Loyalty
INVESTMENT
& INSURANCE

MEDICAL APPLICATION FORM

1- **Policy Holder Name: ..... Middle Name: ..... Last Name: .....**

2- **Place & Date of birth (Day/Month/Year): ....**

3- **Sex: .....**

4- **Marital Status:**

Single ..... Married ..... Separated ..... Divorced ..... Widowed .....

5- **Full Address:**

- **Residence: .....**

Tel: .....

- **Business: .....**

Tel: .....

6- **Profession or type of work: ....**

- **Is your work administrative: ....**
- **Is your work manual and does not involve machinery: ....**

- **Do you use machines in your work: ……**

7- Height (cm): …… Weight (Kg): ……

8- Are you a member of National Social Security Fund: ……

Or benefit from any other medical services? ……

9- Do you Practice any sports activities? ……

10- <u>In Hospital Class:</u>

First ……

Second ……

Third ……

<u>Out Hospital Benefits:</u>

Yes ……

No .....

11- Legal dependents that are to benefit from the medical policy:

NAME	SEX	RELATION	D.O.B	NSSF YES/NO	HEIGHT	WEIGHT	Hospitalization cost	Out-hospital treatment cost

12- Did you exclude any of your family members from this insurance policy?

Yes .....

No .....

If the answer is yes, explain: .....

13- Are you currently insured or were you previously insured?

Yes .....

No .....

Loyalty
INVESTMENT
& INSURANCE

14- Have you or any of your family members been declined an insurance application?

Yes .....

No .....

If the answer is yes, please explain: .....

.....
.....

15- Have you or any of the applicants ever had or been told to have, been treated or are currently undergoing observation, medical treatment or surgical operation which has not yet been performed for any diseases or disorders:

a- Any respiratory disorders: e.g. asthma, bronchitis, pneumonia, persistent coughs, etc.

Yes: .....

No: .....

b- Any ear, nose, throat or eye(s) disorder? E.g. otitis, sinusitis, tonsillitis, retinal detachments, cataracts, etc.

Yes: .....

No: .....

c- Any brain (neurological) disorder, heart disorder, hypertension, raised cholesterol, stroke or circulatory disease? E.g. epilepsy, prolonged headache, migraine, heart murmur, palpitation etc.

Yes: .....

No: .....

d- Any liver, pancreas, gallbladder disorders? E.g. hepatitis, cirrhosis, stones, etc.

Yes: .....

No: .....

e- Any stomach, intestines or rectal disorders? E.g. gastritis, ulcers, piles, etc.

Loyalty
INVESTMENT
& INSURANCE

Yes: .....

No: .....

f- Any kidney, urinary or genital disorders? E.g. stones, urinary infection, blood/protein urine, etc.

Yes: .....

No: .....

g- *Female applicants:* any female or gynecological disorder? E.g. endometriosis, cyst(s), fibroid (s), irregular menstruation, etc.

h- Yes: .....

No: .....

i- Any pain or deformity or disorders of muscles, back, limbs or joints? E.g. gout, arthritis, slipped disc, etc.

Yes: .....

No: .....

j- Any endocrine or blood disorders? E.g. thyroid, diabetes, anemia, etc.

Yes: .....

No: .....

k- Any cancer, tumor, cyst or growth of any kind?

Yes: .....

No: .....

l- Any other illness, physical defects, congenital anomalies, injury, disability or symptoms or recurrent complaints that may indicate a disorder not mentioned above

Yes: .....

No: .....

Loyalty
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16- If any of the answers to the questions A to L is Yes, please state the question number(s) and provide details below

Quest #	Name of applicant	Nature of disability	Date treated/Hospitalization	Duration	Name/Nature of surgery/Treatment	Result of treatment	Name & address of doctor/hospital

DATE: .....

Signature of the applicant: .....