Health Declaration - Group Medical Insurance Scheme

Name of Employer & Policy Number

Name of employee/ life assured

Date of Birth | Dept. / Designation

Passport No. | **Emirates ID No.** | **Visa Location:**

Mobile Number | **Email Address**

Existing Policy details with expiry details if any:

If you answered yes to any of the questions mentioned below, please provide us with the latest medical report for the related medical condition.

1	Has any application for life or disability cover ever been refused, postponed or accepted with an extra premium or with special terms?	☐ Yes	☐ No
2	Are you exposed to any particular dangers in the pursuance of your profession or in your leisure time (such as handling dangerous materials, prolonged stays in countries outside of Europe, practicing dangerous and hazardous sport such as private aviation, gliding, motorgliding or hang-gliding, parachuting, diving, Skiing, mountaineering, martial arts, motor sports or any racing)? Please specify _____ _____	☐ Yes	☐ No
3	Do you suffer or have you ever suffered from diseases or disturbances effecting the:	☐ Yes	☐ No
	a) Heart, Circulation or Cardiovascular System (e. g. hypertension, coronary artery disease, cardiac defects, stroke, angina pectoris, thrombosis) If yes; please specify the disease and treatment and provide medical reports whereever applicable _____	☐ Yes	☐ No
	b) Brain (e. g. vertigo, frequent headaches, migraine) If yes; please specify the disease and treatment and provide medical reports whereever applicable _____	☐ Yes	☐ No
	c) Blood (e. g. blood-clotting disorder) If yes; please specify the disease and treatment and provide medical reports whereever applicable _____	☐ Yes	☐ No
	d) Respiratory Organs (e. g. asthma, repeated or chronic bronchitis, allergic rhinitis) If yes; please specify the disease and treatment and provide medical reports whereever applicable _____	☐ Yes	☐ No
	e) Ears (e. g. impairment or acute loss of hearing, tinnitus) If yes; please specify the disease and treatment and provide medical reports whereever applicable _____	☐ Yes	☐ No
	f) Eyes (e. g. impairment or acute loss of hearing, tinnitus) in case of ametropia please indicate: diopters left _____ right _____	☐ Yes	☐ No
	g) Larynx, Thyroid If yes; please specify the disease and treatment and provide medical reports whereever applicable _____	☐ Yes	☐ No

	h) **Pancreas, Liver** (e. g. hepatitis, icterus), **Spleen** If yes; please specify the disease and treatment and provide medical reports whereever applicable _____	☐ Yes	☐ No
	i) **Kidneys** (z. B. kidney stones), **Urinary Tract and Genitals** If yes; please specify the disease and treatment and provide medical reports whereever applicable _____	☐ Yes	☐ No
	j) **Oesophagus** (e. g. reflux disease), **Stomach** (e. g. gastric ulcers, chronic gastritis) If yes; please specify the disease and treatment and provide medical reports whereever applicable _____	☐ Yes	☐ No
	k) **Nervous System or the Psyche** ((z. B. seizure disorder, multiple sclerosis, paralysis, mental-health problems, depressions, eating disorders) If yes; please specify the disease and treatment and provide medical reports whereever applicable _____	☐ Yes	☐ No
	l) **Bowels** (e. g. morbus crohn, colitis ulcerosa, duodenal ulcers) If yes; please specify the disease and treatment and provide medical reports whereever applicable _____		
	m) **Musculoskeletal System** (e. g. spinal column, intervertebral discs, shoulder-, hip-, or knee-joints, dysfunctions of muscles, tendons, joints and/or ligaments) If yes; please specify the disease and treatment and provide medical reports whereever applicable _____		
	n) **or** have examinations resulted in diagnosing **Tumours** (e. g. cancer), **Diabetes, Allergies, Rheumatic Diseases** (e. g. chronic arthritis), **Gout, Poisoning, Infectious Diseases, elevated Blood Lipids** (e. g. Cholesterol) **or elevated Liver Function Tests?** If yes; please specify the disease and treatment and provide medical reports whereever applicable _____		
4	Do you suffer from any other physical or mental impairments (e. g. congenital handicaps, deformities, impairments following operations, infections, accidents, or amputations)? If yes; please specify the disease and treatment and provide medical reports whereever applicable_____	☐ Yes	☐ No
5	Do you take medicines or drugs on a regular basis? If yes; please specify the disease and treatment and provide medical reports whereever applicable_____	☐ Yes	☐ No
6	Did you undergo any medical examinations, treatments or consultations by doctors within the last 5 years other than regular check-ups with normal findings? If yes; please specify the disease and treatment and provide medical reports whereever applicable_____	☐ Yes	☐ No
7	Have you undergone operations or treatments in hospitals or at health resorts during the past 10 years, or have any of the latter been planned and advised to be taken into consideration? If yes; please specify the disease and treatment and provide medical reports whereever applicable_____	☐ Yes	☐ No
8	Has an HIV infection been detected?	☐ Yes	☐ No
9	Please indicate your height and your current weight _____ cm _____ kg	☐ Yes	☐ No

10	Are you suffering from any Auto-immune disorders like Gullian-Barre Syndrome, Psoriasis, Rheumatoid Arthritis, Ulcerative colitis, Multiple Sclerosis If yes; please specify the disease and treatment and provide medical reports whereever applicable_____	☐ Yes	☐ No
11	Are you planning for surgery for any recently ailment diagnosed recently If yes; please specify the disease and treatment and provide medical reports whereever applicable_____	☐ Yes	☐ No
12	Following questions need to be answered by Female member;	☐ Married	☐ Single
	a) Please provide your marital status	☐ Yes	☐ No
	b) Have you suffered/are you suffering from any Gynecological problems?	☐ Yes	☐ No
	c) Are you pregnant at present? (Yes/No) If yes, Please fill the pregnancy declaration form		
	i. Any disease or disorder in the cervix, uterus, ovary (ies) or vagina; abnormal bleeding, cancer or abnormal growth?	☐ Yes	☐ No
	ii. Any disease or disorder of breast(s), such as breast lump, cyst, fibrocystic disease, cancer or abnormal growth?	☐ Yes	☐ No
	iii. Have you undergone mammogram or pap smear recently	☐ Yes	☐ No
	If yes; please specify the disease and treatment and provide medical reports whereever applicable_____		

General Declaration from the Member

If you are suffering from any critical illness such as cancer, Cerebrovascular accident –Stroke and related complications, Vertebral column and spinal injury, Organ failure, bedridden status; please provide further data, such as name of the respective disease, time and duration and whether it has been cured completely without leaving any problems. Please give the name of doctor in charge.

_____

_____

_____

I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of the proposal.

I understand that this form will constitute an integral part of my proposal for life assurance/ medical insurance and that failure to disclose any material fact known to me/ any mis-representation in this form may invalidate the assurance/insurance contract.

Date **Signature of the person to be insured**

Maternity questionnaire (To be filled by the treating Doctor): Liva/09/2020

Member Name: _____

Expected Date of Delivery (EDD):_____

Last Ultrasound Date:_____

1. As per last Ultra Sound report, is there any - abnormal findings /more than one fetus seen? If yes, please elaborate & attach the reports:

_____

_____

2. Any History of Caesarian Section?

_____

_____

3. Any History of Premature Delivery or premature babies?

_____

_____

4. Has treatment or medication for infertility been taken to achieve this pregnancy?

_____

_____

5. Is there any other conditions as per below list?

a)	Heart Conditions/High Blood Pressure:	☐ Yes	☐ No
b)	Autoimmune Conditions:	☐ Yes	☐ No
c)	Diabetes/Gestational Diabetes:	☐ Yes	☐ No
d)	Thyroid Conditions:	☐ Yes	☐ No
e)	Kidney Disease:	☐ Yes	☐ No
f)	Abnormality in weight gain:	☐ Yes	☐ No
g)	Any placenta problems with this pregnancy:	☐ Yes	☐ No
h)	Any episode of vaginal bleeding with this pregnancy:	☐ Yes	☐ No

6. Please provide any additional information which you feel will be relevant to this pregnancy

_____

_____

I certify that the above information is a record of a careful examination and answers to the above questions are complete and true to the best of my knowledge and belief.

Name of Specialist (OB-GYN):

Date: **Signature & Stamp**

liva

Life's good when you're covered