Oman Insurance Company (P. S. C.)

Head Office : P. O. Box : 5209, Dubai, United Arab Emirates
Tel. : **2660133** – Telex : **46030** OIC EM - Telefax : **2669103** - Cable Address : **"TAMINOMAN"**
Wed Site : www.oicem.com - E-Mail : life@oicem.com

1 – Personal Details of life to be Assured :

a) Full Name Mr./ Mrs./ Miss

b) Date of Birth | Age | Place of Birth | Nationality | Passport No.

c) Marital Status ? Mar. ☐ Sing. ☐ Div. ☐ Wid. ☐ Sep. ☐

d) Permanent Address | Tel. No. Office / Res.

Send Premium Notices to

e) Name & address of Employer | Occupation & Nature of Business | Describe Duties

f) Monthly Income : ☐ Salaried ☐ Self – employed ☐ Other

2 – Details of Assurance :

a) Type of Assured ☐ With Profit ☐ Without Profit

b) Sum Assured | c) Term | d) Currency

e) Additional Benefits :

☐ Accident Indemnity Benefit ..... For ..... Years ☐ Accidental Death Benefit ..... For ..... Years

☐ Level Term Assurance Benefit ..... For ..... Years ☐ Family Income Benefit ..... For ..... Years

☐ Hospital Indemnity Benefit ..... For ..... Years ☐ Waiver of Premium Benefit for ..... Years

☐ Permanent Total Disability Benefit ..... For ..... Years ☐ Critical Illness Cover ..... For ..... Years

f) Mode of Premium payment ☐ Annual ☐ Semi – Annual ☐ Quarterly

g) Non-forfeiture Options : ☐ Paid up ☐ Automatic premium Loan ☐ Extended Term Insurance

3 – List below all life assurance now inforce on your life and applied for

Name of Co.	Policy No.	Plan	Sum Assured	Year Issued	Other Benefits	Amount

4 – BENEFICIARIES (Include address if not same as Residence in 1. Above)

(PRIMARY)

a- Full Name ..... Age ..... Relationship .....

(CONTINGENT)

B- Full Name ..... Age ..... Relationship .....

5 – owner (To be completed if Owner is not the Proposed Insured)

a) Full Name : .....

b) Address for correspondence | P.O. Box No. : | City | Country | Tel. No.

6 – Medical Information

a) Please state name and address of the Doctor you last consulted : .....

Reason for Consultation ..... Date .....

(If answer is Check Up state exact reason and results)

b) Please state : Your Height ..... (M) Weight ..... Kgs. Alcohol Consumption : ..... Daily/Weekly Cigarette Smoking ..... Daily/weekly

	Yes.	No.
c) Has your weight changed during the last year ?		
d) Have you ever suffered from : High Blood Pressure, Heart Disease, Rheumatic Fever, Diabetes or Sugar in your urine, Cancer, Lung or Kidney Disease, Nervous disorder or disorder of the Stomach or Abdominal Organs?	☐	☐
e) Have you ever had an X-ray ECG or other diagnostic tests ?	☐	☐
f) 1- Have you consulted a Doctor in the last 5 years for any other condition ?	☐	☐
2- Are you currently receiving any form of medical treatment ?	☐	☐
3- Do you have any physical deformity or defect of vision or hearing ?	☐	☐

	Yes.	No.
g) Do you intend to seek medical advice, treatment, or have any medical tests / operation planned ?	☐	☐
h) AIDS (Acquired Immune Deficiency Syndrome) Describe in detail any affirmative answers ?	☐	☐
1) Have you received medical advice, or treatment, in connection with AIDS or an AIDS related condition or a sexually transmitted disease ?	☐	☐
2) Have you been told you had AIDS or Aids Related Complex ?	☐	☐
3) Have you had or been told had a positive blood test for antibodies to the AIDS virus (Human Immune Deficiency Virus) ?	☐	☐
4) Do you have any of the following which are unexplained : fatigue, weight loss, diarrhoea, enlarged lymph nodes, or unusual skin lesions ?	☐	☐
i) Are you at present in good health and capable to work ? (if not give reason)	☐	☐
j) Has any of your immediate family suffered from Diabetes, High Blood Pressure, Heart Disease, Stroke or Tuber Culosis. Cancer, Kidney Disease ?	☐	☐
k) Females 1- Are you pregnant ? (if yes state duration) 2- Disorders of the breast or female organs or Complications of pregnancy ?	☐	☐

7 – Other Information :

a) Do you participate or intend to engage in any hazardous activities related to your occupation or recreation (e.g. scuba diving, mountaineering, motor sports) or aviation other than as a passenger on scheduled services ? (if applicable complete questionnaire)	☐	☐
b) Has any application for insurance on your life (life, accident. Critical illness or health) been declined, Postponed or accepted on special terms ?	☐	☐
C) Are you currently making, or do you intend to make, any life, accident, critical illness or health proposals to any other insurance company ?	☐	☐

Please give below full details for any yes answer including duration of any illness and doctor(s) consulted, use separate sheet, if necessary

Q. No.	Date	Details

Special Instructions	Home Office Acknowledgment

Paid with this Application for proposed : Life Insurance ..... Health Insurance ..... Total .....

DECLARATION : The Proposed Insurance and the Applicant, if the Applicant is other than the Proposed Insured, represent, each to the best of his knowledge and belief, that all statements and answers given in this application are true, complete and correctly recorded, and expressly agree as follows ; (1) This application together with those in any required medical examination, questionnaire or amendments shall be the basis for any policy issued on this application, (2) Except as otherwise provided in the conditional receipt, if issued, with same number of this application, any policy issued on this application shall not take effect unless all of the following conditions are met : (a) The full premium is paid (b) All of the statements and answers given in this application continue to be true and complete as of the date of delivery of the policy; (3) No information acquired by any representative of the Company shall be binding upon the Company unless set out in writing in this application; (4) No agent or medical examiner is authorized to accept risk or to make, modify or discharge any contract of insurance or waive any of the Company rights or requirements; (5) Acceptance of a policy issued on this application shall constitute a ratification of any modification made by the Company as recorded under Home Office Endorsements, except that in those states where it is required by law, any change in amount, classification, plan of insurance or benefits shall be subject to written ratification by the Proposed Insured or Applicant. (6) (a) If the Applicant is not the Proposed Insured, any life insurance issued on this application shall be owned by the Applicant, and the power to exercise all right, privileges, options and elections granted or conferred by the provisions of such policy are hereby vested solely in the Applicant. (b) Any health insurance policy issued on this application shall be owned by the Proposed Insured.

AUTHORIZATION : As the Proposed Insured (or Payor) I authorize any physician, hospital, clinic, insurance company or other organization, institution or person having any records or knowledge of me or any family members to be covered, or of our health, to give Oman Insurance Company Dubai – U.A.E. any and all information about us with reference to our health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. A photographic copy of the authorization shall be as the original.

Application dated at ..... On this ..... Day of ..... 200 .....

Witness .....

..... Signature of proposed insured (Signature of payor if proposed insured is under age 15)

Licensed Resident ..... Agent ..... Code No. .....

..... Signature of applicant (owner) if other than proposed insured.

IMPORTANT : Before signing this declaration please check that the answers given in the application are correct. An incorrect answer may invalidate the policy.

IMPORTANT NOTICE :

Clients are always requested to pay their premium payments through Bank Drafts or crossed Cheques drawn in favour of Oman Insurance Co. (p.s.c.) preferably bearing the name & Application / Policy number Payment by Cash is accepted only at the Company's Office or at branhes of Mashreq Bank on our behalf where such payment will be promptly acknowledged through a proper receipt issued on behalf of the Manager.

شركة عمان للتأمين (ش.م.ع.)

This forms part of the Application for Life Insurance.

Application Number: _____

PAYMENT WAY:

☐ **Cash** ☐ **Cheque** ☐ **Direct Debit*** ☐ **Credit Card****

Amount (in words): AED_____

_____ AED

***Bank Payment Order:**

Account Holder's Name: _____

Account Number: _____ Bank Name: _____

Branch / Address: _____

_____

Account Holder's Signature above Printed Name
(if other than the Proposed Life Insured)

****Credit Card Details:** ☐ Initial Premium Only ☐ Initial & Renewal Premiums

Credit Card Holder's Name: _____

Credit Card Number: | | | | | - | | | | | - | | | | | - | | | | |

Expiry Date: (mm/yy) _____ / _____ Bank Name: _____

_____

Credit Card Holder's Signature above Printed Name
(if other than the Proposed Life Insured)

If Credit Card payment will be valid only for INITIAL PREMIUM, please check other PAYMENT WAY for succeeding premiums.

_____ _____

Proposed Life Insured's Signature above Printed Name Date (dd-mm-yyyy)

_____ _____

Agent's Signature above Printed Name Date (dd-mm-yyyy)