CELL INSURANCE COMPANY (PVT) LTD

THE WALLET DOCTOR
HOSPITAL CASH PLAN PROPOSAL FORM

INSURED DETAILS

Surname

First name

Title

Date of Birth

Gender Male Female

ID/Passport Number

Nationality

Broker/Agent

CONTACT DETAILS

Residential Address

E-mail Address

Phone Number

Mobile No:

Preferred method of communication SMS E-MAIL

Preferred method of payment BANK MOBILE

Insured Banking Details

EMPLOYMENT DETAILS

Employer Name

Employer Address

Occupation

Period of Insurance

From _____ To _____

DETAILS of the PERSONS to be INSURED

Name	D.O.B	ID Number / Birth Cert. No.	Gender M / F	Relationship	Plan [Basic/Supreme]	Premium USD

Total Premium _____

DECLARATION

I hereby declare that all the information provided is in all respects correct and that no material facts have been suppressed or withheld.

If such information has been provided on my behalf, I agree that this declaration and the answers given shall be the basis of the contract between myself and the company.

I further agree that as a result of my acceptance to take up the above cover, I am giving permission to my employer to deduct the premium from my salary (where applicable).

I understand that cover commences after being officially accepted by the company and the first premium has been paid.

By signing, I accept the usual terms and conditions prescribed by the company and endorsed on their policy.

Dated this ..... day of ..... Year .....

Signature of Proposer .....

CONTACT DETAILS

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