Capital Taiyo Life Insurance

Health Insurance Proposal

Agent Name ----------

Agent No ----------

Date ……../……../……

Name …… Father's Name ……

Date of birth ……D …….M …….Y Age …… (How old will you be in next year?)

Marital Status Yes ☐ / No ☐ Male ☐ / Female ☐ Nationality……

Body Weight…… Lb Height …… Feet …… inches

Occupation …… Ph Number ……

N.R.C No/ Passport No. ……

Home Town …… Township …… City …… Region

Address ……

Purpose of residing in Myanmar Business Purpose ☐ Visiting ☐ Others ☐

Guardian of Insured (If the insured person is under 18) ……

Beneficiary Name…… Date of birth ……D …….M …….Y

Relationship to the Insured…… Ph No. ……

N.R.C No./ Passport No. ……

Address ……

Premium Payment

For Group	Monthly ☐	3 months ☐	6 months ☐	Yearly ☐
Individual	6 months ☐	yearly ☐		

Both Option (1) and option (2) can be bought in companion with Basic Cover. The selective additional covers are not sold separately. The insured may purchase only up to extra 2units of the Basic (Additional) Unit.

Purchased Unit

No	Type Of Coverage	Benefits	Purchased Unit
1.	Basic coverage	- Hospitalization Due to Disease - Hospitalization Due to Accident - Accidental Death - Death Due to Disease	1 unit to 10 unit
2.	Option (1)	- Surgery - Treatment for Miscarriage (At the Hospital Only)	1 unit to 10 unit
3.	Option (2)	- Outpatient Treatment	1 unit to 10 unit

Current Health Condition

(1) Do you have any prescriptions, medical check-up, physical examination and treatment (including hospitalization and surgery) by doctor within three months? Yes ☐ No ☐

(2) Do you have any prescriptions, medical check-up, physical examination and treatment (including hospitalization and surgery) within 5 years according to the diseases mentioned in the table below?

Heart Disease/ Blood Pressure	Hypertension	Yes ☐ No ☐	Arrhythmia	Yes ☐ No ☐
	Myocardial Infract	Yes ☐ No ☐	Valvular Heart Disease	Yes ☐ No ☐
	Heart Rhythm Disorder (arrhythmias)			Yes ☐ No ☐
Cerebral	Intracranial Hemorrhage	Yes ☐ No ☐	Cerebral Infract	Yes ☐ No ☐
	Bleeding from Membrane	Yes ☐ No ☐	Intracranial Aneurysm	Yes ☐ No ☐
Mental/ Nerve	Depression	Yes ☐ No ☐	Schizophrenia	Yes ☐ No ☐
	Alcohol Dependent Syndrome	Yes ☐ No ☐	epilepsy	Yes ☐ No ☐
	Memory Impairment			Yes ☐ No ☐
Lungs	Lungs Disease			Yes ☐ No ☐
Stomach/Liver/Kidney	Gastric Ulcer	Yes ☐ No ☐	Hepatitis	Yes ☐ No ☐
	Cirrhosis	Yes ☐ No ☐	Nephritis	Yes ☐ No ☐
	Nephrosis	Yes ☐ No ☐	Kidney Failure	Yes ☐ No ☐
Vision	Cataract	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐
	Retinitis Pigmentosa			Yes ☐ No ☐
Tumor (Cancer/Non-Cancer)	Carcinoma			Yes ☐ No ☐
Ladies Only	Ovarian Cyst	Yes ☐ No ☐	Hyperlipidemia	Yes ☐ No ☐
	Mammary gland	Yes ☐ No ☐	Caesarian Section	Yes ☐ No ☐
Others	Hypercholesterolemia	Yes ☐ No ☐	Diphtheria	Yes ☐ No ☐
	Asthma	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐
	Back Pain	Yes ☐ No ☐	Arthritis	Yes ☐ No ☐
	Rheumatic Fever	Yes ☐ No ☐	Inpotency/ Infertality	Yes ☐ No ☐

(3) Do you take any treatment more than a week in order to medical check-up, physical examination and treatment (including hospitalization) within 5 years according to the diseases excluded in the table? Yes ☐ No ☐

Body Injury

(4) Vision Failure, Fingers and Toes depredation (or) inability, Or Spine Disorder and Other Body Injury Yes ☐ No ☐

(a) Parts _____ (b) Conditions _____ (c) Cause _____

(d) Stabilization Period of Disease ____ Year ____ Month (e) Optical (Power) - (Left) ____ (Right) ____

Medical Check-Up

(5) If you have checked X-ray, Ultrasound, CT Scan, Biopsy, ECG, Urine Test, Blood Test and Other checks up in the previous year; and found irregularity Yes ☐ No ☐

(a) Under Treatment _____ Year _____ Month (b) Unusual matter _____

(6) If you tick "YES" in question 1 to 5, Please fill the details in following;

(a) Disease Injury Name _____ (b) Hospital Name _____

(c) Current Condition Completely cured ☐ Under examination ☐ Under treatment ☐ Under observation ☐ Other ☐

If you are under observation for a particular disease, frequency of doctor visit (_____ Times _____ in a month)

(d) Duration of Treatment from _____ Year _____ Month to _____ Year _____ Month

(e) If you have any Doctor's Specific Instruction, please mention; _____

Symptoms notice by one self

(7) Do you feel any of the following symptoms within 6 months?

(Fatigue, weight loss, diarrhea, dizziness, skin infection) Yes ☐ No ☐

Cancer

(8) Do you notice any swelling/lump/mass in your body? Yes ☐ No ☐

Pregnancy

(9) Are you pregnant? Do you feel any symptoms of being pregnant such as irregular period cycle, dizziness? Yes ☐ No ☐

(If "Yes" Please submit Doctor Recommendation showing that this is regular pregnancy)

Others

(10) Do you like smoking? Yes ☐ No ☐

If so, Yes ☐ Sometimes ☐ Daily intake per day? ☐

(11) Are you alcoholic? Yes ☐ No ☐

Do you drink alcohol daily? Yes ☐ Sometimes ☐ Total consumption per day? ☐

Previously insure with other company

(12) If you've insured this health insurance with other Insurance Company -Name _____ Policy No: _____

Insured Period _____ from _____ to Units of coverage _____

Confession

(13) I hereby warrant that the information and medical conditions mentioned above are true and complete.

If the applicant has provided untruthful information through misrepresentation, fraud, omission, then the benefits of the policy shall be forfeited.

Witness Signature _____ Insured Signature _____

Witness Name _____ Insured Name _____

NRC no. _____ NRC no. _____

Address _____ Address _____

If the insured is Healthy in Sight Yes ☐ No ☐

Underwriter Signature _____ Date ____/_____/_____

Name _____

Position _____