وفـــا للتـــأميـن
Wafa Insurance

PROPOSAL FORM – PERSONAL ACCIDENT INSURANCE

Name of Proposer (in full) _____

Address _____

_____

Name and Address of person to be insured (if different from Proposer above)

_____

_____

N.B. Where the person to be insured is not the Proposer, all personal details must be completed by the person to be insured, and the Declaration must be signed by both the Proposer and the person to be insured.

Occupation (please give full details):

_____

_____

Then please delete as necessary

Professional, administrative or clerical only

Supervising only ☐ Yes ☐ No

Working manually without machinery ☐ Yes ☐ No

Using machinery ☐ Yes ☐ No

Date of birth _____ ID NO/IQAMA NO _____

Period of Insurance : From _____ To _____ (both dates inclusive)

1. Height: _____ Weight: _____
2. Have you consulted a doctor or medical attendant in connection with illness or accident during the last 5 years? ☐ Yes ☐ No
3. Have you ever suffered from any infection of the eyes, ears, heart, from fits, paralysis, slipped disc or any other disorders of the back, nervous disorders, varicose veins, rupture or any other mental or physical infirmity or defect? ☐ Yes ☐ No
4. Are you now in sound health and free from all physical defects or infirmities? ☐ Yes ☐ No
5. Are there any circumstances connected with you occupation, habits or pursuits, which render you specially liable to accidents? (Please see note of main policy exceptions attached) ☐ Yes ☐ No
5. 6. Do you drive, or travel by any motor vehicle (other than a public transport vehicle) in connection with your occupation during working hours? ☐ Yes ☐ No

7. Are you now insured or proposing to effect further insurance against Personal Accident with this or any other Insurer? ☐ Yes ☐ No

8. Have you ever had a Personal Accident, Sickness or life Assurance declined, terminated or subject to special terms by any Insurer? ☐ Yes ☐ No

9. Beneficiary : Relationship with Proposer & Name and address

_____

_____

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS YES, PLEASE GIVE FULL DETAILS OVERLEAF

10. Please insert the compensation required below:-

Result of Bodily Injury (Please see Definitions of cover attached)	Compensation selected	Premium
Section 1 – Death		
Section 2 – Restricted Permanent Disablement		
Section 3– Full Permanent Disablement		
Section 4 – Temporary Total Disablement	Per week	
Section 5 – Medical Expenses a maximum of	Per Accident	

11. Under Section 4 do you wish to exclude payment by the Insurer for an initial period of disablement?
If 'yes', please insert the number of weeks (2, 4 or 8) weeks _____ % discount

TOTAL _____

Declaration:
I/We declare that the answers given in the Proposal are true to the best of my/our knowledge and i/we have withheld no information whatever which might influence the decision of the Insurer regarding the Proposal.

I/We agree that the Proposal shall be incorporated in and shall form the basis of the contract between the Proposer and the Insurer and a policy in the form issued by the Insurer for the insurance now proposed is acceptable.

I /We agree to inform the Insurer of any material change in risk.

I/We have understood the terms and conditions of the Policy contract which I/We are entering into, as explained by the Company's representative.

Signature of the Proposer _____

Date _____

N.B. Cover does not commence until the Proposal is accepted by the Insurer and the first premium paid.

Agent / Brokers name : _____
Code number : _____