Life Care Solutions

No.51/4, 2nd Floor, Sarakki Gate,Kanakapura Main Road, 1st phase, J.P. Nagar, Bangalore-560 078

Ph : 080-26649606/7. Fax : 080-28918720

Ref :	**MEMBERSHIP FORM INDIVIDUAL MEMBERSHIP**	Application No:

Name:	M/F	DOB :	Policy Opted
Weight : Age :	Height :	B.Group :	

COUPLE / FAMILY MEMBERSHIP

Name	Policy Opted	Date Of Birth	Age	Height	Weight	B.Group
Husband :						
Wife :						
Child M/F						
Child M/F						

Present Address :

Permanent Address :

Office Address :

Period Of Insurance : From _____ To _____

Profession or Occupation : _____

Annual Income _____ | Income Tax PAN No :_____ | Nationality : _____

Any visible distinguish mark :

Emergency Contact	Nominee
Name :	Relationship :
Address :	Name & Address
Phone : Mob :	Phone No :
Trace assisters for Emergency Identification	
Vehicle Type/Make :	Reg. No. :
Licence No :	
Mode of Payment : Cash ( ) Cheque ( )	Bank : Branch :
Name of Address of family Medical Practitioner & Telephone number, if any :	

INSURED PERSON

1. [Please answer the following questions in Yes or No
2. (A dash is not sufficient) and give full details if any answer is Yes.]_____
3. Are you in good health and free from physical and mental disease or infirmity or medical complaints ? _____
4. If not in good health give full details : _____
5. Have you ever suffered from any of the disease / illness ? _____
   (If yes, give details)
   (a) Any nervous, mental or psychiatric disease

(b) Slipped disc or other spinal disorder (Fainting episode, blackout, fits) paralysis or any kind _____
(c) High blood pressure, heart diseases, including ischemic heart disease, other circulatory disorder etc. (rheumatic fever) _____
(d) fistula, piles, hernia, varicose veins _____
(e) any disease of the bones or joint including rheumatic disease
(f) disease of uterus, ovaries or breast or any specific gynecological disorders _____
(g) any respiratory or allergic disease. _____
(h) any disorder of the stomach ulcer, bowel or gal bladder, kidney stones etc. _____
(i) any cancer, malignant growth, boil, cyst or wound etc. _____
(j) any other complaint requiring specialist's consultation or surgical or hospital treatment or investigations. _____
(k) any complaint or tendency that may necessitate such consultation or treatment in the future. _____
(l) any dimness of vision / cataract _____
(m) any disease of ears or difficulty or interference with hearing _____
(n) diabetes or any urinary diseases. _____
(o) any other illness or disease or accident or operation sustained by you

6. (a) have you ever suffered from dental problems ? Yes/No _____
   (b) if yes, specify same _____
   (c) when were you treated last for same _____

7. Are there any additional facts affecting the proposed insurance which should be disclosed to insures ?
8. Please give details of any knowledge of any positive or presence of any ailment, sickness or injury which may require medical attention

1.

2.

3.

9. Please specify Sum insured opted : Rs.

I hereby declare and warrant that the above statements are true and complete, I consent and authorize the insurance to seek medical information from any Hospital / Medical Practitioner who has at any time attend or may attend concerning any disease or illness which affects my physical or mental health. I agree that this proposal shall from the basis of the contract should the insurance be effected. If after the insurance is effected it is found that the statements, answers or particulars stated in the Proposal from and its Questionnaires are incorrect or untrue in any respect, LCS and the insurance Company shall no liability under the insurance.
I have read the prospectus and I am willing to accept the coverage subject to the terms, conditions and exceptions prescribed by the insurance Company therein.

Place :

Date: Name & Signature

ASSIGNMENT

I _____ hereby assign the moneys payable, in the event of my death, arising out of accidents payable under the Policy, by Life Care Solutions(LCS) on behalf of The Oriental Insurance Company Limited, to Mr./Ms._____ (relation with the insured) _____ and I further declare that his/her receipt shall be final and sufficient to the Insurance Company.

Signature Name and address of the witness_____

_____

_____

_____ Signature of the Proposer/Insured

Place:_____ Date : _____