MEDGULF
THE MEDITERRANEAN & GULF COOPERATIVE INSURANCE & REINSURANCE CO. (S.J.S.C)
ميدغلف
شركة المتوسط والخليج للتأمين وإعادة التأمين التعاوني (ش.م.س)

REQUEST FOR GROUP PERSONAL ACCIDENT INSURANCE QUOTATION

Applicant's Name:		
Address:		
Fax No.:	**Tel. No.:**	**R.C. No.:**
Line of Business:		
Contact Person:		**Position:**
Presently Insured By:		**Until:**

A – Census : Please complete the table below or provide a soft copy of the list with Serial number, Date of birth, Class and Sum Insured.

AGE BAND	CLASS A		CLASS B		CLASS C	
	Duties:		Duties:		Duties:	
	No. of Employees	Sum Insured (Cumulative)	No. of Employees	Sum Insured (Cumulative)	No. of Employees	Sum Insured (Cumulative)
Up to 30						
31to 40						
41 to 50						
51 to 60						
61 to 65						
66 to 70						
Total						

B – Benefits : Please chose the sum insured and additional benefits you require for each class.

Class	Age Limit	Definition of Individual Sum Insured			
A		☐	SR.	☐	( ) x Monthly Salary with Max. ( ) Min. ( )
B		☐	SR.	☐	( ) x Monthly Salary with Max. ( ) Min. ( )
C		☐	SR.	☐	( ) x Monthly Salary with Max. ( ) Min. ( )

Additional Benefits Required			
☐	**PTDr: Permanent Total Disability (Loss of eyes or limbs only)**	☐	**PTDw: Permanent Total Disability (Functional loss of eyes, limbs or organs)**
☐	**PPDr: Permanent Partial Disability (Loss of an eye or limb only)**	☐	**PPDw: Permanent Partial Disability (Functional loss of any eye, limb or organ)**
☐	**TPD: Temporary Total Disability (Weekly Indemnity 60%of salary)**	☐	**MX: Medical Expenses up to SR 100,000**

The Applicant warrants that, to the best of his knowledge, the above information is true and complete and will be the basis of the insurance quotation being requested.

Signed in _____ on behalf of the applicant this _____ day of _____ of the year _____

Name & Position:	**Signature & Stamp:**