الأهلـــية للتـــأمـــين
Al Ahlia Insurance

INDIVIDUAL MEDICAL INSURANCE APPLICATION FORM

Personal Details

Name: _____ CPR: _____

Sex: ☐ Nationality: _____ Date of Birth: _____ Occupation: _____

Weight : _____ Height : _____ Applicant Status / Married ☐ Single ☐

Dependents to be included

Name	Sex	Relation ship	CPR	DOB	Weight (kgs)	Height (meters)

Address

Physical Address Villa No. _____ Road No. _____ Block No. _____

P.O. Box _____ Town/City _____ Country _____

Contact No.(s) _____ Telefax No. _____

E-mail Address _____

Type of Cover Required

☐ **Elite Gold** ☐ **Elite** ☐ **Riaya** ☐ **Himaya**

Effective Date ……..……..

Previous Medical History

Did you (or any of the listed members) suffer from any serious illness or underwent any major surgical operation in the past 5 years? OR, do you (or any of the listed members) currently have an illness or undergoing a certain medical treatment?

☐ No ☐ Yes. If Yes please state the details below or attach to this form:

Have been diagnosed with any form of cancer or have suffered from any pre-malignant conditions including familial colorectal polyposis, cancer-in-situ, papilloma of the bladder, abnormal class IV cervical smear test, polyps (intestinal and of the urinary bladder), oral leukoplakia.

☐ No ☐ Yes. If Yes please state the details below or attach to this form:

Have been diagnosed with any form of cardiovascular disease or have not suffered from any underlying conditions including hypertension, arteriosclerosis, diabetes mellitus, abnormal ECG, hyperlipidaemia, hyperuricemia and obesity.

☐ No ☐ Yes. If Yes please state the details below or attach to this form:

Medical Condition

Did you (or any of the listed members) or any member of your family have any of the following illnesses/disorders? Please tick the appropriate box and underline the illness/condition referred to. **All questions must be answered.**

		Yes	No	Name of Dependents
a)	Tumours: Benign / Malignant			
b)	Headache / Migraine Disorders			
c)	Mental Illness / Nervous Disorders			
d)	Eye Diseases			
e)	Asthma / Allergies / Pulmonary Diseases			
f)	Cardiovascular Diseases / Arterial Hypertension			
g)	Liver / Stomach / Intestinal Diseases			
h)	Diabetes / Other Hormone Diseases			
i)	Urinary Track Diseases / Diseases of the Sexual Organs			
j)	Rheumatism / Muscle, Joint or Bone Disease			
k)	Back Problems			
l)	Skin Diseases			
m)	Cosmetic Operations			
n)	Any other diseases / disorders			
o)	Have you been tested for HIV-antibodies			
p)	Hepatitis B or C			
q)	Endometriosis, ovarian growth, fibroid, irregular menstrual bleeding or any other gynaecological disease or disorder.			
r)	Any other illnesses, congenital or hereditary disorders, any hospitalisations or physical impairment not listed above			

Do you take or have taken any kind of medicine on a regular basis? No ☐ Yes ☐
If Yes, please state type, condition obtaining treatment for and medication dosage:

Are you a smoker (or any of the listed members) ?

☐ No ☐ Yes. Please state number of cigarettes a day

Previous Insurance History

Have you (or any listed members) had any Medical Insurance with ArigCare previously?

☐ No ☐ Yes. Please state the policy number and expiry date

Have you (or any listed members) had any Medical Insurance other than ArigCare in the past 3 years?

☐ No ☐ Yes. Please state name of insurers and number of years with each

Declaration

I declare that to the best of my knowledge and belief the statements on this application form are full, true and correct, and I agree that the acceptance of my application shall be on the basis of these statements and any disclosure of material facts may lead to the rejection of any claim.

Applicant's Signature: ---------- Date: ----------