LIGHTHOUSE
INSURANCE ADVISORS SAL

GROUP HEALTHCARE INSURANCE
MEDICAL PROPOSAL AND QUESTIONNAIRE

Group name :

Insured name : _____ _____ _____
(First) *(Father)* *(Family)*

Address : _____

Phone(s) : _____ _____ Nationality: _____

Family members **to be insured** under the Group Insurance:

	Name	Relation	Sex	Class	DOB	Height (cm)	Weight (Kg)
Employee							
Spouse							
Child							
Child							
Child							
Child							

Have you, or any of your family members applying for the cover, ever been diagnosed or received any treatment (including hospital or surgery) or felt any disorder or pain or had any symptoms indicating:

	Yes	No		Yes	No
1 - Hypertension			9 - Congenital anomalies, hereditary/genetic diseases		
2 - Disease of the cardiovascular system			10 - Injury and poisoning		
3 - Disease of the skin and subcutaneous tissue			11 - Sense organs diseases (ear, eyes, nose)		
4 - Disease of the respiratory system and asthma			12 - Diseases of blood and blood forming organs, AIDS		
5 - Disease of digestive system			13 - Neoplasm/Cancer (benign or malignant)		
6 - Disease of genitourinary system and kidney			14 - Mental /psychiatric disorders, Diseases of the nervous system		
7 - Disease of the musculoskeletal system and connective tissue			15 - Previous medical/surgical hospitalization , procedures and operations		
8 - Diseases of endocrine system, nutritional metabolic diseases and immunity disorders, diabetes			16 - Any (chronic) disease(s) , symptoms and complains not mentioned above		

For female proposed insured: are you actually pregnant: Yes ☐ No ☐

In case the answer is YES to any of the conditions/diseases above or in case any medication is required on a regular basis, please specify full details on the back of this sheet. I authorize my doctor, health institute or other organization or person that has any information about my health and/or activities (and those of my Dependents) to provide the Insurance Company with the said information. This shall include hospital and any other records pertaining to medical advice, diagnosis, and treatment. A photocopy of authorization has the same validity as the original.

Date: _____ /_____ /_____ Signature:

If you have answered YES to any of the medical questionnaire questions of this Proposal Form, please give full details here

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Proposer's Name: _____ **Signature**