2nd floor, Barkly Wharf,
Caudan Waterfront, Port louis.
Tel: 207 2500, Fax: 208 8936.
email: prudence@intnet.mu

LA PRUDENCE
MAURICIENNE
ASSURANCES LTÉE

PERSONAL ACCIDENT INSURANCE COVER FOR SMALL PLANTERS REGISTERED WITH THE SMALL PLANTERS WELFARE FUND

PROPOSAL FORM

I. Policyholder

1.1 Full name: Small Planters Welfare Fund

1.2 Address: 1st Floor, FSC Building, St Pierre.

1.3 Contact Details:

Telephone Number: 433 2052/ 4336985 Fax Number: 433 3249
E-mail : spwfsp@intnet.mu

1.4 Period of insurance

from the ____________ day of ________20_____

to the ____________ day of ________20_____

II. Insured Person/s (Registered Members & Dependants (if any)

Name	First Name/s	Date of Birth	SEX (M/F)	Present Occupation /Occupational Duties	Relationship with Registered Member
1.Registered Member					
2.					
3.					
4.					
5.					
6.					

(The company has to be informed of any change in occupational duties during the period of insurance)

Note: Insured persons being members of the Armed Forces or being engaged in ambulance service, in professional or non-professional aviation as pilot or crew in cave exploration (speleology), in clearing of high explosives, in diving of any kind, in fire fighting (professional), in mountaineering necessitating use of ropes/guides, in nuclear energy activities, in oil exploration/drilling production, in police and security activities, in polo, in racing of any kind, in professional sports activities, in stevedoring in taming of wild animals, in tunnelling or underground mining, or in shipping have to be referred to Head Office of The Company for assessment.

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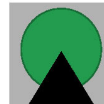
LA PRUDENCE MAURICIENNE ASSURANCES LTÉE



Beneficiary

1. Full name:
2. Address:
3. Relationship:

III. Health explanation:

Yes/No

1. Have you or any insured persons to the best of your knowledge ever had abnormal blood pressure, ulcers, tuberculosis, hernia, diabetes, cancer, syphilis, paralysis, arthritis, rheumatism, any disorder or Disease of the mental, genito-urinary or digestive systems, back, spine or heart?
If so, give nature, date, period of disability, name of doctor and result.

2. Have you or any insured persons ever been under observation or had medical or surgical advice or treatment, or been hospitalized during the past five years?

If so, give dates, ailment, duration and result

3. To the best of your knowledge are you now in good health and free from physical impairment or deformity? **If not**, give full particulars.

4. Have you ever been declined or accepted on special terms for life accident or illness insurance or have any insurers ever cancelled or declined to renew your policy?

IV. Personal Accident/Medical Insurances existing (or applied for)

Company	Kind of policy	Sums insured	Date issued

V. The Insurance is subject to the usual policy conditions.

DECLARATION

I/We hereby declare that the above statements and particulars contained in this Proposal are true and complete, that at the present time, other than as stated, I/We have no reason to anticipate any claim under the insurance now being requested.
I/We agree that this Proposal and declaration shall be the basis of the contract between me/us and The Company. I/We agree that this Proposal together with any other information supplied by me/us, shall form the basis of any contract of insurance effected thereon, and shall be incorporated therein. I/we undertake to inform The Company of any material alteration to these facts, whether occurring before or after completion of the contract of insurance.

Signed at on this day of

Authorised Signatory on behalf of Entity to be Insured

Capacity : ____