**Life Department**



**Group Life Quotation Request Form**

Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ P.O. Box \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This table shows the benefits offered in Group Life & Personal Accidents policy; please choose the benefits you want (DAC is mandatory):**

|  |  |  |
| --- | --- | --- |
| **Benefit** | **Remarks** | |
| **Yes** | **No** |
| Death due to any cause (DAC) |  |  |
| Accidental Death Benefit (double indemnity) |  |  |
| Permanent Total Disability Due to **Accident** Benefit (PTD- Acc, Own or Similar) |  |  |
| Permanent Total Disability Due to **Sickness** Benefit (PTD- Sick, Own or Similar) |  |  |
| Permanent Partial Disability Due to **Accident** Benefit (PPD- Acc) |  |  |
| Permanent Partial Disability Due to **Sickness** Benefit (PPD- Sick) |  |  |
| Temporary Total Disability Due to **Accident** Benefit (TTD- Acc) |  |  |
| Temporary Total Disability Due to **Sickness** Benefit (TTD- Sick) |  |  |
| Accidental Medical Expenses (AME) |  |  |
| Repatriation Expenses of mortal remains (RE) |  |  |
| Terminal Illness |  |  |
| Critical illness |  |  |

**- Please advise if any further requirements/conditions are needed:**

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**Necessary Required Information:**

3-5 years Claims Experience: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total No. of Employees: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Sum Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Target Rate / Premium: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Basis of Sum Insured: ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_  Multiple Salary  Flat Sum Insured

Remarks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Required Attachments:**

List of Employees: Yes No Claims Experience: Yes No

Existing TOB:  Yes  No

Applicant name : \_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contacts of Life Department:**

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