

**To be used by the Insurance Company only**

**Individual Medical Insurance Application Form**

Date of Acceptance	
Policy Ref	
Contract Period	
From	To

**This application is NOT an insurance policy nor an insurance acceptance and does NOT place any obligation on Enaya Insurance Company**

Name of the Proposer													
Civil Id Number													
Address		City			Street								
													
Family Status				Single [ ]		Married [ ]		Divorced [ ]		Widowed [ ]			
Nationality				D.O.B.				Sex		Male [ ] Female [ ]			
Height			cm		Weight			Kg		Blood Group			
Profession				Smoker				Yes [ ] No [ ]					
Spouse	Name												
	Civil ID												
	Nationality				D.O.B.								
	Sex		Male [ ]		Female [ ]		Height		cm		Weight		Kg
	Profession				Smoker		Yes [ ]		No [ ]		Blood Group		
Child 1	Name												
	Civil ID												
	Nationality				D.O.B.								
	Sex		Male [ ]		Female [ ]		Height		cm		Weight		Kg
	Profession				Smoker		Yes [ ]		No [ ]		Blood Group		
Child 2	Name												
	Civil ID												
	Nationality				D.O.B.								
	Sex		Male [ ]		Female [ ]		Height		cm		Weight		Kg
	Profession				Smoker		Yes [ ]		No [ ]		Blood Group		
Child 3	Name												
	Civil ID												
	Nationality				D.O.B.								
	Sex		Male [ ]		Female [ ]		Height		cm		Weight		Kg
	Profession				Smoker		Yes [ ]		No [ ]		Blood Group		
Child 4	Name												
	Civil ID												
	Nationality				D.O.B.								
	Sex		Male [ ]		Female [ ]		Height		cm		Weight		Kg
	Profession				Smoker		Yes [ ]		No [ ]		Blood Group		
Child 5	Name												
	Civil ID												
	Nationality				D.O.B.								
	Sex		Male [ ]		Female [ ]		Height		cm		Weight		Kg
	Profession				Smoker		Yes [ ]		No [ ]		Blood Group		
Is there any family member who is not insured?				Yes [ ] No [ ]				If yes, please specify reason below:					

Kindly answer the following questions related to your medical history during last 10 years fully & accurately for each person listed above by putting (x) next to it:

Srl	Diseases	Yes	No	Srl	Diseases	Yes	No
1	Cardio-Vascular Diseases			10	Malignant Tumors		
2	Respiratory Diseases			11	Sexually Transmitted Diseases and AIDS		
3	Diseases of the Digestive System			12	Congenital Malformation or Disablement		
4	Kidney & Urinary Tract Diseases			13	Other Diseases, Accidents, Previous or Future operations you already know about		
5	Osteoarticular & Muscular Diseases or Transplants			14	Are you following or has any ever followed any medical treatment? Are you currently taking any medication?		
6	Diseases of the Nervous System			15	Does the adherent have any allergy against any Drug, Food or others?		
7	Endocrine Glands and Diabetes Diseases			16	For Women: Are you currently pregnant?		
8	ENT or Eye Diseases						
9	Hematological Diseases						

In case the answer is yes to any of the Diseases/Conditions above please specify full details in the below table, add extra sheets, if necessary.

Name	Disease	Diagnosis Status	Treatment	Date	Hospital and/or Dr. Name

Do you currently have any Medical Insurance Policy (Individual, Family or Group) with Enaya Insurance Company or Insurance Company? Yes [ ] No [ ]

If Yes, Please complete the following information:

Company Name	Policy No.	Insured Name	Expiry date

I, ..... the undersigned declare that the above mentioned information are correct and complete regarding myself and my dependents. Failure to disclose any material information, whether by omission or false declaration, which should have been provided to the date of the Insurance Company, grants the insurance Company the right to cancel my or my dependants plans in coverage starting from the effective date of the policy without having any financial obligation.

I also grant full and irrevocable authorization to the Insurance Company to inquire about my actual state of health and that of my dependant from any Medical Center of Hospital or Doctor, and I waive my right of medical confidentiality to the benefit of the Insurance Company.

Applicant Signature: ..... Date: .....

Down Payment: .....

Collected by: .....