Capital
INSURANCE GROUP
THE PACIFIC'S INSURER

Medical Proposal

Members details

First Name ..... Last Name ..... Sex: M ☐ F ☐

Date of birth ..... (dd/mm/yyyy) Marital Status .....

Bank/Acct No. (Optional) .....

Residential Address .....

.....

E-mail .....

Tel. (Home) ..... Tel. (Bus.) .....

Name of Employer ..... Business address .....

DEPENDENT DETAILS

Couple & Family Plan – This policy insures your dependents children up to the age 18-25 who are UNMARRIED Full Time student.

Relationship to Insured	Name	Occupation	Sex M or F	Date Of Birth
Spouse				
1st Child				
2nd Child				
3rd Child				
4th Child				
5th Child				
6th Child				

Capital INSURANCE GROUP
THE PACIFIC'S INSURER

Medical Proposal

Beneficiaries

Name	Relationship to Member	Sex M or F	Date Of Birth	Beneficiary %

GP Details

Both pages must be completed even if all questions are answered no

Member GP Details

Member's Physician (Name) ..... Telephone .....

Physician's Address .....

If you have changed doctors within the last 3 months, please give the name and address of your previous doctor .

.....

.....

Capital INSURANCE GROUP
THE PACIFIC'S INSURER

Medical Proposal

IMPORTANT QUESTIONS	Tick √ Yes or No												
	Employee		Spouse		1st Child		2nd Child		3rd Child		4th Child		Comments
	H	W	H	W									
i) Please state the member & spouse' (if applicable) height & weight. Please state in cm and kg.													
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
A. Do you or your dependents engage in any hazardous activity or occupation such as scuba/skin diving, motor racing or other professional sports? If so give details of location and frequency. *Note: this is an exclusion under the policy unless declared and accepted in writing by us.*													
B Has any accident, sickness or Life Company ever declined a proposal from you, or cancelled or declined to renew your policy or required it to be endorsed, or required an increased premium to be paid? If so, please provide details.													
C. Have you ever made a claim against any company for accident or illness? If so, state the name of the company, date amount and nature of claim.													
D. Are you, your spouse or other dependents aware of any condition that is likely to require medical treatment in the future? If so, please provide details.													
E. Any sexually transmitted disease, eg, syphilis, gonorrhea, non-specific urethritis, herpes, HIV infection or AIDS? *Note: these are policy exclusions and claims relating hereto will NOT be accepted.*													
F. Are you aware of any existing illness or injury that you have received a diagnosis, treatment or considered seeking a diagnosis or treatment for at any time prior to the date of this application?													
G. Is there anything else that you're aware of that you think might affect our decision to offer cover to you?													
H. Do you have any pre existing policies with Capital Life Insurance Co. Ltd? If so, please provide details.													

Declaration & Authorization *(Please read carefully before signing)*

IMPORTANT NOTES

- Please note that your answers to the questions on this form will be used to assess this Proposal. All material facts must be disclosed since part or all of the benefit might be forfeited if relevant information were to be withheld. A material fact is one that is likely to influence the assessment and acceptance of the Proposal. If you are unsure whether a particular fact is material, you should disclose it. You must not assume that we shall be asking your doctor for confirmation of what you have told us.
- Cover will not start until we have assessed and accepted your application, and the first premium has been paid. If you have a birthday while your application is being processed, the terms may differ from those originally quoted.
- In most instances your payments will be as originally quoted. Revised terms may be offered to you, but occasionally we may be unable to offer any terms.
- We may ask you to contact your doctor to speed up the completion of reports that we have requested.
- If we ask you to attend a medical examination, it will be necessary for us to share the application information with another company authorized by us. They will make the arrangements for the examination to take place.
- It may be necessary to send your application and relevant medical reports to our Reassurers for their opinion or agreement of the terms offered if they are to participate in cover.
- On occasion the email of medical reports may help to ensure a speedier assessment of your application. We only accept emailed information direct to our Underwriting email address. This ensures that we maintain strict confidentiality. If you do not agree to allow the emailing of information, please indicate by deleting the appropriate section of declaration.

ACCESS TO MEDICAL REPORTS

- It may be necessary for us to obtain medical reports to support your application. Before we can ask any doctor that you have consulted to complete a report, we need your permission. Although there are no legal provisions in PNG, we follow best – UK legislation. None in PNG practice and undertake the following:
- You do not have to give your consent, but if you do not, we may be unable to proceed. This does not stop you from applying to other companies for insurance.
- You can ask to see the report before the doctor returns it to us. If you do, we shall tell the doctor to retain the report for 21 days so that you can arrange to see it. If you have not made arrangements to see the report within this time, your doctor will send the report to us.
- If you choose not to see the report at this stage, you may ask the doctor for a copy within 6 months of it being sent to us. A duplicate report can be sent to your doctor on request should you wish to see it at a later date.
- If you consider any aspect of the report to be incorrect or misleading, you may ask the doctor to amend it. If your doctor refuses to make the amendments, you may ask him/her to attach a statement outlining your views, which will then accompany the report.
- Your doctor can withhold access to the report if he/she feels that it would cause physical or mental harm to you or others.
- Your medical report will contain details of relevant consultations, treatment, operations, investigations and test results that you have undergone at any surgery, hospital or clinic.
- I/We do not* wish to see the report before it is sent to Capital Life Insurance Limited. (*Only delete the word "not" if you wish to see the report before it is sent).

Capital INSURANCE GROUP
THE PACIFIC'S INSURER

Medical Proposal

DECLARATION

Please sign this Declaration once you have read it together with the important Notes. If you are unsure as to whether any information should be given, you should provide it. If you are applying for insurance with other companies at the same time, by signing the Declaration you are consenting to copies of medical reports being sent to these other companies at their request. However, if we are approached by another company to provide copies of highly sensitive information we shall ask for your specific written permission before doing so.

- I/We will inform you immediately of any changes that occur before the plan starts. I/We understand that failure to do so may result in the contract being declared void, and that a claim for the proceeds may not be paid.
- To the best of my/our knowledge and belief all the statements made, which includes anything I/We may have said, have been recorded accurately in this application or are attached in a sealed Private and Confidential envelope, and are true and complete.

☐ This disclosure will form the basis of the contract.

☐ Please tick if you have attached a Private and Confidential envelope.

- I/We agree to Capital Life Insurance Limited obtaining medical information from any doctor whom I/We have consulted about my/our physical or mental health, in order to assess my/our proposal. You may obtain relevant information from other insurers about previous or concurrent applications for life, critical illness, sickness, disability, accident or private medical insurance that I/we have applied for. I/We authorize those asked for such information to provide it on the production of a copy of this consent. This consent allows Capital Life Insurance Limited to obtain medical reports at any time during the life of the cover or after my death to support any claim made on the cover proceeds.
- This information can also be used to maintain management information for business analysis.
- We agree that a copy of the agreement given in this declaration will have the validity of the original.
- I/We agree to Capital Life Insurance Group accepting medical reports emailed directly to the company from my doctor's surgery. I/We also do not* object to copies of the report being emailed to another company that I have applied at their request (*Delete the word "not" if you do not wish us to email information.)

By signing this declaration, I am/we are allowing Capital Life Insurance Limited to process my/our application using the information that I/we have provided. This information can also be used to process any claim made on this policy.

Member's Signature..... Signed at (City/ Town)..... Date.....

EMPLOYER ACKNOWLEDGEMENT (HR/AUTHORISED ADMINISTRATOR)

Name ..... Position..... Date.....

FOR OFFICE USE ONLY: UNDERWRITING COMMENTS

Date processed.....
(dd/mm/yyyy)