



HEALTH DECLARATION - GROUP MEDICAL INSURANCE SCHEME

Name of Employer & Policy Number

Name of employee/ life assured.

Date of Birth

Dept. /Designation

Passport No:

Emirates ID No:

Visa Location:

Mobile Number:

Email Address

Existing Policy details with expiry details if any:

If you answered yes to any of the questions mentioned below, please provide us with the latest medical report for the related medical condition.

1. Has any application for life or disability cover ever been refused, postponed or accepted with an extra premium or with special terms? Yes No
2. Are you exposed to any particular dangers in the pursuance of your profession or in your leisure time (such as handling dangerous materials, prolonged stays in countries outside of Europe, practicing dangerous and hazardous sport such as private aviation, gliding, motor-gliding or hang-gliding, parachuting, diving, Skiing, mountaineering, martial arts, motor sports or any racing)? Please specify..... Yes No
3. Do you suffer or have you ever suffered from diseases or disturbances effecting the:
 - a) **Heart, Circulation or Cardiovascular System** (e. g. hypertension, coronary artery disease, cardiac defects, stroke, angina pectoris, thrombosis) Yes No
If yes; please specify the disease and treatment and provide medical reports where-ever applicable.....
 - b) **Brain** (e. g. vertigo, frequent headaches, migraine) Yes No
If yes; please specify the disease and treatment and provide medical reports where-ever applicable.....
 - c) **Blood** (e. g. blood-clotting disorder) Yes No
If yes; please specify the disease and treatment and provide medical reports where-ever applicable.....



- d) **Respiratory Organs** (e. g. asthma, repeated or chronic bronchitis, allergic rhinitis) Yes No
If yes; please specify the disease and treatment and provide medical reports where-ever applicable.....
- e) **Ears** (e. g. impairment or acute loss of hearing, tinnitus) Yes No
If yes; please specify the disease and treatment and provide medical reports where-ever applicable
- f) **Eyes** (e. g. impaired vision) – Yes No
in case of ametropia please indicate: diopters left right.....
- g) **Larynx, Thyroid** Yes No
If yes; please specify the disease and treatment and provide medical reports where-ever applicable.....
- h) **Pancreas, Liver** (e. g. hepatitis, icterus), **Spleen** Yes No
If yes; please specify the disease and treatment and provide medical reports where-ever applicable.....
- i) **Kidneys** (z. B. kidney stones), **Urinary Tract** and **Genitals** Yes No
If yes; please specify the disease and treatment and provide medical reports where-ever applicable.....
- k) **Oesophagus** (e. g. reflux disease), **Stomach** (e. g. gastric ulcers, chronic gastritis) Yes No
If yes; please specify the disease and treatment and provide medical reports where-ever applicable.....
- l) **Nervous System or the Psyche** (z. B. seizure disorder, multiple sclerosis, paralysis, mental-health problems, depressions, eating disorders) Yes No
If yes; please specify the disease and treatment and provide medical reports where-ever applicable.....
- l) **Bowels** (e. g. morbus crohn, colitis ulcerosa, duodenal ulcers) Yes No
If yes; please specify the disease and treatment and provide medical reports where-ever applicable.....
- m) **Musculoskeletal System** (e. g. spinal column, intervertebral discs, shoulder-, hip-, or knee-joints, dysfunctions of muscles, tendons, joints and/or ligaments) Yes No
If yes; please specify the disease and treatment and provide medical reports where-ever applicable.....
- n) **Skin** (e. g. eczema, allergy) Yes No
If yes; please specify the disease and treatment and provide medical reports where-ever applicable.....



- o) or have examinations resulted in diagnosing **Tumours** (e. g. cancer), Yes No
Diabetes, Allergies, Rheumatic Diseases (e. g. chronic arthritis),
Gout, Poisoning, Infectious Diseases, elevated **Blood Lipids** (e. g.
Cholesterol) or elevated **Liver Function Tests**?
If yes; please specify the disease and treatment and provide medical
reports where-ever
applicable.....
4. Do you suffer from any other physical or mental impairments (e. g. Yes No
congenital handicaps, deformities, impairments following operations,
infections, accidents, or amputations)?
If yes; please specify the disease and treatment and provide medical
reports where-ever
applicable.....
5. Do you take medicines or drugs on a regular basis? Yes No
If yes; please specify the disease and treatment and provide medical
reports where-ever
applicable.....
6. Did you undergo any medical examinations, treatments or consultations Yes No
by doctors within the last 5 years other than regular check-ups with
normal findings?
If yes; please specify the disease and treatment and provide medical
reports where-ever
applicable.....
7. Have you undergone operations or treatments in hospitals or at health Yes No
resorts during the past 10 years, or have any of the latter been planned
and advised to be taken into consideration?
If yes; please specify the disease and treatment and provide medical
reports where-ever
applicable.....
8. Has an HIV infection been detected? Yes No
9. Please indicate your height and your current weight cm kg
10. Are you suffering from any Auto-immune disorders like Gullian-Barre Syndrome, Yes No
Psoriasis, Rheumatoid Arthritis, Ulcerative colitis, Multiple Sclerosis
If yes; please specify the disease and treatment and provide medical reports
Where-ever applicable.....
11. Are you planning for surgery for any recently ailment diagnosed recently Yes No
If yes, please provide the details of surgery posted for and provide medical reports
Where-ever applicable.....

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Following questions need to be answered by Female member;

- a) Please provide your marital status Married Single
- b) Have you suffered/are you suffering from any Gynecological problems? Yes No
- c) Are you pregnant at present? (Yes/No) **If yes, Please fill the pregnancy declaration form.**
- d) Have you ever undergone any investigation or treatment or received medical advice or consulted a physician for
- i) Any disease or disorder in the cervix, uterus, ovary (ies) or vagina; abnormal bleeding, cancer or abnormal growth? Yes No
- ii) Any disease or disorder of breast(s), such as breast lump, cyst, fibrocystic disease, cancer or abnormal growth? Yes No
- iii) Have you undergone mammogram or pap smear recently Yes No
If yes; please specify provide medical reports.....

General Declaration from the Member

If you are suffering from any critical illness such as cancer, Cerebrovascular accident –Stroke and related complications, Vertebral column and spinal injury, Organ failure, bedridden status; please provide further data, such as name of the respective disease, time and duration and whether it has been cured completely without leaving any problems. Please give the name of doctor in charge.

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I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of the proposal.

I understand that this form will constitute an integral part of my proposal for life assurance/ medical insurance and that failure to disclose any material fact known to me/ any mis-representation in this form may invalidate the assurance/insurance contract.

Date

Signature of the person to be insured
