



INDIVIDUAL / FAMILY MEDICAL APPLICATION FORM

Name of the Plan _____ Hospitalization Class _____
 Contact Mobile No _____ P. O Box _____
 Email _____ Address _____
 Marital Status _____ If Married No of Children _____

Name			Date of Birth			Gender	Relatio nship	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?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been declined for life and/or health insurance	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>	Do you ride motorcycles? (if "Yes," specify if you require coverage for motorcycle accident)	<input type="checkbox"/>	<input type="checkbox"/>

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.)	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>
Blood & Blood Forming Organ Systems? (i.e.: anemia, thalasemia, bleeding disorders, blood	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Neoplasms, Tumors? (specify type, location, treatment, whether malignant or benign)	<input type="checkbox"/>	<input type="checkbox"/>
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.)	<input type="checkbox"/>	<input type="checkbox"/>	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.)	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>	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.)	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory System? (i.e. sinusitis, allergies, tonsillitis/laryngitis, bronchitis, emphysema, pneumonia, etc	<input type="checkbox"/>	<input type="checkbox"/>	Skin-Subcutaneous Tissue? (i.e. dermatitis, acne, seborrhea, puritis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever undergone surgery to remove a body organ or structure? (specify body organ/ Structure, date & place of surgery?)	<input type="checkbox"/>	<input type="checkbox"/>	Are you HIV positive or have any medical condition or symptom indicative of HIV infection or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>

