

Oman United Insurance CO. SAOG

Medical Application Form

NAME	RELATION (E/S/C)	D. O. B	SEX (M/F)	MARITAL STATUS	HEIGHT (CM)	WEIGHT (KG)	OMAN (VISA)
	PRINCIPLE						
	SPOUSE						
	CHILD						
	CHILD						

CIVIL ID		Mobile number	
Coverage Start Date:		Cover End Date:	
Network of GN or RN or RN 2 or RN 3:		Annual Benefit Limit of RO 3,000 or 5,000 or RO 10,000:	
Plan/Cover Type would be IP+OP		20% co-pay on all services at GN and 10% co-pay on all services at RN/RN2/RN3	
Pre-existing and Chronic Limit are not Covered		Optional Covers (Dental/Optical/Maternity etc.) are not available	

Have your health insurance request was ever declined or accepted on substandard terms?

If yes, then please provide details?

Yes <input type="checkbox"/>	No <input type="checkbox"/>
Yes <input type="checkbox"/>	No <input type="checkbox"/>

Is there a member in your family that is not proposed for Insurance?

Please answer all questions mentioned below as either Yes or No:

No.	Details	Declaration
1.	Are you under any medical observation/undergoing any medical/ surgical/ treatment or have been advised for the same?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.	Do you have any chronic illness? A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics: It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests. It needs ongoing or long-term control or relief of symptoms. It may require rehabilitation or the patient to be trained to cope with it. It continues indefinitely. Symptoms / medical condition may recur or likely to recur.	Yes <input type="checkbox"/> No <input type="checkbox"/>
3.	Are you taking any medication (pharmaceutical/alternative medicine) or have been advised?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4.	Do you have any physical problems/ disability for which you are undergoing physiotherapy or have been advised for?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5.	Have you been admitted in the hospital in the last 10 years?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6.	Are you currently pregnant or show signs and symptoms of pregnancy or planning to get pregnant? (This question apply only to married females) If the answer to above is YES kindly fill the attached supplementary maternity questionnaire.	Yes <input type="checkbox"/> No <input type="checkbox"/>
7.	Do you have any previous surgical history or are you advised to undergo any kind of surgeries in the near future?	Yes <input type="checkbox"/> No <input type="checkbox"/>
8.	Have you been ever diagnosed/treated and cured or undergoing treatments for cancer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
9.	Is there any other medical condition or disorder or any symptoms that you should be declared, and you are unable to relate to the above-mentioned Questions?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Please fill below details if you have answered any question as "YES" from above.

- Please specify name of the patient: _____

- Medical Condition / Diagnosis: _____
(if we have more than one sickness please use another form)

- Diagnosis status: Cured / No Symptoms Ongoing Symptoms Ongoing Hospitalization Pending Hospitalization
 Ongoing treatment Pending treatment

- Treatment taken as: Out-Patient Hospitalization Treated both ways Operated on Date: _____

- Can the illness be described as follows? Acute Chronic Recurrent

- Please specify the medication genuine names, the brand name as well as the daily/weekly quantity:

- In case you are suffering from hypertension, please specify your recent Systolic and Diastolic readings below:

o Systolic: _____ Diastolic: _____

- In case of diabetes, please specify whether insulin dependent, also specify/attach latest HbA1c result. Yes No HbA1c: _____

Based on above declarations, insurer reserves the right to request for additional medical report/documents to complete the assessment of medical conditions.

False declaration shall result in no coverage and cancellation of the insurance policy

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 Dependents that I am aware of the general terms of this insurance and I accept them for myself and on behalf of my dependents. I, the undersigned declare that all the above information as well as all declarations on the additional questionnaire (personal information) are true and complete.

I hereby agree that in case of cancellation of policy, an admin expenses fee of RO 10 would be charged from proportionate premium for unexpired term of the policy. However if any claim is made before cancellation of the policy, no refund of proportionate premium would be made.

This information shall be considered as an integral part of the insurance policy.

Date: _____

Signature: _____

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Supplementary Pregnancy Questionnaire

If you are currently pregnant please answer the below questions.

Name of the Pregnant Female:

Last Menstrual period date :

Do you have earlier history of Caesarean Section, Premature Delivery or Premature babies? Or any other complications related to maternity, till date?

Have you undergone any treatment or taken any medications for infertility to achieve this pregnancy?

Please send a copy of the latest ultrasound report and specify if there are any abnormal findings or more than one foetus seen.

Do you have any of the below conditions?

Medical Condition	YES / NO
Any Heart Disease or hypertension	Yes <input type="checkbox"/> No <input type="checkbox"/>
Autoimmune Diseases	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes/gestational diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Thyroid Diseases	Yes <input type="checkbox"/> No <input type="checkbox"/>
Kidney Diseases	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any placenta problems with the current pregnancy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any episode of vaginal bleeding with this pregnancy	Yes <input type="checkbox"/> No <input type="checkbox"/>

If answer to any of the above is yes please support with relevant medical records and detailed information on the same.

Disclaimer: 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.

Name: _____

Signature: _____

Date: _____