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| Insured No. | | | …………………………… | | | | | | | | Agent/Broker No. | | | | | | | …………………………… | | | | | | | | Policy No. | | | | ……………………………………………………… | | | | | | |
| This proposal form includes a medical questionnaire and constitutes the basis of the decision of the company to contract with me or to refrain thereof. It also constitutes the basis of the terms, conditions and exclusions of the policy. Any concealment or misstatement may void the policy pursuant to section 982 of the code of obligations. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Particulars of Applicant** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Policy holder’s full name: ……………………………………………………………………………………… | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Commercial register no.: ……….………….………… | | | | | | | |
| (First, Middle/Father’s, Last) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Insured full name: …………………………………………………………………………………………………………………………………….…………………………. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (First, Middle/Father’s, Last) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: ………………………………………………………………………………………………………………………………………………..…………………………. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Building, floor, street, city, P.O. Box/Post code) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Gender:  Male  Female | | | | | | | | | | Date of birth: …………/…………/…………… | | | | | | | | | | | | | | | ID/Pass No.: ……………………………….…………...………………… | | | | | | | | | | | |
| Phone: | …………………………; | | | | | | | …………………………; | | | | | | | | | …………………………; | | | | | | | | E-mail: …………………………………………………………………….. | | | | | | | | | | | |
|  | Home | | | | | | | Office | | | | | | | | | Mobile | | | | | | | |  | | | | | | | | | | | |
| Requested period of insurance: from: …………/…………/…………… to: …………/…………/…………… | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Insurance plan** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **In-Hospital Class:**  Lux  A  B  C SP  SPB | | | | | | | | | | | | | | | | | | | | | | | | **Plans:**  Group Plan  Abroad Emergency Cover | | | | | | | | | | | | |
| **Network:** | | | | | Full | | | | | | | | Limited | | | | | | | | | | | | | | | | | | | | | | | |
| **Co-insurance:** | | | | | Co-Nil | | | | | | | | Co-NSSF | | | | | | | | | | | | | | | | | | | | | | | |
| **Out-Hospital Plans:** | | | | | Ambulatory full network: XS:  0%  10%  15%  20% | | | | | | | | | | | | | | | | | | | | | | Ambulatory limited network: XS:  15%  20% | | | | | | | | | |
|  | | | | | Prescription Medicine: XS:  0%  10%  15%  20% | | | | | | | | | | | | | | | | | | | | | | Doctor’s Visit | | | | Dental Care | | | Vision Care | | |
| **Marital Status:** | | | | single | | | married | | | | | | | widowed | | | | | | divorced | | | | | | | | | | | | | | | | |
| **Family Members** | | **Name** | | | | | | | | | | | | | **Sex** | **Date of Birth** (Day**/**Month**/**Year) | | | | | | **Height & Weight** | | | **Nationality** | | | | **Profession** | | | **With NSSF?** | | | **Is there a family member that will not be insured?**  No  Yes, please specify reason: | |
| Insured | |  | | | | | | | | | | | | |  |  | | | | | | ……cm/……Kg | | |  | | | |  | | | Yes  No | | |
| Spouse | |  | | | | | | | | | | | | |  |  | | | | | | ……cm/……Kg | | |  | | | |  | | | Yes  No | | |
| Children | |  | | | | | | | | | | | | |  |  | | | | | | ……cm/……Kg | | |  | | | |  | | | Yes  No | | |
|  | |  | | | | | | | | | | | | |  |  | | | | | | ……cm/……Kg | | |  | | | |  | | | Yes  No | | |
|  | |  | | | | | | | | | | | | |  |  | | | | | | ……cm/……Kg | | |  | | | |  | | | Yes  No | | |
|  | |  | | | | | | | | | | | | |  |  | | | | | | ……cm/……Kg | | |  | | | |  | | | Yes  No | | |
|  | |  | | | | | | | | | | | | |  |  | | | | | | ……cm/……Kg | | |  | | | |  | | | Yes  No | | |
|  | |  | | | | | | | | | | | | |  |  | | | | | | ……cm/……Kg | | |  | | | |  | | | Yes  No | | |
| **Have you or any of your family members (listed above) been previously insured?  No  Yes, please provide the name of the company and the expiry date of the medical insurance contract** …………………….…………………….……………………………………….…………………….…………… | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **If any of the persons was treated or had an operation due to any of the below diseases, please mark it with an (x)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Cardio-vascular diseases (hypertension, myocardial infarction…) | | | | | | | | | | | | | | | | | | | yes no | | | | 1. Has any of you ever followed or is following a medical treatment? | | | | | | | | | | | | | yes no |
| 1. Respiratory diseases (asthma, tuberculosis…) | | | | | | | | | | | | | | | | | | | yes no | | | | 1. Has any of you recently undergone medical examination or test(s)? | | | | | | | | | | | | | yes no |
| 1. Digestive system diseases (ulcer, liver diseases…) | | | | | | | | | | | | | | | | | | | yes no | | | | 1. Allergy(ies) against a drug, food or other | | | | | | | | | | | | | yes no |
| 1. Kidney & urinary tract diseases | | | | | | | | | | | | | | | | | | | yes no | | | | 1. Significant variation in weight during the last 12 months | | | | | | | | | | | | | yes no |
| 1. Osteo-articular & muscular diseases or transplants | | | | | | | | | | | | | | | | | | | yes no | | | | 1. Were you or are you currently under diet? | | | | | | | | | | | | | yes no |
| 1. Nervous system diseases (depression, multiple stenosis, epilepsy…) | | | | | | | | | | | | | | | | | | | yes no | | | | 1. Regular practice of hazardous sport or leisure, or motorcycle riding | | | | | | | | | | | | | yes no |
| 1. Endocrine glands & diabetes diseases (triglyceride, thyroid diseases…) | | | | | | | | | | | | | | | | | | | yes no | | | | 1. Were you or are you a smoker? | | | | | | | | | | | | | yes no |
| 1. ENT or eye diseases | | | | | | | | | | | | | | | | | | | yes no | | | | If yes, for how long? ……………; type & qty./day: ………………..  ………………………………………………………………………… | | | | | | | | | | | | | |
| 1. Hematological diseases (anemia) | | | | | | | | | | | | | | | | | | | yes no | | | |
| 1. Malignant tumors (cancer, leukemia…) | | | | | | | | | | | | | | | | | | | yes no | | | | 1. For women: are you currently pregnant? | | | | | | | | | | | | | yes no |
| 1. Sexually Transmitted Diseases & AIDS (positive serology or disease) | | | | | | | | | | | | | | | | | | | yes no | | | | If yes, expected date of delivery: …………………………………… | | | | | | | | | | | | | |
| 1. Congenital malformation or disablement | | | | | | | | | | | | | | | | | | | yes no | | | | 1. Irregular or heavy menstrual periods, breast diseases / troubles, or any other gynecological diseases | | | | | | | | | | | | | yes no |
| 1. Other diseases, accidents, previous or future operations | | | | | | | | | | | | | | | | | | | yes no | | | |
| If the answer for one of the above listed questions is yes, kindly specify the name of the individual affected by or treated for a disease, the corresponding number in the above table as well as all the relevant details and tests results (if any). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name** | | | | | | **Disease No.** | | | | | | **Diagnosis** | | | | | | | | | **Treatment** | | | | | | | **Date** (Day/Month/Year) | | | | **Physician/Hospital Name** | | | | |
|  | | | | | |  | | | | | |  | | | | | | | | |  | | | | | | |  | | | |  | | | | |
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| The undersigned asserts that the information provided in this proposal in respect of myself and of my family is complete, precise and true. I hereby authorize the insurance company and its Third Party Administrator or any party they may duly appoint to inquire about my medical situation and that of my family members and request that they be provided with all information connected to our medical history from doctors, hospitals and other medical providers or insuring parties and recognize that they are entitled to access our medical files. This authority is given for the purpose of this proposal form and of the insurance contract, which may be issued as a result thereof. I hereby waive the right to the medical confidentiality in respect of myself or of the members of my family to the extent necessary for the insurance company to investigate the accuracy of the information provided in this document and to assess the truth of my medical situation. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date: …………/…………/…………… | | | | | | | | | Signature: …………………………………… | | | | | | | | | | | | | | | | | | | | | | | | UWM.FR02/02E-IF, October 2018 | | | |