

Medical Application Form

Application Number: _____

Applicants Name: _____

Inception Date: _____

<i>Tick the required plan below:</i>	
Gold	
Silver Premium	
Silver Classic	
Green	
Silk Road	

<i>Tick the required option below:</i>	
Co-insurance 20% on all OP services	
Co-insurance 10% on all OP services	
Deductible 20% with maximum of AED 50/-	
Deductible 20% with maximum of AED 75/-	

NAME	Relation	D. O. B.	Nationality	Sex	Height	Weight	Emirate of Visa issuance	Emirate of Residence
First Name Middle Name Family Name	(E/S/C)	(DD/MM/YY)		(M/F)	(CM)	(KG)		

Has Orient / MedNet previously covered any of the above applicants?

YES If yes, please provide details

No

Is there a member of your family who is not proposed for insurance cover?

YES If yes, please provide details

No

Marital Status: _____ No. of Children: _____ Profession : _____
 Street: _____ City: _____
 P.O. Box: _____ Mobile. No: _____
 Email Address: _____

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.

Please tick relevant box if you have ever been diagnosed with and/or received any treatment/felt any disorder/pain/had any other symptoms:

*Examples mentioned below are only descriptive and are not meant to limit aforementioned medical conditions.
(Please tick relevant box)

<p>1. Infectious and parasitic diseases (e.g. Typhoid, Enteritis, Tuberculosis, Malaria)*</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p>11. Pregnancy, complications of pregnancy, child birth and the puerperium incl. abortions</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p>2. Neoplasms/Cancer (benign or malignant)*</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p>12. Disease of the skin and subcutaneous tissue (Abscess , ulcer , cellulitis , cysts , dermatitis , eczema , herpes , corn , pigmentation or melanoma ...</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p>3. Diseases of the</p> <ul style="list-style-type: none"> • Endocrine system (Pituitary, Thyroid disorders, Poly cystic Ovaries, Diabetes)* • Nutritional (Vitamin Deficiency , Anaemia , Rickets ...) • metabolic diseases (Glucose intolerance , Lipid disorders , Gout ...) • immunity disorders <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p>13. Diseases of the musculoskeletal system and Connective tissue (Myalgia or Body pain , arthropathy , joint stiffness o dislocation , Lumbago , Sciatica , Inter vertebral Disc disorders, Scoliosi or any acquired bone deformity....</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p>4. Diseases of blood and blood forming organs (All types of Anaemia, Coagulation defects such as Haemophilia or Sickle cell, Thrombocytopenia.)</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p>14. Congenital anomalies (cardiovascular anomalies, Cleft lip or plate and hereditary/genetic diseases (Down syndrome...)</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p>5. Mental-/psychiatric disorders (Anxiety, Depression, Insomnia, Schizophrenia, Mental retardation...)</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p>15. Certain conditions originating in the perinatal period (e.g. Maternity hypertension – Cervical incompetence, Premature rupture of membrane)</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p>6. Diseases of the ,</p> <ul style="list-style-type: none"> • nervous system • (Cerebral haemorrhage, Thrombosis, Seizure, Bell's palsy, Parkinsonism, Multiple sclerosis, Pituitary adenoma, meningitis) • sense organs <p>ears (Ear infection , wax , surgery of tympanic membrane , ortho sclerosis or hearing impairment ...)</p> <p>Eyes (Conjunctivitis, Glaucoma, Cataract, other Retinal or lens disorders, Visual disturbance or blindness)</p> <p>Nose (Rhinitis, Sinusitis, nasal allergy, nasal polyp, epistaxis)</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p>16. Diseases of genitourinary system (cystitis or Urinary bladder disorders , male testicular disorders , Variocele , female ovarian or uterine disorders , female cervical , vaginal or vulval disorders , Salpingitis or PID ,)</p> <p>kidney diseases (Renal colic or stone , Renal failure , nephritis or nephrotic syndrome)</p> <p>And breast disorders (Abscess, cyst, neoplasm or any mass, nipple discharge or disorder, Pain or hypertrophy)</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p>7. Diseases of the cardiovascular system (Hypertension, Ischemic and Coronary heart disease, Myocarditis, Arrhythmia, Valve disorders, ventricular hypertrophy or cardiomyopathy)</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p>17. Previous medical/surgical hospitalisations, procedures and operations</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p>8. Diseases of the respiratory system(Bronchitis , Pneumonia , Upper respiratory tract infections , allergy , Asthma , Respiratory distress , Lung fibrosis , pulmonary embolism)</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p>18. Any (chronic) disease(s), symptoms and complaints not mentioned above</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>

<p>9. Diseases of digestive system(Peptic or gastric ulcer , reflux , gastritis , bleeding varices , intestinal obstruction ,inflammatory bowel disorders , Colitis , chron's disease)</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	<p>19. Any Pre-existing disease(s), symptoms and complaints within the last ten years</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p>10. Injury and poisoning</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>	

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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Date: _____

Signature: _____