|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| 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 |