Traders Insurance Company
1st Floor Alexander Building, Beach Road, San Jose Village
P.O. Box 502473, Saipan, MP 96950
Tel: (670) 234-7788/7789/7798/7799 Fax: (670) 234-8899

RESET FORM | PRINT | SUBMIT

TRAVEL PERSONAL ACCIDENT INSURANCE APPLICATION FORM

This application form is to be completed by the APPLICANT. All questions should be answered fully and accurately.

Signing of this application does not bind company to offer nor the applicant to accept insurance. But it is agreed that this application shall be the basis of any insurance issued. No inference should be made however from the inclusion of any question in this application that the subject matter to which that question relates will be covered under the policy. The policy terms are only as stated in the policy which should be read carefully. Attention is drawn to the applicant obligations at law to disclose all material facts which would affect the issuance of the proposed insurance.

NAME OF APPLICANT : _____

BIRTH DATE : _____ **HEIGHT :** _____ **WEIGHT :** _____ **GENDER : Male** ☐ **Female** ☐

CIVIL STATUS : _____ **OCCUPATION :** _____ **ANNUAL INCOME :** _____

HOME ADDRESS : _____ **TELEPHONE NO. /FAX NO. :** _____

EMPLOYER : _____ **NATURE OF BUSINESS :** _____

BUSINESS ADDRESS : _____ **TELEPHONE NO./FAX NO. :** _____

BENEFICIARY : _____ **RELATIONSHIP / BIRTH DATE :** _____

POLICY PERIOD : FROM : 12:01 AM : _____ **TO : 12:01 AM :** _____

PURPOSE OF TRAVEL : _____

PERSONS TO BE COVERED

NAME	DATE OF BIRTH	RELATIONSHIP	OCCUPATION

PLEASE ANSWER THE FOLLOWING QUESTIONS WITH EITHER A YES OR NO, IF ANSWER IS YES PLS. GIVE DETAILS.	YES	NO
1. Have you or any of the persons listed above ever applied for or received indemnity for any injury or sickness?	☐	☐
2. Do you or any of the persons listed above engage in any hazardous sports?	☐	☐
3. Have you or any of the persons listed above ever been treated for or been told that you have heart disease, epilepsy, syphilis, Diabetes, renal disease, injury to or disease of the spine or sacro-iliac joint, or mental or nervous disorder?	☐	☐
4. During the past five years, have you or any of the persons listed above ever been disabled or suffered from any disease or receive any medical or surgical treatment or advice?	☐	☐
5. Do you or any of the persons listed above have any deformity, impairment of hearing or vision, or loss of hand, foot or vision?	☐	☐
6. Have you or any of the persons listed above ever held any elective public office?	☐	☐

DECLARATION

I/We hereby apply for insurance against risks as set out in the Company's "Travel Personal Accident" Policy and I/We hereby declare that the above particulars and answers are true and complete in every respect and that no material fact has been suppressed or withheld, and I/we agree that this proposal and declarations shall be the basis of the contract between myself/ourselves and the Company, and I/we further agree to accept a Policy subject to the usual conditions prescribed by the Company, and endorsed on its Policy, and to pay the first premium there under when called upon to do so.

Signature of Applicant : _____ **Date :** December 12, 2009