



INTERNATIONAL INSURANCE COMPANY (SL) LIMITED

20 Bathurst Street, P.O. Box 465, Freetown, Sierra Leone. E-mail: info@iic-sl.com
Tel: 232-22-222159/290458, Fax 223794 Website: www.iic-sl.com

PROPOSAL FOR TRAVELLERS PERSONAL ACCIDENT INSURANCE

- NOTE:
1. Where the Proposer and the Person to be insured are different individuals, the information asked for should relate to the Insured person.
 2. Please give a definite reply to each question.

(Answers in Block Letters Please)

1. (a) Name of the Proposer (**Mr./Mrs./Miss**)
- (b) Name of the Insured Person (**Mr./Mrs./Miss**)
- (c) Relation between the Proposer and the Insured Person
2. Residential Address
-
3. Address for Correspondence
-
4. Telephone number(s).....
5. Profession
Occupation
Trade or Business
(Please describe fully with nature of duties)
.....
.....
.....
6. Please State:
Date of Birth
- Height in metres
- Weight in Kgs.
7. Have you suffered or do you suffer from:

Any physical defect or infirmity **yes/no**
 Gout, Arthritis, Diabetes, Paralysis, Fits of any kind or any other chronic disease **yes/no**
 Any other disability **yes/no**

(if yes, give full particulars)

.....

8. (a) Have you ever proposed for accident and/or sickness and/or Life Insurance? **yes/no**

(If yes, please state)

NAME OF COMPANY	AMOUNT OF INSURANCE

(b) Has any Company ever declined to issue a policy to you? **yes/no**
 Declined to continue your Insurance? **yes/no**
 Not invited the renewal of your policy? **yes/no**
 Imposed any restriction or special condition? **yes/no**

(If yes, please give Name and Address of the Company)

NAME OF COMPANY	ADDRESS

(c) Is this Insurance to be additional to any other Accident or Sickness Policy or Employees' Scheme? **yes/no**
(If yes, please give the following particulars).

NAME OF THE COMPANY	POLICY NO.	SUM INSURED

9. Have you ever claimed or received compensation under any Accident or Sickness Policy **yes/no**

(If yes, give the particulars)

Name of Insurer	Amount	Date

10. Please indicate:
Capital Sum Insured Le

Table of Cover required

Period of Insurance:

From To

11. Do you wish to obtain cover against insurance of medical expenses following accident? **yes/no**

If yes, please indicate amount of medical expenses Le

DECLARATION

I declare that the above answers are true to the best of my knowledge and belief, that I have disclosed all particulars affecting the assessment of the risk. I agree that this proposal and declaration shall be the basis of the contract between me and International Trust Insurance Company Limited.

Place..... Date

.....
(Signature of proposer)

.....
(Signature of the Insured Person)

Assignment (Applicable when proposal is for own Life)

I do hereby assign the moneys payable in the event of my death by International Insurance Company (SL) Ltd

to
(Name of the Person)

of

my**(relation)**

and I further declare that his/her receipt shall be sufficient discharge to the Company.

Assignment witnessed by. **(Mr/Mrs/Ms)**

ID Card No. Address

.....
(Signature)

Agency

FOR OFFICIAL USE

Premium Rate
Annual Premium
Additional Premium
(for(cover)
Loading
Total Premium
Total Amount Payable
Approved by

Policy No.