It is essential that every question should be answered completely, accurately and in detail as otherwise the right to benefit may be prejudiced. This application may be completed by the Domestic Help or on his/her behalf by the Employer.

Employer Details

☐ Mr.	☐ Mrs.	☐ Miss	First name:	
Middle name:			Last name:	
Mobile number:			Landline number:	
Email:			P.O. Box:	Postal code:
Address:				

Domestic Help Details

☐ Mr.	☐ Mrs.	☐ Miss	First name:	
Last name:			Date of Birth:	
ID No.:			Nationality:	

Domestic Help - Medical History

If the answer to any question below is 'YES', please furnish details such as date, duration and, where appropriate, state if fully recovered.

1.	Have you ever suffered from spitting of blood or any chest disease or lung affection, tuberculosis, rheumatism, urinary trouble, internal disorders, asthma, cancer, diabetes or any nervous or recurring disease?	☐ Yes	☐ No
2.	Is your sight or hearing impaired? Any ear complaint, perforated eardrum or any discharge of the ear?	☐ Yes	☐ No
3.	Have you ever had a fit or any kind of paralysis?	☐ Yes	☐ No
4.	Have you any physical defect or infirmity of any kind?	☐ Yes	☐ No
5.	Have you in the last 2 years, suffered from any other illness or accident for which you have received medical attention?	☐ Yes	☐ No

Period of Cover and Premium

Period of insurance:	From:	DDMMYYYY	To:	DDMMYYYY
Basic Premium	+ Tax		=	Total Amount

Declaration

1. I have never been declined, or accepted on special terms, or had a policy cancelled for Life, Accident, Illness or Disability Insurance.
2. I am in good health and there are no circumstances of occupation, habits or activities, which render me especially liable to accident, illness or disablement.
3. I hereby declare that to the best of my knowledge and belief the above statements and particulars are true and correct and that I have witheld no information material to this Application form. I undestand that failure to disclose all material facts known to me could invalidate the policy.

(Note: Where there is any doubt that facts would be considered material, those facts should be disclosed.)

Signature of Domestic Help	Employer's signature
Name:	Name:
Date:	Date:

Cover Options

Benefits	Medical / Repatriation Expenses sum insured following Accident Only		Medical / Repatriation Expenses sum insured following Accident & Illness	
	☐ Bronze	☐ Silver	☐ Gold	☐ Diamond
1. Accidental Death	3,000	5,000	3,000	5,000
2. Permanent Total Disablement (Accident)	3,000	5,000	3,000	5,000
3. Permanent Partial Disablement (Accident)	3,000	5,000	3,000	5,000
4. Temporary Total Disablement (Accident)	OMR 20 per week for upto 52 weeks	OMR 25 per week for upto 52 weeks	OMR 20 per week for upto 52 weeks	OMR 25 per week for upto 52 weeks
5. Medical Expenses	1,000	2,500	1,000	2,500
6. Repatriation/Funeral/ Burial Expenses	500	1,000	500	1,000
Premium Payable	**29***	**39***	**69***	**89***

*Including taxes. All figures in OMR

Notes:

1. Sum Insured/Limit is the maximum amount payable in a year.
2. Policy Effective & Commencement date: The effective date for this policy will be after seven days from the date of payment of the policy.
3. An Excess/Deductible of OMR 10 applies on each and every medical expenses claim.
4. Maximum hospital bed limit is OMR 10 per day.
5. This policy is subject to specified list of medical Network in related to Medical Expenses Section - list available upon request.

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