Personal Accident / Sickness

PROPOSAL FORM

INSTRUCTIONS TO PROPOSER
All questions must be answered by the INSURED PERSON.
PROPOSER DETAILS

1. Proponent’s/beneficiary’s full name: ...........................................................................................................
   Address for notices: ........................................................................................................................................
   ...........................................................................................................................................................................

2. Insured person’s full name: ............................................................................................................................
   Date of birth: ........................................... Sex: ...............Height: ............... Weight: ......................
   Occupation: ......................................................................................................................... Employer’s name: ..........................
   What actual duties do you perform: (be specific) ...........................................................................................

INSURED PERSON’S PERSONAL / MEDICAL STATEMENT

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<tr>
<td>3.</td>
<td>Have you ever had any accident, sickness or life proposal declined or cover under any policy rated up, cancelled, renewal refused or any special conditions imposed thereon?</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>4.</td>
<td>Have you ever had medical or surgical advice, treatment, been hospital confined or undergone any blood tests in the last five years?</td>
<td>Yes ☐ No ☐</td>
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<td>5.</td>
<td>Have you ever had or suffered from: Diabetes, Goiter, Epilepsy, Heart Disease, Chest Pains, High Blood Pressure, Nervous or Mental Disorder, Rheumatic Fever, Varicose Veins, Haemorrhoids, Tuberculosis, Asthma or Respiratory Disease, Back or Muscle Pains, Rheumatism, Hernia, Cancer, Tumour or Growth of any kind, Sudden Weight Loss, Venereal Disease, Ulcers, any diseases of the Eye, Ear or Stomach?</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>6.</td>
<td>Have you ever claimed for an accident or sickness benefit under any insurance policy?</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>7.</td>
<td>Do your work duties or leisure activities render you liable to injury or sickness, i.e. diving, snow skiing, handling asbestos, prolonged typing activities etc?</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>8.</td>
<td>Will the total amount of your weekly compensation from this policy and all other sources including Accident Compensation Benefit exceed 85% of your nett Pre-Disability Income?</td>
<td>Yes ☐ No ☐</td>
</tr>
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<td>9.</td>
<td>Are there any reasons that would cause you to consider yourself not in good physical health?</td>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>
10. How many flights do you anticipate undertaking this year:

   As a passenger: In a non-scheduled charter aircraft: .............  Private Aircraft: .......... 
   As a pilot: In a non-scheduled charter aircraft: .................  Private Aircraft: .......... 

11. Are you presently insured under any accident or sickness insurance? If so, give details:

   .................................................................................. $...................... $.................................
   (Insurer)  (Capital Benefits)  (Weekly/Monthly Benefits)

INSURANCE APPLIED FOR

   Capital Benefits: $......................
   Accident Weekly: $...................... For ............ Weeks  Excess .............. Days
   Sickness Weekly: $...................... For ............ Weeks  Excess .............. Days
   First Period of Insurance: From ............... 20...... To ............... 20......

DECLARATION

I/WE declare that the information given above is true and correct in every respect and that I/WE have not withheld any information within my/our knowledge likely to affect the Company’s decision as to my/our eligibility for this insurance. I/WE hereby agree and accept that this proposal and declaration shall be the basis of the proposed contract between the Company and myself/ourselves and I/WE agree to accept the Company’s policy and the terms and conditions contained therein. I/WE understand that any material misrepresentation or concealment of fact will render this policy and any insurance provided, VOID.

12. DATE: .........................  DATE: .........................

   Proponent’s Signature  Insured Person’s Signature