Medical Application Form

Application Number:

Applicants Name: Inception Date:

Tick the required plan below:	
Silver Premium	
Silver Classic	
Green	

Tick the required option below:	
Deductible AED 50/- per consultation	
Deductible AED 50/- per consultation and 10% co-pay on Pharmaceutical	

NAME First Name Middle Name Family Name	Relation (E/S/C)	D. O. B. (DD/MM/YY)	Nationality	Sex (M/F)	Height (CM)	Weight (KG)	Emirate of Visa issuance	Emirate of Residence

Has Orient / MedNet previously covered any of the above applicants?

☐ Yes **If yes, please provide details**

☐ No

Is there a member of your family who is not proposed for insurance cover?

☐ Yes **If yes, please provide details**

☐ No

Marital Status: _____ No. of Children: _____ Profession : _____

Street: _____ City: _____

P.O. Box: _____ Mobile. No: _____

Email Address: _____

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.

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P.O. Box 27966, Dubai – UAE
Tel.: +971 4 253 1300 Fax: +971 4 251 5079
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Please tick relevant box if you have ever been diagnosed with and/or received any treatment/felt any disorder/pain/had any other symptoms:
*Examples mentioned below are only descriptive and are not meant to limit aforementioned medical conditions.
(Please tick relevant box)

1. Infectious and parasitic diseases (e.g. Typhoid, Enteritis, Tuberculosis, Malaria ....)* Yes No ☐ ☐	11. Pregnancy, complications of pregnancy, child birth and the puerperium incl. abortions Yes No ☐ ☐
2.Neoplasms/Cancer (benign or malignant)* Yes No ☐ ☐	12. Disease of the skin and subcutaneous tissue (Abscess , ulcer , cellulitis , cysts , dermatitis , eczema , herpes , corn , pigmentation or melanoma ... Yes No ☐ ☐
3. Diseases of the • **Endocrine system** (Pituitary, Thyroid disorders, Poly cystic Ovaries, Diabetes .....)* • **Nutritional** (Vitamin Deficiency , Anaemia , Rickets ...) • **metabolic diseases** (Glucose intolerance , Lipid disorders , Gout ...) • **immunity disorders** Yes No ☐ ☐	13. Diseases of the musculoskeletal system and Connective tissue (Myalgia or Body pain , arthropathy , joint stiffness o dislocation , Lumbago , Sciatica , Inter vertebral Disc disorders, Scoliosi or any acquired bone deformity…. Yes No ☐ ☐
4. Diseases of blood and blood forming organs (All types of Anaemia, Coagulation defects such as Haemophilia or Sickle cell, Thrombocytopenia,) Yes No ☐ ☐	14. Congenital anomalies (cardiovascular anomalies, Cleft lip or plate and hereditary/genetic diseases (Down syndrome...) Yes No ☐ ☐
5. Mental-/psychiatric disorders (Anxiety, Depression, Insomnia, Schizophrenia, Mental retardation...) Yes No ☐ ☐	15. Certain conditions originating in the perinatal period (e.g. Maternity hypertension – Cervical incompetence, Premature rupture of membrane .....) Yes No ☐ ☐
6. Diseases of the , • nervous system • (Cerebral haemorrhage, Thrombosis, Seizure, Bell's palsy, Parkinsonism, Multiple sclerosis, Pituitary adenoma, meningitis ....) • sense organs ears (Ear infection , wax , surgery of tympanic membrane , ortho sclerosis or hearing impairment ...) Eyes (Conjunctivitis, Glaucoma, Cataract, other Retinal or lens disorders, Visual disturbance or blindness ....) Nose (Rhinitis, Sinusitis, nasal allergy, nasal polyp, epistaxis ....) Yes No ☐ ☐	16. Diseases of genitourinary system (cystitis or Urinary bladder disorders , male testicular disorders , Variocele , female ovarian or uterine disorders , female cervical , vaginal or vulval disorders , Salpingitis or PID , ...) **kidney diseases** (Renal colic or stone , Renal failure , nephritis or nephrotic syndrome) **And breast disorders** (Abscess, cyst, neoplasm or any mass, nipple discharge or disorder, Pain or hypertrophy ....) Yes No ☐ ☐
7. Diseases of the cardiovascular system (Hypertension, Ischemic and Coronary heart disease, Myocarditis, Arrhythmia, Valve disorders, ventricular hypertrophy or cardiomyopathy .....) Yes No ☐ ☐	17. Previous medical/surgical hospitalisations, procedures and operations Yes No ☐ ☐
8. Diseases of the respiratory system(Bronchitis , Pneumonia , Upper respiratory tract infections , allergy , Asthma , Respiratory distress , Lung fibrosis , pulmonary embolism ....) Yes No ☐ ☐	18. Any (chronic) disease(s), symptoms and complaints not mentioned above Yes No ☐ ☐

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9. Diseases of digestive system(Peptic or gastric ulcer , reflux , gastritis , bleeding varices , intestinal obstruction ,inflammatory bowel disorders , Colitis , chron's disease ....) Yes No ☐ ☐	19. Any Pre-existing disease(s), symptoms and complaints within the last ten years Yes No ☐ ☐
10. Injury and poisoning Yes No ☐ ☐	

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:** _____

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:		
• Outpatient		
• Hospitalized		
• Treated both ways		
• Operated on: / / (dd/mm/yyyy)		

How often do the symptoms occur? **Or can the illness be described as follows?**		
• Acute		
• Chronic		
• Recurrent		

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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