

Medical Application Form

Insured Name: _____ Inception Date: _____
 Required Plan: _____ Policy No.: _____

NAME please specify Employee (E), Child (C) or Spouse (S)			Relation	D. O. B.	Nationality	Sex	Height	Weight	Photo card	UAE Resident
First Name	Middle Name	Family Name	E/S/C	DD/MM/YY		M/F	CM	KG	Yes/No	

Has DIC previously covered any of the above applicants? Yes No
 Is there a member in your family that is not proposed for Insurance? Yes No If Yes, please explain under section Comments
 Marital Status: _____ No. of Children: _____ Active at work since: _____
 Street: _____ City: _____
 P.O. Box: _____ Tel. No: _____

I hereby declare and agree, with respect to both, myself and to my Dependants, that I am aware of the general terms of this insurance and I accept them. With the above, I authorise my doctor, health institution or other organisation or person that has any information about my health and/or activities (and those of my **Dependants**) to provide the **Insurer** with the said information. This shall include hospital and any other records pertaining to medical advice, diagnosis, treatment or disturbances. A photocopy of this authorisation has the same validity as the original.

Have you ever been diagnosed or received any treatment (including hospital or surgery) or felt any disorder or pain or had any symptoms indicating:

(Please tick relevant box)	Yes	No
1. Infectious and parasitic diseases	<input type="checkbox"/>	<input type="checkbox"/>
2. Neoplasms/Cancer (benign or malignant)	<input type="checkbox"/>	<input type="checkbox"/>
3. Diseases of the endocrine system, nutritional-, metabolic diseases and immunity disorders, diabetes	<input type="checkbox"/>	<input type="checkbox"/>
4. Diseases of blood and blood forming organs	<input type="checkbox"/>	<input type="checkbox"/>
5. Mental-/psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>
6. Diseases of the nervous system and sense organs (ears, eyes, nose)	<input type="checkbox"/>	<input type="checkbox"/>
7. Diseases of the cardiovascular system incl. hypertension	<input type="checkbox"/>	<input type="checkbox"/>
8. Diseases of the respiratory system	<input type="checkbox"/>	<input type="checkbox"/>
9. Cirrhosis/ Hepatitis / Wilson's disease / Pancreatitis/ Liver disease / Crohn's disease / Ulcerative Colitis /Piles or any other disease of Mouth , Oesophagus , Liver , Gall bladder , Stomach or Intestines or any other part of Digestive System?	<input type="checkbox"/>	<input type="checkbox"/>
10. Kidney stones/ Renal Failure/ Dialysis/Chronic Kidney Disease/Prostate Disease or any other disease of Kidney, Urinary tract or reproductive organs?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
11. Pregnancy, complications of pregnancy, child birth and the puerperium incl. abortions	<input type="checkbox"/>	<input type="checkbox"/>
12. Disease of the skin and subcutaneous tissue	<input type="checkbox"/>	<input type="checkbox"/>
13. Diseases of the musculoskeletal system and connective tissue	<input type="checkbox"/>	<input type="checkbox"/>
14. Congenital anomalies, hereditary/genetic diseases	<input type="checkbox"/>	<input type="checkbox"/>
15. Certain conditions originating in the perinatal period	<input type="checkbox"/>	<input type="checkbox"/>
16. Injury and poisoning	<input type="checkbox"/>	<input type="checkbox"/>
17. Previous medical/surgical hospitalisations, procedures and operations	<input type="checkbox"/>	<input type="checkbox"/>
18. Any (chronic) disease(s), symptoms and complaints not mentioned above	<input type="checkbox"/>	<input type="checkbox"/>
19. Any Pre-existing disease(s), symptoms and complaints within the last ten years	<input type="checkbox"/>	<input type="checkbox"/>
20. Motor Neuron Disease / muscular dystrophies/ Myasthnia Gravis or any other disease of Neuromuscular system (muscles and/or nervous system)	<input type="checkbox"/>	<input type="checkbox"/>
21. Stroke/ Paralysis/ Transient Ischemic Attack / Multiple Sclerosis/ Epilepsy/ Parkinsonism/ Alzheimer's Depression /Dementia or any other disease of Brain and Nervous System?	<input type="checkbox"/>	<input type="checkbox"/>
22. Smoke, consume alcohol, or chew tobacco or use any recreational drugs? If Yes please then provide the frequency and amount consumed	<input type="checkbox"/>	<input type="checkbox"/>



In case the answer is YES to any of the conditions/diseases above please specify full details (preferably by a Medical Physician) on the additional questionnaire (Personal Information), which will be found attached to this application form.

In case medication is required on a regular basis please specify the full details such as genuine name, brand name and daily/weekly quantity on the additional questionnaire (Personal Information), which will be found attached to this application form.

Comments:

Only to be filled out if you have answered "Yes" in the question of any family members, who is not proposed for Insurance.

I agree that no indemnity will be paid under the proposed insurance policy for medical expenses arising from disorders which were declared prior to completion of this Application and which were not disclosed to the insurer at the date of this application. Failure to disclose material information to the insurer will invalidate the proposed insurance policy.

I hereby agree, with this in respect to both, myself and my Dependants that I am aware of the general terms of this insurance and I accept them for myself and on behalf of my dependants. I the undersigned declare that all of the above information as well as all declarations on the additional questionnaire (personal information) are true and complete. This information shall be considered as an integral part of the insurance policy.

Date: _____

Signature: _____

Medical Conditions

Name of applicant	Age:	Sex:
Date of application: / / (dd/mm/yyyy)		
Medical condition/diagnosis: (if more than one sickness, please complete a separate form for each)		
Date of last treatment/symptoms: / / (dd/mm/yyyy)	ongoing treatment = current date	

Diagnosis Status:

- Cured/ no symptoms
- Ongoing symptoms
- Ongoing hospitalization
- Pending hospitalization
- Ongoing treatment
- Pending treatment

Yes No

In case of any *Diagnosis Status* the applicant was treated as:

- Outpatient
- Hospitalized
- Treated both ways
- Operated on: / / (dd/mm/yyyy)

How often do the symptoms occur? Or can the illness be described as follows?

- Acute
- Chronic
- Recurrent

Did you have any bone fractures or injuries to bones or tendons?

Has any material used for osteosynthesis etc. been removed?

In case medication is required on a regular basis please specify the genuine name, the brand name as well as the daily/weekly quantity below.

In case you are suffering from hypertension please specify your Systolic and Diastolic readings below.

Systolic:

Diastolic:

In case of diabetes please specify whether insulin dependent.

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Are you currently pregnant?

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- If Yes, have there been any complications to date?
- Last Menstrual period date -
- Are you currently trying to get pregnant?
- Are you undergoing any form of fertility treatment?



MEDICAL PRACTITIONER(S) MOST FREQUENTLY VISITED IN THE LAST 2 YEARS:

- Name:
- Address:
- Telephone No.:

I understand and acknowledge any pregnancy not declared at the time of this application's coverage will be at the sole discretion of the insurer. The insurer has the right to not cover any maternity claims to any undeclared pregnancy. I also acknowledge and understand any pregnancy, which arises within forty calendar days from the date of this application; coverage will also be at the discretion of the insurer.

Date: _____

Signature: _____