Allied Cooperative Insurance Group (ACIG)

شركـة المجموعة المتحدة للتأمين التعاوني (أسيج)

Call us:
920012331
www.acig.com.sa

GROUP MEDICAL INSURANCE PROPOSAL FORM

ACIG

للتأمين بأمان

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Please complete this form using **CAPITAL LETTERS** and by ticking the relevant boxes

Client Details: -

Company Name		**C.R No.**	
Business Activity / Industry	☐ **Industrial** ☐ **Clerical** ☐ **Construction & Contracting** ☐ **Transportation Others (please specify)…….....**	**Sponsor No.**	
Contact Person		**Position**	
Tel No.	**Fax No.**	**Postal Address**	

Broker (if any): ……..(only SAMA-approved brokers are permitted)

Please complete the tables set out in **Annexure B**.

Also please complete the summary tables which follow with the number of beneficiaries falling within each sub-category where the number of beneficiaries is taken to mean the number of employees and eligible dependents currently within the company or group. Eligibility for cover is defined in line with the rules of the CCHI. The eligibility criteria are set out in Annexure A of this Proposal Form.

Age Bracket Years	VIP				A				B				C			
	Employee	Female Employee	Wife	Children	Employee	Female Employee	Wife	Children	Employee	Female Employee	Wife	Children	Employee	Female Employee	Wife	Children
0 – 17																
18 – 35																
36 – 45																
46 – 55																
56 – 60																
61-65																
> 65																
Total																

What is the average age of your employees?.....

Nationalities	VIP				A				B				C			
	Employee	Female Employee	Wife	Children	Employee	Female Employee	Wife	Children	Employee	Female Employee	Wife	Children	Employee	Female Employee	Wife	Children
Saudi's																
Arabs																
Asians																
Westerners																
TOTAL																

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	VIP				A				B				C			
	Employee	Female Employee	Wife	Childr en	Employee	Female Employee	Wife	Children	Employee	Female Employee	Wife	Children	Employee	Female Employee	Wife	Children
Riyadh & Central Province																
Jeddah & Western Province																
Dammam & Eastern Province																
TOTAL																

Present Arrangement:	
Current Insurer (if Insured):	
Expiry date: **Inception date of current year of cover:**	**Inception date of first year of cover with current insurer:**
If you currently are insured by another insurance company please provide the reason(s) for seeking to change your insurance company.	
Is In-House Clinic in operation□ Yes □ No	**No. of locations: - ……**

Claims Experience: Please provide us with the summary of your claims experience for the last 3 years as set out below.

Year	VIP			A			B			C		
	No. of Members	No. of Claims	Amount	No. of Members	No. of Claims	Amount	No. of Members	No. of Claims	Amount	No. of Members	No. of Claims	Amount

In-patient Claims

Year	VIP			A			B			C		
	No. of Members	No. of Claims	Amount	No. of Members	No. of Claims	Amount	No. of Members	No. of Claims	Amount	No. of Members	No. of Claims	Amount

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Additional Information:

- For each of the past three years please indicate how many employees have left your employment and how many new employees have been appointed. Please provide this information for each class of cover that is relevant i.e. VIP, A, B, and C:.....
  .....
- Is there workmen compensation cover or group life & disability insurance in place? If yes, have there been any claims under this cover for each of the last three years. Please provide a schedule with details on each claim i.e. Name of claimant, Date of claim, Type of claim (Death, Disability etc), Amount of claim.....
- Please provide details, (i.e. Name of claimant, Employee or Dependent, Gender, Age, Nationality, Cause of claim, Amount of claim), of the ten costliest medical claims arising from your employees or one of their dependents for each of the last three years.....
  .....
  .....
  .....
- Are you aware of any employees which have been admitted to hospital in the last month or which will be admitted to hospital within the next two months from the date of this application? If yes, please provide details of the reasons for the hospital admissions.....
  .....
- Are you aware of any employees or dependents of employees who are chronically ill? If yes, please provide details.....
  .....
- Are any of your employees currently on sick leave? If yes, please provide details.....
- Have any of your employees been on sick leave for longer than two work weeks during the previous year? If yes, please provide details.....
  .....
- Are any of your employees or their eligible dependents pregnant at this point in time? If yes, please provide details.....

Standard Coverage: -

The Scope of cover will be same for all classes as per the CCHI standard policy. However, the members under each of the classes will be assigned VIP, A, B & C service providers respectively as per ACIG's classifications of providers. (Please find appended to this proposal the lists of providers.)

Basic

Cover Type	VIP	A	B	C
Annual Limit	SR 500,000	SR 500,000	SR 500,000	SR 500,000
Pre-existing & Chronic	Covered	Covered	Covered	Covered
Co-Insurance	20% Max SR 100	20% Max SR 100	20% Max SR 100	20% Max SR 100
Outpatient	Covered	Covered	Covered	Covered
Inpatient	Covered	Covered	Covered	Covered
Intensive Care Unit	Covered	Covered	Covered	Covered
Maternity Complications	Covered	Covered	Covered	Covered

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Dental

Cover Type	VIP	A	B	C
Consultation, Filling, X-ray, Extraction, Root Canal Treatment & Gum Infection Treatment Medicines	Covered	Covered	Covered	Covered
Sub – Limit	SR 2,000	SR 2,000	SR 2,000	SR 2,000
Co-Insurance	20% Max SR 100	20% Max SR 100	20% Max SR 100	20% Max SR 100

Optical

Cover Type	VIP	A	B	C
Optical Aids	Covered	Covered	Covered	Covered
Sub – Limit	SR 400	SR 400	SR 400	SR 400
Co-Insurance	20% Max SR 100	20% Max SR 100	20% Max SR 100	20% Max SR 100

Maternity

Cover Type	VIP	A	B	C
Ante-Natal Care, Normal Delivery, Caesarian, Abnormal Delivery, Miscarriage, Legal Abortion and one post-natal care	Covered	Covered	Covered	Covered
Sub – Limit	SR 15,000	SR 15,000	SR 15,000	SR 15,000
Waiting Period	Nil	Nil	Nil	Nil
Co-Insurance	20% Max SR 100	20% Max SR 100	20% Max SR 100	20% Max SR 100

Applicant's Declarations: -

I / We confirm the above mentioned information is correct to the best of my/our knowledge and belief and shall form the basis of insurance cover. I/We also understand that the insurance cover is compulsory for all our employees and their eligible dependents and our best endeavours will be used to ensure that all our employees and their eligible dependents will enrol for the compulsory cover. I / We understand that any non-disclosure of material facts and/or any breach of good faith on my/our part will provide the right to ALLIED COOPERATIVE INSURANCE GROUP to cancel the contract at any time during the period of insurance cover.

Name:	Signature:	Date:
Position:	Stamp:	

Date Submitted: ……..

Date Received by ACIG: ……..……..

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التأمين بأمان