

**TRAVEL INSURANCE PROPOSAL FORM**

Title (Mr/ Mrs/ Miss / Dr) \_\_\_\_\_ Surname \_\_\_\_\_

First Name(s) \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Medical Aid Number** \_\_\_\_\_ Passport Number \_\_\_\_\_ Nationality \_\_\_\_\_  
*(For Pulamed members only)*

Postal address \_\_\_\_\_

Physical Address \_\_\_\_\_

Email Address \_\_\_\_\_

Contact Nos. Work \_\_\_\_\_ Res \_\_\_\_\_ Mobile \_\_\_\_\_

Departure Date \_\_\_\_\_ Return Date \_\_\_\_\_

Destination \_\_\_\_\_ Beneficiary \_\_\_\_\_

Name of Doctor \_\_\_\_\_ Tel No. of Dr \_\_\_\_\_

**Additional Members Information** *(Your Pulamed dependents travelling with you on this trip)*

Title	Full Names	Date of Birth	Passport Number	Nationality

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

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