

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		MF	CM	KG	Yes/No	

Has Nextcare 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. Diseases of digestive system	<input type="checkbox"/>	<input type="checkbox"/>
10. Diseases of genitourinary system, kidney diseases and breast disorders	<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"/>



Takaful Oman Insurance SAOG

PO Box 207, Post Code: 134, Sultanate of Oman

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: _____



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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
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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

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

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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

- Acute
- Chronic
- Recurrent

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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

Has any material used for osteosynthesis etc. been removed?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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.

<input type="checkbox"/>	<input type="checkbox"/>
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Date: _____

Signature: _____