LIFE INSURANCE CORPORATION (PNG) LIMITED
A Group Company of *National Teachers Insurance Ltd*

REGISTERED OFFICE: "Insurance Rumana", Sec 35, Lot 48, Frangipani Street, Hohola, NCD
P.O. Box 5684, Boroko, National Capital District, Papua New Guinea
TELEPHONE: 3232900 FACSIMILE: 3231307 EMAIL: enquires@ntilic.com.pg

LIC HEALTHCARE SCHEME
Group Life & Medical, Emergency Evacuation and Personal Accident Insurance Policy

Membership Application Form (MAF)

PLEASE READ AND UNDERSTAND KEY TERMS & CONDITIONS OF YOUR GROUP POLICY BEFORE FILLING THIS MAF AND RETURNING THE ORIGINAL TO THE INSURER.

NAME OF YOUR EMPLOYER/GROUP:
Plan Option: Tick 1 box ☑ ; or Leave Blank if Unsure.
☐ **Single Member (inc Dependent Natural Parents upto Age 65 Years)**
☐ **Family Member (inc Parents upto Age 65 Years, Spouse, Dependent Children)**

APPLICANT/STAFF (answer as appropriate):

Surname	First Name (Given Names)	Gender	Marital Status
		□ Male □ Female	□Never Married □Married □ De-facto □Separated/Divorced □Widowed

No. of Children	Usual Location of Employment (City/Town)	Payroll No/ File No	Date Employed (approx)	Position/Occupation	Date of Birth	Age

Residential Address:			
Email Address:			
Mobile Number:		**Telephone: (work)**	

1. Are you insured under any other medical or life insurance policy? Yes □ No □ (Tick √). *If Yes, please provide details here:*

2. Do you (or your qualifying dependants) have a pre-existing sickness or medical condition? Yes □ No □ (Tick √). *If Yes, provide details of illness/medical condition in the space below*

3. Have you (or your qualifying dependents) consulted a doctor in the last 12 months? Yes □ No □ (Tick √). *If Yes, provide details of illness/medical condition in the space below.*

4. Name & Address of your (Family) Doctor (if any). If none, please name the clinic/hospital you regularly visit.

YOUR DUTY OF DISCLOSURE
Before you enter into a Contract of Insurance with us, you have a duty to disclose to us every matter that you know or could reasonably be expected to know is relevant to our decision whether to accept the risk of insurance and, if so, on what terms. You have the same duty to disclose those matters to us as stated in *Point 1 to 4 above,* before you renew, extend, vary or reinstate a Contract of Insurance. LIC has the right to ask for any medical examination, anytime during policy period. **Please use a separate page if the space provided here is insufficient. Your duty is not limited by us asking General Information questions.**

NON-DISCLOSURE
If you fail to comply with your Duty of Disclosure, we may be entitled to reduce or deny our liability under the Contract in respect of a claim or may cancel the Contract.
If your non-disclosure is fraudulent at any time, the Insurer reserves the option of voiding the contract from inception.

DECLARATION OF FAMILY MEMBERS FOR MEDICAL COVER (Qualifying Dependants) if any.

This Policy includes Medical Cover for your Natural Parents upto the age of 65 Years. If you are under the Family Plan you may also declare your Spouse; and any of your Legally Adopted or Biological Children (up to 18 years; 25 years if Full Time Single Student).

Please Declare All your Qualifying Dependants Below. Undeclared Dependants will not be covered. See PDS for Details.

	A	B	C	D	E
	Relationship to Member/Applicant (spouse, son, daughter, mother, etc)	**Given Name(s)**	**Surname**	**Date of Birth**	**Age**
1					
2					
3					
4					
5					
6					
7					
8					

DECLARATION OF NOMINATED LIFE BENEFICIARIES

In this section, you should declare the names of anyone whom you nominate to receive the Life Insurance Benefits in your policy. Nominee(s) could be your spouse, your child over 18 years old, extended family members or friends (up to 2 persons). In the event of your death, your nominated beneficiaries will be entitled to receive a lump sum payment as declared below.

Where only one name is declared, or there is uncertainty of the beneficiaries, LIC will pay full benefits to the first name declared below.

	A	B	C	D	E
	Relationship to Member/Applicant (e.g. spouse, daughter, mother, father, niece, uncle, friend, etc)	**Given Name(s)**	**Surname**	**Date of Birth**	**Percentage (%) Total =100%**
1					
2					

DECLARATION

1. *The Duty of Disclosure, Non-Disclosure and inadequate space to Answer notices set out above has been read by me.*
2. *All answers and statements made out in this application are true and accurate in every respect and no information has been withheld which is likely to affect your decision about accepting this insurance application.*
3. *I acknowledge the insurer reserves the right to decline any application and/or ask for medical examination report.*
4. *I Acknowledge and will adhere to that the Terms and Conditions of my Policy are set out in the LIC HeathCare Product Disclosure Statement documents available from the Insurer.*
5. *I understand that the insurance benefits are payable only to the nominated beneficiaries as named above.*
6. *I acknowledge that I may update this form by submitting a new one through my Employer HR at any time if circumstances above change.*
7. *Where applicable, I understand that any claims will be processed in accordance with the LIC HeathCare Group Insurance policy Terms and Conditions in consultation with the relevant HR Officer/Office*

_____ **APPLICANT'S SIGNATURE (Member/Plan Owner)**

_____/_____/_____ **Date Signed**

INSURER OFFICE USE ONLY:		**OFFICE ADMINISTER USE (As Relevant)**
Application Form Checked:	□	**Name of Officer:**
Premium Checked:	□	
LIC Officer Notes:		*The Information shown on this application accurately and correctly records the information given by the Applicant*
Approval & Comments LIC Manager:		**Signature & Date & Seal of HR Officer:**
		□ Single □ Family
OUTSTANDING UNDERWRITING REQUIREMENTS	**Accepted □ Conditionally Accepted □ Rejected □**	**DATE**

This Policy Is Underwritten By Life Insurance Corporation (PNG) Ltd, in adherence to the Life Insurance Act 2000 legislation & Life Insurance Prudential Standards issued by the Bank of Papua New Guinea in its capacity as the Government Regulator