بـوبـيـان تـكـافـل
Boubyan Takaful
15 YEARS عام

INDIVIDUAL / FAMILY
MEDICAL APPLICATION FORM

Name of the Plan ____________
Contact Mobile No ____________
Email ____________
Marital Status ____________

Hospitalization Class ______________________________
P. O Box ______________________________
Address ______________________________
If Married No of Children ______________________________

Name			Date of Birth			Gender	Relationship	Height	Weight	Occupation
First Name	Middle Name	Family Name	DD	MM	YY	M / F	E/A/S/C	In CM	In KG	

Chapter A - Insurance History & Extra Professional Activities (if "Yes" please specify the reason)

Description	Yes	No	Description	Yes	No
Have you ever been accepted for life and/or health insurance on sub-standard terms?	☐	☐	Have you ever been declined for life and/or health insurance	☐	☐
Do you want to be covered for all amateur sport activities? (if "Yes," specify the most dangerous sport you currently practice or would intend to practice in the future)	☐	☐	Do you ride motorcycles? (if "Yes," specify if you require coverage for motorcycle accident)	☐	☐

Chapter B – Medical History of the Insured (if "Yes" please specify the reason)

Has you ever been diagnosed, treated or felt any disorder, pain or had any symptoms related to the following

Description	Yes	No	Description	Yes	No
Musculoskeletal & /or Connective Tissue System? (i.e.: fractures, joint or cartilage problems, back problems, deformities, bone infections, osteoporosis, arthritis, rheumatism, etc.)	☐	☐	**Digestive System?** (i.e. reflux, ulcers, diverticuli, bleeding-infection-obstruction-perforation of the esophagus, stomach, intestines or colon, problems of the teeth/ gums/ mouth/ jaw, problems with the liver	☐	☐
Blood & Blood Forming Organ Systems? (i.e.: anemia, thalasemia, bleeding disorders, blood	☐	☐	**Cancer, Neoplasms, Tumors?** (specify type, location, treatment, whether malignant or benign)	☐	☐
Endocrine, Nutritional, Metabolic and/or Immunity System? (i.e. diabetes, thyroid or pituitary gland problems, adrenal gland, ovary or testes problems, hormone problems, gout, multiple sclerosis, cystic fibrosis, metabolic disorders, immune problems, etc.)	☐	☐	**Nervous System or Sense Organs?** (i.e. ear injury/infection, vertigo, hearing problems, eye injury/disease, retina problems, glaucoma, vision problems, muscular dystrophy, brain/nerve degeneration, meningitis, paralysis, seizures, epilepsy, neuralgia, etc.)	☐	☐
Genitourinary System? (i.e. kidney/bladder infections, renal failure, kidney stones, endometriosis, menstrual cycle problems, salpingitis, ovarian cysts, prostate problems, impotence, testicle infections, sperm abnormalities, fertility problems, etc.	☐	☐	**Cardiovascular System?** (i.e. stroke, cerebral ischemia, rheumatic fever, atherosclerosis, aneurysm, embolism, peripheral vascular disease, hypertension, heart valve disease, irregular heart beat, pulmonary embolism, phlebitis, varicosities, etc.)	☐	☐
Respiratory System? (i.e. sinusitis, allergies, tonsillitis/laryngitis, bronchitis, emphysema, pneumonia, etc	☐	☐	**Skin-Subcutaneous Tissue?** (i.e. dermatitis, acne, seborrhea, puritis, etc.)	☐	☐
Have you ever undergone surgery to remove a body organ or structure? (specify body organ/ Structure, date & place of surgery?)	☐	☐	Are you HIV positive or have any medical condition or symptom indicative of HIV infection or AIDS?	☐	☐

Chapter C – Insured Profile(if the answer is "Yes" please specify the reason)

Description	Yes	No	Description	Yes	No
Do you smoke? (if Yes, what do you smoke? and number per day)	☐	☐	Do you practice any kind of routine exercise?	☐	☐
Do you drink alcohol (if yes, specify preferred type and daily/weekly consumption)	☐	☐	How often do you consult a physician per year?	☐	☐
How many hours do you sleep per day?	☐	☐	How many hours do you work per day?	☐	☐
How many times do you travel per year?	☐	☐	Have you ever taken any drugs?	☐	☐
Do you undergo routine medical check-ups?	☐	☐		☐	☐

Chapter D – Family Medical History (Father, Mother, Siblings)

Has any member of your family had symptoms or been diagnosed or received treatment for the following

Description	Yes	No	Description	Yes	No
Inherited disorder or genetic disease?	☐	☐	Hemophilia?	☐	☐
Muscular Dystrophy?	☐	☐	Multiple Sclerosis ?	☐	☐
Cancer?	☐	☐	Mental illness or disorders?	☐	☐
Nervous system and / or sense organ disease ?	☐	☐	Illness of the cardiovascular system?	☐	☐
Diabetes?	☐	☐		☐	☐

Detailed Answers to Questionnaire

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The above questions must be answered by the Applicant and/or by the proposed family member for insurance. False declarations shall result in no coverage and the cancellation of the insurance policy under consideration in this application, as from the effective date, with no premium refund.

In case of positive answer (yes), kindly provide the company with details per family member, on the opposite form by first specifying the member's number as indicated on the members schedule, the chapter, the question number and the explanation details.

Declaration

I the undersigned hereby declare that, to the best of my knowledge, all the above answers are full, complete and true. I further, on my behalf and on behalf of my legal dependents listed here above, give full and irrevocable authorization to my hospital, physician or other person who attended us or any member of my family to give **XXXX**, or its representative all information pertaining to our state of health; and I hereby waive our right of medical confidentiality to the benefit of **XXXX** and its representative.

Applicant Signature : ______________________________ Date : ________________

Important

It is however, agreed and understood that the final premium shall be defined by **United Insurance Company**, as a result of the underwriting process. In case of additional premium and/or specific exclusion(s), the Applicant shall be advised by phone, prior to the issuance of the Policy applied for. In case of the Applicant acceptance, the relevant policy shall be issued.