigarettes a day, one shisha a week, etc.)?

D. Do you do engage in hazardous sports activities (private flying, sky/skin/scuba diving, motorcycle/motorboat racing, rock climbing, bungee jumping and so on)? Yes ☐ No ☐
If Yes, please complete the relevant questionnaires and submit it together with this application.

E. Have you ever applied for Life or Critical illness cover and not been accepted on normal terms or had an application postponed or declined? Yes ☐ No ☐
If Yes, please state the details of the application below.

Insurer Name	Application Date	Benefits	Decision

F. Are you currently a member of the armed forces (active or reserve list)? If Yes, please fill up the Armed Forces supplementary questionnaire. Yes ☐ No ☐

G. Do you intend to travel outside your current country of residence in the future for holiday or occupation? Yes ☐ No ☐

If Yes, please provide the details below.

Country of travel	Stay Duration	Purpose of visit

H. **Medical Provider**

Please provide details of the doctor / clinic / hospital you are visiting for your well-being (in the UAE or abroad).

Name	
Address	
Phone	

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6. Medical Questionnaire

Medical Questions – Part A

In case you answer Yes to any of the below questions, please fill up the corresponding supplementary questionnaires available with your agent. It is compulsory to submit the questionnaires with this application.

Do you have or have you ever been diagnosed as having:

1.	High blood pressure?	Yes ☐	No ☐
2.	High cholesterol?	Yes ☐	No ☐
3.	Asthma, chronic cough or any lung problem?	Yes ☐	No ☐
4.	Indigestion, ulcer, colitis, chronic or current diarrhea or any disorder of the digestive system?	Yes ☐	No ☐
5.	Diabetes or impaired fasting glucose?	Yes ☐	No ☐
6.	Arthritis, spinal (back & neck), gout, or any joint, muscular or bone disorder?	Yes ☐	No ☐
7.	Growths, cysts, lumps, or abnormal skin lesions?	Yes ☐	No ☐
8.	Mental health problems such as depression, anxiety, bipolar, eating disorder?	Yes ☐	No ☐

Medical Questions – Part B

In case you answer Yes to any of the below questions, please give full details in the space provided in section 8. Please use separate sheet if necessary.

Have you ever been told that you currently have or had:

9.	Epilepsy, fits, multiple sclerosis, nervous breakdown or any disorder of the brain or nervous system?	Yes ☐	No ☐
10.	Chest pain, heart attack, murmur, palpitation or any heart disorder?	Yes ☐	No ☐
11.	Paralysis, stroke or transient ischemic attack?	Yes ☐	No ☐
12.	Liver or gall bladder disorders (i.e. fatty liver, gallstones)?	Yes ☐	No ☐
13.	Kidney disorder or disorder of the urinary system (i.e. kidney stones, blood/protein in the urine)?	Yes ☐	No ☐
14.	Cancer or tumor (benign or malignant)?	Yes ☐	No ☐
15.	Enlarged gland or other glandular disorders (i.e. thyroid)?	Yes ☐	No ☐
16.	Anemia, thalassemia, hemophilia and other blood disorder?	Yes ☐	No ☐
17.	Unexplained recurrent or persistent fever, weight loss, or any skin disorder?	Yes ☐	No ☐
18.	Any sexual transmitted disease (i.e. syphilis, gonorrhea) or viral disease (AIDS, hepatitis)	Yes ☐	No ☐
19.	Prostate disorders (male), cervical or ovarian disorders (female)?	Yes ☐	No ☐
20.	Impaired vision, speech or hearing or any disorder of the eyes and ears?	Yes ☐	No ☐
21.	Any other illness, injury, disability, deformity or physical defect in any part of your body not mentioned above?	Yes ☐	No ☐

Medical Questions – Part C

In case you answer Yes to any of the below questions, please give full details in the space provided in section 8. Please use separate sheet if necessary.

22.	Are you present in good health and capable to do daily tasks?	Yes ☐	No ☐
23.	Has your weight changed during the last 12 months?	Yes ☐	No ☐
	If Yes, by how much and why?		
24.	During the past five (5) years, have you consulted, been examined or treated by any physician or health practitioners; had an X-ray, ECG or any laboratory tests; had observation or treatment in any hospital or other medical facility; or been advised to have surgical operation?	Yes ☐	No ☐
25.	Have you ever received treatment for any blood products or undergone blood transfusion?	Yes ☐	No ☐
26.	Have you ever suffered from any illness lasting or requiring treatment for more than 14 days?	Yes ☐	No ☐

6.	Medical Questionnaire (continued)		
27.	Are you currently taking any medication or receiving any form of medical treatment?	Yes ☐	No ☐
28.	Have you ever taken drugs other than for medical purpose?	Yes ☐	No ☐
29.	Do you intend to seek medical advice, treatment, or any medical tests or surgical operation in the near future?	Yes ☐	No ☐
	For Women only In case you answer Yes to any of the below questions, please give full details in the space provided at the end of section 8. Please use separate sheet if necessary.		
30.	Are you currently pregnant?	Yes ☐	No ☐
	If Yes, how many months? Please secure an attending physician statement from your obstetrician regarding the status of the pregnancy (i.e. proceeding as normal – without complications).		
31.	Have you ever had any disorder of the breasts or of menstruation?	Yes ☐	No ☐
32.	Have you ever had any pregnancy related complications (i.e. gestational DM, preeclampsia)?	Yes ☐	No ☐

7. Additional Information (based on responses in section 6)

Please use additional sheet in case of more details.

Question No.	Details of disease/disorder, date and duration of illness, type of treatment, doctors consulted. Please provide copies of the reports related to these together with the application.

8. Family History

Please provide details of your family history below.

Relation	Age now / Age at death	State of Health / Cause of Death	Age at onset of disease
Father			
Mother			
Brother			
Brother			
Sister			
Sister			

9. Declaration and Authorization

I declare that I have clearly understood the terms and conditions of the product I am applying for and have clearly understood its features and benefits including the associated risk factors and charges. I further declare that I have answered all the questions in this proposal form after clearly understanding them and that I have duly signed this form at required places. I confirm to have fully understood the nature of the questions and the importance of disclosing all information while answering such questions. I declare that the answers given by me to all questions in the proposal form are true and complete in every respect and that I have not withheld any material information or suppressed any material fact. I undertake to notify Oman Insurance Company ('Company') of any change in any information given by me in this proposal form. I confirm that I clearly understand that in case of any misstatement, misrepresentation and/or suppression of any data and/or information and/or where I do not inform the Company of any changes in information provided in this proposal form, the Company has the right to repudiate any and all claim(s) under any policy if issued based on this proposal form and/or at sole discretion of the Company to consider any issued policy based on this proposal form as void. I hereby authorize Oman Insurance Company to contact me anytime and through any medium (phone, email, sms etc.) for purpose of obtaining more information about this proposal form and/or for keeping me informed about their other products and/or promotion activities. I hereby also authorize my past/present employer/business associates, medical practitioner(s)/hospitals/laboratories/medical providers, insurance companies, financial institutions to release to Oman Insurance Company all details, records, facts and information (including medical details, KYC records, AML-CTF &FATCA details) as required anytime by Oman Insurance Company for assessment of risk and/or for processing of claims if subsequently an insurance policy is issued based on this proposal form. I also accept the consequences of any political risks associated with the de-pegging/revaluation of the UAE Dirhams vis-à-vis the US Dollars. This proposal form shall be a part of the insurance policy in case of its acceptance by the Company.

Date & Place of Signing		Insured's Signature	
Date & Place of Signing		Policy Owner's Signature	

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10. Premium Payment Details

A.	Who will pay for this policy?	Policy Owner ☐	Life Assured ☐		
B.	Premium Type	Single ☐	Regular ☐		
C.	Payment Frequency (if regular)	Annual ☐	Semi Annual ☐	Quarterly ☐	Monthly ☐
D.	Payment Method	Cheque ☐	Credit Card ☐	Direct Debit ☐	

Please complete the appropriate 'Payment Method' section.
All cheques must be payable to 'Oman Insurance Company (P.S.C.)

E.	Total Amount (in words)		In figure (USD)	

For payment by Cheque

A.	Name of Issuing bank:			
B.	Cheque No:		Dated	

For payment by Credit Card

A.	Name of Card Holder				
B.	Credit Card No		Card Expiry Date	/	
C.	Card Type	Visa ☐	Mastercard ☐		
D.	Premium Payment	Initial Premium Only ☐	Initial & Renewal Premium ☐		

E. I as the Proposer/Policyholder, hereby agree to make the premium payments to Oman Insurance Company ('Company) and authorize the Company to debit the above mentioned credit card account with the premium amount as applicable and required for the insurance policy if being issued based on this proposal form. I hereby also authorize the Company to continue debiting the above mentioned credit card account with the premium amounts as subsequently required during the policy term and to receive credit for the same, till such time this authorization is revoked/cancelled by me. I agree to inform the Company if the credit card number as mentioned and authorized herein for debits expires or needs to be changed or stopped.

Date Signature

For Direct Debit

A.	Name of Issuing Bank	
B.	Account Number	
C.	IBAN (23 digits)	

D. I as the Proposer/Policyholder, wish to avail direct debit from my above mentioned bank account number and I hereby authorize my above mentioned bank to debit the premium payment amount as mentioned above from my above mentioned bank account number in favor of Oman Insurance Company, and to continue the direct debit from my above bank account for premium amounts as required by Oman Insurance Company, till such time this authorization is revoked/cancelled by me.

Date Signature

11. Declaration

I understand and agree that notwithstanding this standing/payment instruction, I will continue to be responsible for payment of required premiums to the Company within the required premium due-dates and that I will not hold Oman Insurance Company (the "Company") responsible in any manner for any actions initiated by the Company (including lapse/termination of policy) for reasons of any outstanding premium as on such premium due date. I confirm that the above filled in details are complete and true and that I will not hold the Company responsible in any manner for any premium payment being delayed or not being effected at all. I also agree that the Company is not obligated to inform me if any of my premium payment is not realized/received by the Company and that I alone will be responsible for consequences of such unpaid premium amounts. In the event of non-realization of first premium deposit, the policy if issued shall be treated as cancelled/void from inception.

Date Signature

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Agent's Report

1. Questionnaire

A.	How long have you known the proposed life assured?	
B.	Explain clearly how well you know the proposed life assured.	
C.	Are you related to the proposed assured?	Yes ☐ No ☐
	If Yes, please provide details.	
D.	Are you aware of the below in relation to the proposed life assured:	
	Any threat or attempted violence on him/her or any of the immediate family members?	Yes ☐ No ☐
	Membership of any civic, social, political, labor or any other organization?	Yes ☐ No ☐
	If Yes, please state the name of the organization.	
	Involvement in lawsuit or court litigation?	Yes ☐ No ☐
	Involvement in political activities?	Yes ☐ No ☐
	Involvement in lawsuit or court litigation?	Yes ☐ No ☐
	Undesirable habit (like gambling, excessive smoking, alcohol consumption and drug abuse)?	Yes ☐ No ☐
E.	Do you know of any abnormality in the health and appearance of the proposed life assured?	Yes ☐ No ☐
	If Yes, please provide details.	

Spouse Details if proposed assured is a female

F.	Name		Age	
G.	Occupation		Monthly Income (AED)	

H. Details of life insurance cover

Insurer	Policy Number	Sum Insured	Start Date	Benefits	Policy Term

2. Agent's Declaration

I hereby certify that I personally saw the proposed assured (and owner and joint life if applicable) and the answers to the questions in this application and reports are correct to the best of my knowledge and belief. I know nothing detrimental to the risk that is not recorder herein.

Code		Name	
Date		Signature	