MEMBERSHIP APPLICATION FORM

Jiban bima corporation
(Only state owned life insurance company of Bangladesh)
Group Health Insurance Department
Head office: 24, Motijhel C/A Dhaka-1000
Phone: 02-223385720, PBAX: 02-223381423

Health Insurance

Please fill in capital letters and Tick Mark in appropriate boxes.

Application No.: _____

Membership No.: _____

1. PERSONAL PARTICULARS

Title □ Mr. □ Ms. □ Mrs. □ Others (Please specify)

Full Name: _____

Father's Name: _____

Sex □ Male □ Female Maritial status □Married □Unmarried □Divorced □ Others

*Date of Birth / / D M Y

Residential Address: _____

_____

Telephone No: _____ Mobile No.: _____

E-mail: _____ Fax: _____

2. OCCUPATIONAL PARTICULARS

If Salaried, Please tick

□ Public Ltd □ Private Ltd □ Public Sector Co □ Others.....

Name of the Company/Firm: _____

Designation (with ID): _____

Address: _____

Telephone No: _____ E-mail: _____

3. Group health insurance (IPD)

□ Self □ Couple (Husband & Wife) □ Parents (Father-Mother)
□ Family (Husband, Wife & Dependent Children)

4. COVERAGE OPTION

5. No. of Children

5. DEPENDENTS FOR INCLUSION

	Name	Date of Birth	Sex	Occupation
Spouse : i)				
Children ii)				
iii)				
iv)				
v)				
Parents vi)				
vii)				

6. PHOTOGRAPH (Please attach two copies of stamp size (2.5cm X 2cm) photograph of each person for Health Insurance

Self 1	Spouse 2	Child	Child
Father	Mother	Child	Child

7. HEALTH QUESTIONAIRE

No insurance cover will apply in respect of any condition or related conditions, which exists or has existed before the acceptance of risk by Jiban bima corporation unless it has been declared to and accepted by Jiban bima corporation It is therefore in your interest, answer these questions fully and provide accurate information.

If the answer is "**Yes**", give details in the space provided bellow.

A. Currently are you or any of the dependents to be included in the plan:-

i) suffering from tuberculosis, diabetes, asthma, rheumatic fever, heart disease, hypertension, epilepsy, kidney disease, genitor-urinary or gynecological disorder, cataract, cancer, mental illness, hernia, any disease of recurring nature or any chronic illness? **Yes** ☐ **No** ☐

Name of person	Disease	Duration

ii) receiving any treatment or on a special diet or on regular checkup or have symptoms of any illness, injury, disability, impairment which are known, evident or suspected? **Yes** ☐ **No** ☐

Name of person	Details

***** Please attach age proof certificate (e.g., National ID, Photocopy of Passport, SSC/Birth Certificate etc.)

iii) Covered under any/health insurance policy from any insurance company for similar benefits? Yes ☐ No ☐

Name of person	**Insurer**	**Benefit limit & date of commencement**

B. Within the last five years, have you or any of the dependents to be included in the plan

i) been incapacitated for a period of minimum 05 days due to injury, illness, disability, impairment or admitted to a hospital/clinic/sanatorium for treatment or operation? Yes ☐ No ☐

Name of person	Reason	Date	Current situation

ii) consulted a specialist or attended a hospital/clinic as an out - patient for the purpose of operation, investigation or X-ray? Yes ☐ No ☐

Name of person	Reason	Date	Current situation

C. At any time, have you or any of the dependents to be included in the plan

i) suffered from any illness, impairment, deformity or disability which still exists or recurring in nature or has left any residual effect or required major surgery, care in ICU/CCU or long term treatment? Yes ☐ No ☐

Name of person	Reason	Period	Current situation

ii) been postponed, declined, or accepted on special terms by any insurance company for a life or health insurance policy? Yes ☐ No ☐

Name of person	Insurer	Reason	Type of insurance and date of cover

D. Any married female (employee or spouse) to be included in the plan

i) Is pregnant now? Yes ☐ No ☐

Name of person	Duration of Pregnancy	EDD (if known)

ii) had complication in any of her previous pregnancy or delivery? Yes ☐ No ☐

Name of person	Name of complication	Mode of delivery

E. Is there any additional information relating to the health of yourself or any of the dependents to be included in the plan which is not yet mentioned, e.g. a pre-existing condition or congenital anomaly? Yes ☐ No ☐

Name of person	Details

8. DECLARATION

I declared that the information given in this application are true and complete to the best of my knowledge. It is agreed that declaration and information given in this application together with any supplementary application, declarations or disclosures made by me shall form the basis of my/our insurance coverage. If after the insurance is affected, it is found that the information furnished in this form ate incorrect or untrue, the JBC shall have the right to decline any claim relating to such information.

Place ..... Date..... Signature (Applicant).....

JBC

Date of receipt:	Policy Number	Date of Commencement

Remarks: