LIGHTHOUSE
INSURANCE ADVISORS SAL

INDIVIDUAL HEALTH INSURANCE PROPOSAL FORM AND MEDICAL QUESTIONNAIRE

First name _____ **Father's name** _____ **Family** _____

Marital Status Married ☐ Single ☐ Divorced ☐ Widow ☐

Full address of applicant _____

Phone number(s) *Fixed -* _____ *Mobile -* _____ *Email -* _____

Class of Insurance *A* ☐ *B* ☐ *S* ☐ **Riders** *Amb.* ☐ *PM* ☐ *DV* ☐

Family members	Name	DOB dd-mm-yy	Nationality	NSSF yes/no	Sex M/F	Height in cm	Weight in kg	Smoking yes/no	Occupation
Subscriber									
Spouse									
Child 1									
Child 2									
Child 3									
Child 4									

If a dependent of yours is not applying for coverage, please state the reason: _____

		Yes	No
1	**Circulatory or Heart disease** (high blood pressure, arrhythmia, murmur, infarction etc.)	☐	☐
2	**Respiratory disease or Allergy** (asthma, bronchitis, emphysema, pneumonia, tuberculosis etc.)	☐	☐
3	**Digestive disease** (constipation, diarrhea, hepatitis, ulcers, pancreatitis etc.)	☐	☐
4	**Renal or Urinary disease** (nephritis, stones, renal colic, albuminuria, hematuria…)	☐	☐
5	**Osteo-articular disease, disease of Hip or Vertebral column** (scoliosis, rheumatism, slipped disc etc.)	☐	☐
6	**Neurological, Cerebral, or Muscular disease** (epilepsy, meningitis, aneurysm, paralysis etc.)	☐	☐
7	**Endocrinal or Metabolic disease** (goiter, nodules, diabetes, cholesterol, gout etc.)	☐	☐
8	**Eye, Nose & Throat disease** (glaucoma, retinopathy, dizziness, otitis, laryngitis, sinusitis etc.)	☐	☐
9	**Blood, Ganglionic or Skin disease** (anemia, hemophilia, adenopathy, eczema, herpes, purpura etc.)	☐	☐
10	**Sexual disease** (AIDS, gonorrhea, syphilis etc.)	☐	☐
11	**Tumors or Swelling** (fibroma, cyst, lipoma, cancer etc.)	☐	☐
12	**Any other disease, past or future operation, Accident or Treatment not mentioned above**	☐	☐
13	**Psychical disease** (nervous depression, fatigue, insomnia, psychosis etc.)	☐	☐
14	**For female applicants**, are you pregnant? If yes please state the expected due date?	☐	☐
15	**Congenital anomalies, Hereditary/Genetic diseases**	☐	☐

If you answered Yes to any of the above questions, please give full details here below:

#	Name	Date	Hospital	Details

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 Dependants) to provide The Insurance Company and/or the Third Party Administrator 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.
I declare that above questions are true to the best of my knowledge and belief, that I have disclosed all particulars affecting the assessment of the risk. I agree that this proposal and declaration shall be the basis of the contract between me and The Insurance Company, in accordance with the Lebanese Code of Obligations and Contracts, Article 974, Paragraph 2.

Signature: **Date (dd/mm/yyyy):** / /

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