PRUDENTIAL

PRUDENTIAL ASSURANCE UGANDA LIMITED
10th Floor, Zebra Plaza, Plot 23 Kampala Road
P.O. Box 2660, Kampala, Uganda

EMPLOYEE PROPOSAL FORM

PLEASE ENSURE THAT ALL RELEVANT SECTIONS ARE COMPLETED.
(IF INSUFFICIENT SPACE, PLEASE ATTACH A SEPARATE SHEET WITH ADDITIONAL INFORMATION)

1. PERSONAL DETAILS

EMPLOYEE SURNAME

EMPLOYEE OTHER NAMES

PASSPORT NO/ NIN:

OCCUPATION

DOB D D M M Y Y

SEX M F

POSTAL ADDRESS

EMPLOYMENT START DATE

TELEPHONE HOME MOBILE

EMAIL

2. PERSONS TO BE COVERED

If the scheme covers your dependents provide information required below.

SURNAME	OTHER NAMES	NIN / PASSPORT	SEX	R/SHIP	DATE OF BIRTH
					D D M M Y Y
					D D M M Y Y
					D D M M Y Y
					D D M M Y Y
					D D M M Y Y
					D D M M Y Y
					D D M M Y Y
					D D M M Y Y

2.1 Are you or any other person to be insured covered by another medical insurance scheme? If "yes", please give details.

Yes No

3. CONFIDENTIAL MEDICAL HISTORY (Please tick YES/NO)

3.1 Are you or any person to be insured in very good health now and usually enjoy good health?

Yes No

3.2 Have you or any other person to be covered ever been hospitalised in the previous 36 months?

Yes No

3.3 Have you or any other person suffered or incurred in the previous 12 months treatment of diseases such as cataract, benign prostatic hypertrophy, hysterectomy for menorrhagia of fibromyoma, hernia, hydrocele, congenital internal diseases, fistula in anus, piles, sinusitis and related disorders?

Yes No

3.4 Have you or any other person suffered or incurred in the previous 12 months treatment of diseases such as diabetes, nervous disorder, tuberculosis, asthma, epilepsy, stroke or any form of heart disease or disorder of lungs? if "yes" give details

Yes ☐ No ☐

3.5 Are you or any of the persons to be covered pregnant?

Yes ☐ No ☐

3.6 Have you or any of the persons to be covered ever experienced depression or psychiatric disorder?

Yes ☐ No ☐

3.7 Have you or any persons to be covered ever suffered from jaundice, liver conditions, gall bladder disease?

Yes ☐ No ☐

3.8 Have you or any persons to be covered ever experienced back, neck, joint problems, arthritis, gout, any physical disability or muscular disorder?

Yes ☐ No ☐

3.9 Is there any illness/factor not mentioned on this proposal that might affect your health in the next 12 months?

Yes ☐ No ☐

IF YOU TICKED YES FOR ANY OF THE ABOVE (EXCEPT 2.1) PLEASE COMPLETE THE SECTION BELOW. ALL IMPORTANT INFORMATION MUST BE DISCLOSED.

Question Number	Name	Date	Please supply full details of disorder, date, duration of treatment, medication (if any)
		D D M M Y Y	
		D D M M Y Y	
		D D M M Y Y	
		D D M M Y Y	

PLEASE ATTACH ANY RELEVANT MEDICAL REPORTS

4. HEALTHCARE INFORMATION

Name of your family/ usual doctor

Postal Address

Physical Address

Telephone

5. DECLARATION

I DECLARE THAT ANY FALSE STATEMENT IN THE PROPOSAL FORM OR NON-DISCLOSURE OF ANY MATERIAL INFORMATION WILL RENDER THE MEMBERSHIP THEREBY NULL AND VOID.

I ACKNOWLEDGE THAT ANY BENEFITS PAID BUT NOT COVERED BY THE TERMS AND CONDITIONS OF THE PRUMED POLICY WILL BE REFUNDED TO THE INSURER.

EMPLOYEE SIGNATURE:.. DATE: D D M M Y Y