

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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 Has an application for a health policy made by you to this or any other insurer ever been withdrawn or dropped, deferred or declined, or accepted with an extra premium?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you smoke or consume tobacco? If yes, please state the quantity per day:	<input type="checkbox"/> Yes <input type="checkbox"/> 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you wear any visual aids, glasses or contact lenses? If yes, please state for what condition:	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. (For females only) Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you suffered any diseases/illnesses and seen a doctor or healthcare professional in the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you undergone any Inpatient stay in a hospital or nursing home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you been taking any medications on a regular basis (e.g. pain killers, chronic medications, hormone treatment)	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Anxiety, schizophrenia, depression, or any other psychological, psychiatric or mental illnesses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Arthritis, rheumatism, gout, osteoporosis, joint replacement, paralysis or any other skeletal and muscular disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Dermatitis, acne, psoriasis, eczema or any other other skin problems or allergic conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Tumours, cancer, lumps, cysts, fibroids or any abnormal growth whether benign or malignant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Heart diseases, high/low blood pressure, heart failure, aneurysm, varicose veins or any other heart and circulatory disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Any disorders of the stomach, intestines, kidney, liver, bladder or any abdominal organ problem and endocrine disorders including diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Abnormal blood tests, anaemia, high cholesterol, malaria, Hepatitis B or C, HIV/AIDS or any other blood disorders and auto immune disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Pneumonia, bronchitis, asthma, tuberculosis and any other breathing or respiratory disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No

20. Any eye, ear, nose, throat and thyroid problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Any urinary, genital or reproductive system problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. (For females only) Any breast problem, disease of the uterus, ovaries, or any gynaecological and obstetrics disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
24. Are you currently under any medical observation or receiving any medical treatment or intending to seek any medical advice?	<input type="checkbox"/> Yes <input type="checkbox"/> No
25. Are you undergoing regular medical reviews or check-ups?	<input type="checkbox"/> Yes <input type="checkbox"/> No
26. Are there any other conditions/facts relevant for disclosure?	<input type="checkbox"/> Yes <input type="checkbox"/> 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/AI 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:

CONFIDENTIAL MEDICAL HISTORY

(FOR FEMALE ONLY)

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1. APPLICANT

First Name	
Surname	

2. PLEASE ANSWER ALL QUESTIONS WITH A 'YES' OR 'NO' AND PROVIDE COMPLETE DETAILS IF THE ANSWER IS 'YES'

1. Are you currently pregnant? If yes, have there been any complications to date? Last menstrual date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you currently trying to get pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you undergoing any form of fertility treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No

3. PLEASE PROVIDE DETAILS IF YOU HAVE ANSWERED 'YES' TO ANY OF THE QUESTIONS FROM 1 TO 3

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

4. LEGAL DECLARATION

I understand and acknowledge any pregnancy not declared at the time of this application's coverage will be at the sole discretion of the insurer. The insurer has the right to not cover any maternity claims to any undeclared pregnancy. I also acknowledge and understand any pregnancy, which arises within forty calendar days from the date of this application; coverage will also be at the discretion of the insurer.

Signature _____ Place & Date _____

Please send this Confidential Medical History to:

MaxMedical - Dubai Insurance Company
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+971 4 269 3030 Extns. 203/238 • maxmedical@dubins.ae • www.maxmedical.ae