MaxMedical
We listen. We serve. We care.

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DUBAI INSURANCE
CARE & COMMITMENT SINCE 1970

CONFIDENTIAL MEDICAL HISTORY

IMPORTANT NOTES:

- Please answer the questionnaire completely and accurately in BLOCK CAPITALS.
- Kindly disclose all known medical conditions or suspected conditions and symptoms, whether or not professional advice has already been sought.
- Further information, if required, will need to be provided.
- Failure to disclose all the material facts may result to termination of cover or non-payment of claims.

1. APPLICANT

First Name					
Surname					
Date of Birth (dd/mm/yyyy)		Height (cm)		Weight (kg)	

2. PLEASE ANSWER ALL QUESTIONS WITH A 'YES' OR 'NO' AND PROVIDE COMPLETE DETAILS IF THE ANSWER IS 'YES' (EXCEPT FOR QUESTION 1)

1.	Are you in good health?	☐ Yes ☐ No
2.	Has an application for a health policy made by you to this or any other insurer ever been withdrawn or dropped, deferred or declined, or accepted with an extra premium?	☐ Yes ☐ No
3.	Do you smoke or consume tobacco? If yes, please state the quantity per day:	☐ Yes ☐ No
4.	Do you drink alcohol? If yes, how many units of alcohol do you drink per week? (1 shot = 1 unit, 250ml beer = 1 unit, 1 glass of wine = 1 unit)	☐ Yes ☐ No
5.	Do you wear any visual aids, glasses or contact lenses? If yes, please state for what condition:	☐ Yes ☐ No
6.	(For females only) Are you pregnant?	☐ Yes ☐ No
7.	Have you suffered any diseases/illnesses and seen a doctor or healthcare professional in the last 5 years?	☐ Yes ☐ No
8.	Have you been absent from work due to illness or injury for a continuous period of more than 10 days during the last one year?	☐ Yes ☐ No
9.	Have you undergone any Inpatient stay in a hospital or nursing home?	☐ Yes ☐ No
10.	Have you been taking any medications on a regular basis (e.g. pain killers, chronic medications, hormone treatment)	☐ Yes ☐ No

3. PLEASE INDICATE IF YOU HAVE HAD COMPLAINTS REGARDING, SYMPTOMS OF, RECEIVED TREATMENT FOR, UNDERGONE TESTS OR INVESTIGATIONS, HAVE BEEN DIAGNOSED OR HOSPITALISED FOR:

11.	Epilepsy, stroke, multiple sclerosis, migraine or any other neurological disorders?	☐ Yes ☐ No
12.	Anxiety, schizophrenia, depression, or any other psychological, psychiatric or mental illnesses?	☐ Yes ☐ No
13.	Arthritis, rheumatism, gout, osteoporosis, joint replacement, paralysis or any other skeletal and muscular disorders?	☐ Yes ☐ No
14.	Dermatitis, acne, psoriasis, eczema or any other other skin problems or allergic conditions?	☐ Yes ☐ No
15.	Tumours, cancer, lumps, cysts, fibroids or any abnormal growth whether benign or malignant?	☐ Yes ☐ No
16.	Heart diseases, high/low blood pressure, heart failure, aneurysm, varicose veins or any other heart and circulatory disorders?	☐ Yes ☐ No
17.	Any disorders of the stomach, intestines, kidney, liver, bladder or any abdominal organ problem and endocrine disorders including diabetes?	☐ Yes ☐ No
18.	Abnormal blood tests, anaemia, high cholesterol, malaria, Hepatitis B or C, HIV/AIDS or any other blood disorders and auto immune disorder?	☐ Yes ☐ No
19.	Pneumonia, bronchitis, asthma, tuberculosis and any other breathing or respiratory disorders?	☐ Yes ☐ No

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20.	Any eye, ear, nose, throat and thyroid problems?	☐ Yes ☐ No
21.	Any urinary, genital or reproductive system problem?	☐ Yes ☐ No
22.	(For females only) Any breast problem, disease of the uterus, ovaries, or any gynaecological and obstetrics disorders?	☐ Yes ☐ No

4. PLEASE ALSO ANSWER THE FOLLOWING:

23.	Are you aware of any condition that requires or may require a physician's or specialist's consultation or treatment in the future?	☐ Yes ☐ No
24.	Are you currently under any medical observation or receiving any medical treatment or intending to seek any medical advice?	☐ Yes ☐ No
25.	Are you undergoing regular medical reviews or check-ups?	☐ Yes ☐ No
26.	Are there any other conditions/facts relevant for disclosure?	☐ Yes ☐ No

5. PLEASE PROVIDE DETAILS IF YOU HAVE ANSWERED 'YES' TO ANY OF THE QUESTIONS FROM 2 TO 26

Question number	Detailed description of illness, severity of symptoms and diagnosis	Treatment(s) received		Date	Current Status
		Inpatient	Outpatient		

6. LEGAL DECLARATION

I hereby:

1) declare that all the information given above is, to the best of my knowledge, true, complete and correct. I understand and accept that non-disclosure or misrepresentation of facts may lead to the refusal of claims or the cancellation of the Policy.
2) authorise Dubai Insurance Company or their authorised representatives to obtain any medical information they require in connection with my membership application from any medical practitioner/authorised provider.
3) confirm that I have read and understood the terms, conditions, limitations and exclusions of the Policy and agree that this proposal and declaration, or any written statement made by me with reference to this proposal, shall be the basis of the contract between the Dubai Insurance Company and me.
4) agree to inform Dubai Insurance Company for any visa change that may happen within the policy year in order for me and my dependants to be transferred/ enrolled in another policy that is compliant with the applicable Insurance Authority (ie., DHA compliant policy for Dubai visa holders or HAAD compliant policy for Abu Dhabi/Al Ain visa holders).
5) 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 the application and which were not disclosed to the Company at the date of the application.

Signature

Place & Date

Please send this Confidential Medical History to: