MEGHNA BANK LTD.
together we sail

## SREYOSHI SAVINGS ACCOUNT SHIELD INSURANCE ENROLLMENT APPLICATION

### TO BE FILLED BY THE CUSTOMER

**Title:** ☐ Ms. ☐ Mrs. **Customer ID No.:** ______________

**A/C Holder's Name [As per NID]:** ______________ **A/C No.:** ______________

**A/C Type:** ______________ **Age:** __________

**Date of Birth [As per NID]:** | D | D | M | M | Y | Y | Y | Y | **NID No.:** ______________

### TERMS & CONDITIONS

- Insurance Entry Age: Minimum 18 years to Maximum 60 years
- If the earlier date of birth passed 180-days from the date of enrollment than the next age will be considered.
- Only the primary account holder will be cover in case of a joint–account.
- Respective bank account's nominee will remain the nominee for the insurance facility.
- A customer needs to maintain a monthly average balance as set by the Bank or above at all time to be eligible for the insurance coverage.
- Insurance coverage shall be effective from the following month of account opening subject to the above conditions being met.
- Critical Illness Waiting Period: 180 days from the date of insurance enrollment
- For COVID–19 only: There shall be a deferral period of 30-days from the date of enrollment. The insurance benefit shall not be applicable if death or infection due to COVID–19 occurs within the deferral period.
- For any affirmative answer from COVID–19 related questions* below and also who have any pre-existing diseases, the policy will not have accepted.
  * If answer from COVID–19 related question no. 2 is affirmative, the prospective customer shall need to submit the diagnosis report of "NEGATIVE" test result

**N: B:** It is recognized by law that Life Insurance is a contract of "Utmost Good Faith" which requires that the Proposed Insured is liable to disclose all material facts truth fully and correctly. Suppressing facts or giving wrong information will adversely impact payment of your claim.

### DECLARATION OF GOOD HEALTH

| No. | Question | Yes | No |
|---|---|---|---|
| 1) | Have you Currently Taking any Medical Treatment?<br>If '**Yes**' State Here: Since When and for Which Condition? Also, write your Medication/Treatment | ☐ Yes | ☐ No |
| 2) | Do you **Smoke** more than 15 Cigarettes/day or 15 gm Pipe Tobacco/day? | ☐ Yes | ☐ No |
| 3) | Do you Consume **Alcohol** regularly? | ☐ Yes | ☐ No |
| 4) | Do you have **Hypertension/High Blood Pressure/High Cholesterol**? | ☐ Yes | ☐ No |
| 5) | Do you have **Chronic Respiratory Conditions** [including Asthma, Chronic Cough, Bronchitis, Bloody Sputum, Tuberculosis, Chronic Obstructive Pulmonary Disease_COPD etc.]? | ☐ Yes | ☐ No |
| 6) | Do you have **Diabetes**? | ☐ Yes | ☐ No |
| 7) | Do you have any type of **Heart/Cardiovascular Diseases?** | ☐ Yes | ☐ No |
| 8) | Do you have **Chronic Kidney Diseases?** | ☐ Yes | ☐ No |
| 9) | Do you have **Liver Diseases** [Hepatitis, Fatty liver, Cirrhosis, Chronic liver disease etc.]? | ☐ Yes | ☐ No |
| 10) | Do you have **Cancer?** | ☐ Yes | ☐ No |
| 11) | Do you currently have **Genito-urinary** disorders related to Prostate, Urinary system, Albumin or Blood in the Urine, Sexually Transmitted Diseases [HIV, Gonorrhea, Syphilis etc.]? | ☐ Yes | ☐ No |
| 12) | Do you have **Mental** or **Nervous** Disorders? | ☐ Yes | ☐ No |
| 13) | Do you have any Physical Disability or any other disorder of the bone, Spine, or Muscle? | ☐ Yes | ☐ No |
| 14) | Have you requiring Hospitalization for more than 07 consecutive days for any Sickness in the last Two Years? | ☐ Yes | ☐ No |
| 15) | Have you ever been tested positive for Viral Diseases, in particular for **Hepatitis B** and **C** or the Human Immunodeficiency Virus **[HIV/AIDS]**? | ☐ Yes | ☐ No |
| 16) | Do you have Diseases of the senses: Eye and Ear disorders including myopia, glaucoma, retinal detachment, blindness, vertigo, deafness, etc. | ☐ Yes | ☐ No |
| 17) | Have any of your Family Members [Parents/Siblings] suffered from: Tuberculosis, Diabetes, Cancer, High Blood Pressure, Heart or Kidney Disease, Psychiatric Illness [including Suicide]? | ☐ Yes | ☐ No |
| 18) | Do you currently have any Other diseases non quoted here-above? | ☐ Yes | ☐ No |
| | **For Female Life Only:** | | |
| 19) | Are you **Pregnant** at present which period is at least 06 [six] months or Over? | ☐ Yes | ☐ No |
| 20) | Have you ever suffered any complications of Pregnancy? | ☐ Yes | ☐ No |
| 21) | Have you ever had any disease of Breast, Uterus, Cervix, Ovaries, or any other part of Reproductive System? | ☐ Yes | ☐ No |

**For any 'YES' answer, write briefly here with mentioning the Question No:**

### SUPPLEMENTARY QUESTIONNAIRE FOR COVID-19

| No. | Question | Yes | No |
|---|---|---|---|
| 1) | Within the last 30 [Thirty] days have you been in direct/ close contact with someone who's been Confirmed [Positive] or Suspected to have Novel Coronavirus/COVID-19? | ☐ Yes | ☐ No |
| 2) | Have you tested **Positive** for Novel Coronavirus/COVID-19? | ☐ Yes | ☐ No |
| 3) | Within the last 30 [Thirty] days have you experienced symptoms of a new or unexplained continuous **Cough**, a **High Temperature** or **Fever**, **Breathing Difficulties,** or any other Symptoms of Novel Coronavirus/COVID-19? | ☐ Yes | ☐ No |
| 4) | Within the last 30 [Thirty] days have you been **self-isolating** due to symptoms of Novel Coronavirus/COVID-19? | ☐ Yes | ☐ No |
| 5) | Within the last 30 [Thirty] days returning to Bangladesh after any Overseas Travel, have you been advised for **Self-isolation**? | ☐ Yes | ☐ No |

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## EXCLUSIONS FOR DEATH

Any Death caused by or resulting, directly or indirectly, wholly or partly, from any of the following factors will not be covered by this insurance:
● All pre-existing disease-related; ● Any concealment of the prior medical illness as given in the form will be considered for exclusion. The proof will be given from the insurer if the concealment is established; ● AIDS and HIV related diseases; ● Voluntary abuse of Alcohol or Drugs or alcohol intoxication; ● War, Riots, Civil commotion, murder etc.; ● Self-inflicted Injury or Suicide or any attempted suicide; ● Illegal act or criminal activity; ● Driving a vehicle/vessel without a valid driving license; ● Participation in competitions, races, contests, matches in land, air or sea; mountain climbing, potholing, paragliding, bungee jumping, parachuting or scuba diving; ● Flying in an aircraft or device for aerial navigation except as a fare-paying passenger on a certified passenger aircraft provided by a commercial airline and operated by a properly certified pilot flying between duly established and maintained airports.

## EXCLUSIONS FOR CRITICAL ILLNESS

**Cancer Excluded:**
- Any CIN stage [cervical intraepithelial neoplasia]
- Any pre-malignant tumor
- Any non-invasive cancer
- Prostate cancer stage 1
- Basal cell carcinoma and squamous cell carcinoma
- Malignant melanoma stage IA
- Any malignant tumor in the presence of any Human Immunodeficiency Virus.

**Heart Attack [Myocardial Infarction] Excluded:**
- Other acute Coronary Syndromes [e.g. stable/unstable Angina pectoris] and Diagnosis must be confirmed by a consultant cardiologist.

**Stroke Excluded:**
- Transient ischemic attacks [TIA]
- Traumatic injury of the brain
- Neurological symptoms due to migraine

**Coronary Artery [Bypass] Surgery Excluded:**
- Angioplasty
- Any other intra-arterial procedures
- Key-hole surgery

**Heart Valve Replacement Excluded:**
- Repair via intra-arterial procedure & via key-hole surgery or any other similar techniques.

## DISCLAIMER

I, understand the importance of disclosing all material information and hereby declare and agree that all answers given to all questions are to the best of my knowledge and belief, complete and true and that I have not withheld any material facts, failing which the Company reserves the right to cancel the policy and /or repudiate any claims under this policy.

## TO BE FILLED BY OFFICE

| Insurance Enrollment Date: | D | D | M | M | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|---|

**Account Holder's Signature**
Name:
Date:
Contact No.:
Email:

**Authorized Officer Seal & Signature**
Date:

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