Medical Application Form (MAF)

Policyholder:

Group/Company Name: _____

Principal Member:

Pricipal's (Employee's) Full Name: _____ Gender: M ☐ F ☐

Date of Birth: DD / MM / YYYY Married: Yes ☐ No ☐ Height (cm): _____ Weight (Kg): _____

Mobile No.: _____ Email: _____

ANTI-SELECTION IS NOT PERMITTED: All eligible dependants must be enroled on the Policy. All eligible dependants refers to the nuclear or immediate family i.e. Father, Mother and their Children (0-18 years old, and those aged 19-23 years old who are full time students and still under their parents' permanant UAE Residency).

Dependants to be Insured:

1st Dependant's Full Name: _____ Gender: M ☐ F ☐

Date of Birth: DD / MM / YYYY Relationship to the Principal Member: Spouse ☐ Child ☐ Height (cm): _____ Weight (Kg): _____

2nd Dependant's Full Name: _____ Gender: M ☐ F ☐

Date of Birth: DD / MM / YYYY Relationship to the Principal Member: Spouse ☐ Child ☐ Height (cm): _____ Weight (Kg): _____

3rd Dependant's Full Name: _____ Gender: M ☐ F ☐

Date of Birth: DD / MM / YYYY Relationship to the Principal Member: Spouse ☐ Child ☐ Height (cm): _____ Weight (Kg): _____

4th Dependant's Full Name: _____ Gender: M ☐ F ☐

Date of Birth: DD / MM / YYYY Relationship to the Principal Member: Spouse ☐ Child ☐ Height (cm): _____ Weight (Kg): _____

5th Dependant's Full Name: _____ Gender: M ☐ F ☐

Date of Birth: DD / MM / YYYY Relationship to the Principal Member: Spouse ☐ Child ☐ Height (cm): _____ Weight (Kg): _____

6th Dependant's Full Name: _____ Gender: M ☐ F ☐

Date of Birth: DD / MM / YYYY Relationship to the Principal Member: Spouse ☐ Child ☐ Height (cm): _____ Weight (Kg): _____

If more dependants please use an additional copy of this page.

Medical History

Please answer all the following questions either "**Yes**" or "**NO**" **for ALL Applicants** to be insured. Do not leave any answers blank as this form will be returned to you to be fully completed delaying your application.

APPLICANTS FROM 66YEARS OF AGE must submit a current medical health report from a UAE-based Registered Medical Practitioner, even if there are no medical declarations to be made on this form.

IMPORTANT: The Insurer is not liable for any existing or foreseeable conditions unless declared and accepted in writing. Non-disclosure may lead to claim rejection or cancellation of cover. When in doubt, disclose.

Have any Applicants to be covered under this policy, ever suffered from, visited a doctor or taken any medication for any of the following medical conditions?

		Yes	No
1.	**Heart and Circulatory System:** e.g., high blood pressure, cholesterol, chest pain, coronary artery disease, heart attack, stroke, rheumatic fever, irregular heartbeat, valve defects, poor circulation, cramps, leg swelling, congenital heart conditions.	☐	☐
2.	**Blood Disorders**: e.g., anaemia, bleeding disorders, haemophilia, leukaemia.	☐	☐
3.	**Respiratory System:** e.g., asthma, chronic bronchitis, pneumonia, persistent cough, emphysema, allergies, coughing up blood, chronic sinusitis.	☐	☐
4.	**Gastro-intestinal or Liver Disorders:** e.g., indigestion, ulcers, gall bladder disease, colitis, Crohn's disease, hepatitis, jaundice, hernia, diarrhoea.	☐	☐
5.	**Cancers and Growths (Benign or Malignant):** e.g., any cancer types, melanoma, Hodgkin's disease, breast cancer.	☐	☐
6.	**Gynaecological Disorders and Births:** e.g., ovarian cysts, cervix conditions, endometriosis, hysterectomy, miscarriages, abnormal pap smear, fibroids, fertility treatments, and any normal deliveries, c-section deliveries, delivery complications or premature births.	☐	☐
7.	**Male Genito-urinary System:** e.g., prostate disorders, testicular tumours.	☐	☐
8.	**Kidney or Bladder Disorders:** e.g., stones, kidney failure, recurrent urinary infections, blood in the urine, nephritis, urine difficulties.	☐	☐
9.	**Musculo-skeletal System:** e.g., past surgeries, arthritis, back or neck pain, spinal disorders, hip/joint problems, osteoporosis, gout, bunions.	☐	☐
10.	**Psychological Disorders:** e.g., depression, anxiety, psychotic disorders, eating disorders, suicide attempts, substance dependency.	☐	☐
11.	**Endocrine Disorders**: e.g., diabetes, thyroid issues, adrenal/nutritional disorders.	☐	☐
12.	**Skin Disorders:** e.g., eczema, psoriasis, skin cancers.	☐	☐

		Yes	No
13.	**Neurological Disorders:** e.g., epilepsy, Multiple Sclerosis, paralysis, Alzheimer's, Parkinson's.	☐	☐
14.	**Eye Disorders:** e.g., glaucoma, blindness, surgery, cataracts.	☐	☐
15.	**Ear, Nose, Throat Disorders**: e.g., hearing impairment, ear infections, tonsillitis.	☐	☐
16.	**Muscular Disorders:** e.g., dystrophy, muscle wasting.	☐	☐
17.	**Hereditary Disorders or Birth Defects**	☐	☐
18.	**HIV/AIDS:** e.g., positive tests or treatment	☐	☐
19.	**Infectious Diseases:** e.g., tuberculosis, malaria, sexually transmitted disease.	☐	☐
20.	**Currently Taking Prescription Medication.**	☐	☐
21.	**Any Covid Complications or Symptoms that Persist.**	☐	☐
22.	**Any Other Medical Conditions or Symptoms:** i.e., which are not detailed above, require or required in the past any medical advice, diagnosis, treatment or hospitalisation.	☐	☐

For Females Applicants Only:

		Yes	No
Is Any Female Applicant Pregnant?		☐	☐
If 'Yes', answer i) and ii):			
i)	**Expected delivery date:** _____		
ii)	**Please provide details of any pregnancy complications:**		
If 'No' answer iii), iv) and v):		Yes	No
iii)	**Are any Female Applicants currently trying to get pregnant?**	☐	☐
iv)	**Are any Female Applicants undergoing any form of fertility treatment?**	☐	☐
v)	**Last menstrual period date:** _____ *(of any Female Applicant who could become pregnant)*		

Disclaimer: Coverage for any undeclared pregnancy, or any pregnancy arising within 40 days of this application, is at the sole discretion of the insurer. The insurer may decline maternity claims for such pregnancies.

Please provide FULL details for any questions answered "Yes".

- If multiple conditions for any question answered "Yes" please provide details for ALL conditons

Question	Name of Applicant	Detailed description of illness / type of ailment / condition	Treatments received? (Inpatient or Outpatient if applicable)?	Date(s)	If you are still suffering, provide details

If insufficient space please use an additional copy of this page.

IMPORTANT: For any declared pre-existing condition please provide any available recent medical reports.

5. Declaration

I declare that the above statements are true and complete. I authorise the Insurer to obtain medical information from any hospital or medical practitioner who has treated or may treat any condition affecting my physical or mental health. I acknowledge that this declaration forms the basis of the insurance contract. The Insurer will not be liable if, after coverage is in place, any statement or information provided is found to be incorrect or untrue. I have read and accept the Terms & Conditions, including all exclusions.

Signature: _____

Full Name: _____

Date: DD / MM / YYYY _____

This form is valid for 30 days. If insurance is not accepted within this period, a new form is required.

Any changes in health or circumstances before the coverage start date must be declared, or they may not be covered.