

GROUP HEALTHCARE INSURANCE MEDICAL PROPOSAL AND QUESTIONNAIRE

Relation Sex Class DOB (cm) (Kg Employee Spouse Child Chil	(roup name	:						
Address :				(F')			(F 'h \		
Phone(s) :	((First)	(First)		(Family)	(Family)		
Name Relation Sex Class DOB Height Weight C(m) (Kg Employee Spouse Child Chi	A	Address	:						_
Name Relation Sex Class DOB Height Weight C(m) (Kg Employee Spouse Child Chi									
Name Relation Sex Class DOB Height Weig (Kg Employee Spouse Child	F	Phone(s)	:			Natio	onality:		_
Relation Sex Class DOB (cm) (Kg Employee Spouse Child Chil	F	amily member	rs to be insured	under the Group	Insuranc	e:			
Employee Spouse Child			Name	Relation	Sex	Class	DOB		Weight (Kg)
Child Chil	Employee)		<u> </u>				(0111)	(119)
Child Chil	Spouse			**************************************	19111111111111111111111111111111111111		***************************************		
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	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	Child						<u></u>		
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 Yes No Yes Yes Yes No Yes Yes Yes Yes No Yes N	Child			<u> </u>		-5			
treatment (including hospital or surgery) or felt any disorder or pain or had any symptoms indicating: Yes No	Child								
treatment (including hospital or surgery) or felt any disorder or pain or had any symptoms indicating: Yes No		<u> </u>		<u> </u>	i				
treatment (including hospital or surgery) or felt any disorder or pain or had any symptoms indicating: Yes No	ı	Have you, or a	ny of your fami	ly members appl	lying for	the cover,	ever been diagnosed or	received a	ny
Yes No 9 - Congenital anomalies, hereditary/genetic diseases									
hereditary/genetic diseases		,					, ,		No
2 - Disease of the cardiovascular system 3 - Disease of the skin and subcutaneous tissue 4 - Disease of the respiratory system and asthma 5 - Disease of digestive system 6 - Disease of genitourinary system and kidney 7 - Disease of the musculoskeletal system and connective tissue 8 - Diseases of endocrine system, nutritional metabolic diseases and immunity disorders, diabetes 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 details on the back of this sheet. I authorize my doctor, health institute or other organization or person that has any information about my he and/or activities (and those of my Dependents) to provide the Insurance Company with the said information. This shall include hospital and other records pertaining to medical advice, diagnosis, and treatment. A photocopy of authorization has the same validity as the original.	1 - Hypert	ension							
3 - Disease of the skin and subcutaneous tissue 4 - Disease of the respiratory system and asthma 5 - Disease of digestive system 12 - Disease 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 For female proposed insured: are you actually pregnant: Yes \(\square \) No \(\square \) 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 details on the back of this sheet. I authorize my doctor, health institute or other organization or person that has any information about my he and/or activities (and those of my Dependents) to provide the Insurance Company with the said information. This shall include hospital and other records pertaining to medical advice, diagnosis, and treatment. A photocopy of authorization has the same validity as the original.									
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subcutaneous tissue						11 - Sens	e organs diseases (ear,		
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Date: / / Signature:	details on the and/or activit	e back of this she lies (and those o	eet. I authorize my of my Dependents)	doctor, health instit to provide the Insur	tute or oth rance Cor	ner organizati mpany with th	on or person that has any infone said information. This shall	ormation abo include hosp	ut my health pital and any
	I	Date:	//				Signature:		



Group HealthCare Insurance Proposal form - continue

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