



**ace insurance limited**

# Personal Accident / Sickness **PROPOSAL FORM**

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## **INSTRUCTIONS TO PROPOSER**

All questions must be answered by the INSURED PERSON.



## PERSONAL ACCIDENT / SICKNESS

### 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

GIVE DETAILS TO YES ANSWER HERE  
 Give details of doctors/hospital etc.

3. 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?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
4. Have you ever had medical or surgical advice, treatment, been hospital confined or undergone any blood tests in the last five years?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
5. 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?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
6. Have you ever claimed for an accident or sickness benefit under any insurance policy?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
7. 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?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
8. 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?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
9. Are there any reasons that would cause you to consider yourself not in good physical health?	Yes <input type="checkbox"/> No <input type="checkbox"/>	



# PERSONAL ACCIDENT / SICKNESS

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