SAHAN INSURANCE
MEDICAL MEMBER APPLICATION FORM

PERSONAL PARTICULARS OF THE APPLICANT

Name of Insured Company	Title (Mr./Mrs./Miss.)	Proposal Commencement Date (DD/MM/YYYY)	
First Name	Middle Name	Last Name	ID/Passport No.
Gender (M/F)	Marital Status	Date of Birth (DD/MM/YYYY)	Mobile No.
Alternative Mobile No.	Blood Group	Height (cm)	Weight (kg)
Email Address	Occupation/Designation	Date of Employment	Staff Payroll No.

PARTICULARS OF DEPENDENTS TO BE INCLUDED ON COVER

No.	Full Name	Dependent Type	Gender	Date of Birth	ID No.
1.					

HEALTH QUESTIONS (Must Complete All Questions)

1. Has any of you or your dependents been hospitalized in the last 3 years? [ ] Yes [ ] No

2. Have any of you or your dependents ever had an accident resulting in a permanent injury? [ ] Yes [ ] No

3. Do any of you suffer from any disease that is recurrent in nature? [ ] Yes [ ] No

4. Are any of you on regular medication? [ ] Yes [ ] No

5. Do any of you have any kind of physical disability? [ ] Yes [ ] No

If you answered 'Yes' to any question, please provide details below:

No.	Name of Applicant	Ailment/Disorder	Date Diagnosed	Current Status

DECLARATION

I declare that to the best of my knowledge, all the information provided in this form is accurate. I authorize Sahan Insurance and its representatives to request past, present, and future medical information from relevant third parties and medical practitioners in relation to this or any related claim. I understand that any deliberate misrepresentation or omission of material facts may result in denial of benefits or recovery of incurred costs.

Signature of Principal Member: _____	Date: _____
Agency Name & Stamp: _____	