



Q #	Name of Employee/Dependent	Type of Disorder	Date of Onset	Surgical/Medical Treatment advised/Performed	Present Health Status	Hospital/Doctor

**IN CASE OF A "YES" ANSWER TO QUESTION # 3, PLEASE GIVE THE NAME OF THE SOURCE (INSURANCE COMPANY OR OTHER) ALONG WITH THE AMOUNT OF COVERAGE BELOW:**

\_\_\_\_\_

\_\_\_\_\_

**DECLARATION & AUTHORIZATION:**

I hereby declare that what has been stated above is true and complete to the best of my knowledge and belief, and I have not withheld any material information and it is understood and agreed that this declaration together with the application of my employer to the New Jubilee Insurance Company Ltd. are the basis for the family Hospitalization Insurance application for and **that any non-disclosure or misrepresentation of facts will make my / our insurance coverage void from inception.**

I hereby authorize any hospital, physician, Insurance Company or any other organization that has any records or knowledge of me or my family's medical history to furnish it to the New Jubilee Insurance Company Limited.

**Note :**  
Please note that use of correction fluid / blanco or overwriting will render the form invalid & fresh form will be required. Any alteration must be signed by the employee.

\_\_\_\_\_  
**(Signature of Employee)**  
for self & on behalf of dependent

\_\_\_\_\_  
**(Signature of Employer)**  
with official Seal

Date : \_\_\_\_\_ Signed at: \_\_\_\_\_

Date : \_\_\_\_\_

**DO NOT WRITE BELOW THIS**

**FOR NJI'S USE ONLY**

Approved :

- |                      |      |                      |          |                      |            |
|----------------------|------|----------------------|----------|----------------------|------------|
| (1). Hospitalization | Std. | <input type="text"/> | Non Std. | <input type="text"/> | EM + _____ |
| (2). Dread Disease   | Std. | <input type="text"/> | Non Std. | <input type="text"/> | EM + _____ |
| (3). Maternity       | Std. | <input type="text"/> | Non Std. | <input type="text"/> | EM + _____ |

Non Std, due to following : \_\_\_\_\_

- (1) \_\_\_\_\_
- (2) \_\_\_\_\_
- (3) \_\_\_\_\_
- (4) \_\_\_\_\_

Underwriting Decision : \_\_\_\_\_

\_\_\_\_\_  
Underwritten by

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approved by