Medical Application Form

Insured Name: ______________________ Inception Date: ______________________

Required Plan: ______________________ Policy No.: ______________________

NAME please specify Employee (E), Child (C) or Spouse (S) First Name / Middle Name / Family Name	Relation E/S/C	D. O. B. DD/MM/YY	Nationality	Sex M/F	Height CM	Weight KG	Photo card Yes/No	Qatar Resident

Has MedNet previously covered any of the above applicants? Yes ☐ No ☐

Is there a member in your family that is not proposed for Insurance? Yes ☐ No ☐ If Yes, please explain under section Comments

Marital Status: ____________ No. of Children: ____________ Active at work since: ____________

Street: ______________________ City: ______________________

P.O. Box: ______________________ Tel. No: ______________________

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.

Have you ever been diagnosed or received any treatment (including hospital or surgery) or felt any disorder or pain or had any symptoms indicating:

(Please tick relevant box)

	Yes	No
1. Infectious and parasitic diseases		
2. Neoplasms/Cancer (benign or malignant)		
3. Diseases of the endocrine system, nutritional-, metabolic diseases and immunity disorders, diabetes		
4. Diseases of blood and blood forming organs		
5. Mental-/psychiatric disorders		
6. Diseases of the nervous system and sense organs (ears, eyes, nose)		
7. Diseases of the cardiovascular system incl. hypertension		
8. Diseases of the respiratory system		
9. Diseases of digestive system		

	Yes	No
10. Diseases of genitourinary system, kidney diseases and breast disorders		
11. Pregnancy, complications of pregnancy, child birth and the puerperium incl. abortions		
12. Disease of the skin and subcutaneous tissue		
13. Diseases of the musculoskeletal system and connective tissue		
14. Congenital anomalies, hereditary/genetic diseases		
15. Certain conditions originating in the perinatal period		
16. Injury and poisoning		
17. Previous medical/surgical hospitalisations, procedures and operations		
18. Any (chronic) disease(s), symptoms and complaints not mentioned above		

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:** ______________________________

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ALKHALEEJ TAKAFUL GROUP مجموعة الخليج التكافلي

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:	**Yes**	**No**
• Cured/ no symptoms	☐	☐
• Ongoing symptoms	☐	☐
• Ongoing hospitalization	☐	☐
• Pending hospitalization	☐	☐
• Ongoing treatment	☐	☐
• Pending treatment	☐	☐

In case of any *Diagnosis Status* the applicant was treated as:

	Yes	No
• Outpatient	☐	☐
• Hospitalized	☐	☐
• Treated both ways	☐	☐
• Operated on: / / (dd/mm/yyyy)		

How often do the symptoms occur?
Or can the illness be described as follows?

	Yes	No
• Acute	☐	☐
• Chronic	☐	☐
• Recurrent	☐	☐

	Yes	No
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. ☐ ☐

Date: ____________________ **Signature:** ____________________

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