

Applicant's Name		
Address		
Fax No.		R.C. No.
Line of Business		
Contact Person		Position
Presently Insured By		Until

A-Census : Please complete the table below or provide a soft copy of the list with Serial number, Date of birth, Class and Sum Insured.

AGE BAND	CLASS A		CLASS B		CLASS C	
	No. of Employees	Sum Insured (Cumulative)	No. of Employees	Sum Insured (Cumulative)	No. of Employees	Sum Insured (Cumulative)
Up to 30						
31 to 40						
41 to 50						
51 to 60						
61 to 65						
66 to 70						
Total						

B-Benefits : Please chose the sum insured and additional benefits you require for each class.

Class	Age Limit	Definition of Individual Sum Insured			
A		<input type="checkbox"/>	SR.	<input type="checkbox"/>	() x Monthly Salary with Max. () Min. ()
B		<input type="checkbox"/>	SR.	<input type="checkbox"/>	() x Monthly Salary with Max. () Min. ()
C		<input type="checkbox"/>	SR.	<input type="checkbox"/>	() x Monthly Salary with Max. () Min. ()

Additional Benefits Required

<input type="checkbox"/>	PTDr: Permanent Total Disability (Loss of eyes or limbs only)	<input type="checkbox"/>	PTDw: Permanent Total Disability (Functional loss of eyes, limbs or organs)
<input type="checkbox"/>	PPDr: Permanent Partial Disability (Loss of an eye or limb only)	<input type="checkbox"/>	PPDw: Permanent Partial Disability (Functional loss of any eye, limb or organ)
<input type="checkbox"/>	TPD: Temporary Total Disability (Weekly Indemnity 60%of salary)	<input type="checkbox"/>	MX: Medical Expenses up to SR 100,000

The Applicant warrants that, to the best of his knowledge, the above information is true and complete and will be the basis of the insurance quotation being requested.

Signed in _____ on behalf of the applicant this _____ day of _____ of the year _____

Name & Position:	Signature & Stamp:
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