Form SL10

NASFUND CONTRIBUTORS SAVINGS & LOAN SOCIETY LIMITED
P.O Box 7732, Boroko, National Capital District, Tel: 313 2000 Fax: 320 0913

NASCARE MEDICAL PROPOSAL FORM

Surname Name: Given Name: Membership No: ☐☐☐☐☐☐☐

CONTACT DETAILS:

Postal Mailing Address: Home Phone/ Mobile:

Home Village: District: Province:

PERSONAL DETAILS:

Date of Birth: / / Sex: ☐ Male ☐ Female Email:

Nationality: Occupation: Employer

Spouse/ Children's name	Date of Birth	Sex	Own or legally adopted

NATURAL PARENTS' NAMES

Member's Father		Alive/ Deceased	Spouse's Father		Alive/ Deceased
Member's mother		Alive/ Deceased	Spouse's mother		Alive/ Deceased

I/We hereby declare that the above answers and statements are true, and that I/We have withheld no information whatever regarding this proposal. I/We agree that this Declaration and answers given above, as well as any proposal or declaration or statement made in writing by me/ourselves or anyone acting on my/our behalf shall form the basis of the contact between me/ourselves. I/We hereby further declare that I/We agree that in the event the declaration shall contain any misstatement, misrepresentations, suppression and or/fraud, the issuance of the policy shall not be nor deemed to be a waiver of such misstatement, misrepresentation, suppression and/ or fraud.

I /We hereby authorise any hospital, surgeon, medical practitioner or clinic or other person who attended to me/us for any reason to disclose to the Insurance Company any and all information with respect to any illness or injury and to provide copies of all hospital or medical records/certifications, including any earlier medical history. A photocopy of this authorisation shall be considered as effective and valid as the original.

I/We acknowledge that the liability of the Insurance Company does not commence until this proposal is accepted by and premium paid to the
Insurance Company.

My usual doctor/physician is:

Address: Telephone:

Fax: Email:

Signature of Principal Insured Member: Date:

DECLARATION

		NO	YES	If yes, please provide details
1.	a. Had Medical Insurance with other company prior to this application			
2.	Have you or any of the persons to be insured;			
	a. Suffered or have any physical defect, infirmity or congenital conditions?			
	b. Currently under observation or receiving treatment or taking any medication?			
	c. Ever been advised to have a surgical operation which has not been performed?			
3	Have you been told that you suffer from			
	a. Chronic cough, spitting blood, asthma, hay fever, pleurisy, tuberculosis or any other disease of the respiratory system?			
	b. High or low blood pressure, heart disease, chest pain, heart attack, shortness of breath, palpitations or any other disorder of the heart or blood vessels?			
	c. Epilepsy fits, dizziness, mental or nervous disorder?			
	d. Diabetes, sugar or blood in urine, kidney, colic or hernia?			
	e. Disease of the eyes, ears, nose or throat?			
	f. Arthritis, sciatica, rheumatism, back, spine, bone joint, muscle or skin disorder			
	g. Ulcer or disorder of the stomach, intestines, hemorrhoids or rectal disorder?			
	h. Ulcer or disorder of the stomach, intestines, hemorrhoids or rectal disorder?			
	i. Cancer, tumor or growth of any kind of any organ system?			
	j. Anaemia, Thyroid disorder (such as goitre) or Rheumatic Fever?			
	k. Sexually transmitted diseases such as syphilis, gonorrhea or non-specific arthritis?			
	l. HIV, AIDS or AIDS-related conditions?			
	m. Any illness, disease or injury not mentioned above?			