INDIAN ASSOCIATION SHARJAH

P.O Box No-2324, Sharjah. UAE.
Telephone- 06-5610845, Fax- 06-5610805
Email: mail@iassharjah.com, admin@iassharjah.com

MEDICAL INSURANCE – APPLICATION FORM

Name of Applicant : _____
(As per Passport)

IAS Member ☐   **Staff** ☐   **FAMILY** ☐

IAS Member or Staff ID No. _____
If Family, please mention IAS Member or Staff, ID No & Relation_____

Address in U.A.E : P.O Box No._____ **Emirate:** _____

Telephone : **Residence:** _____

                        : **Mobile:** _____

E-mail : _____

Date of Birth : _____   **Gender: M/F**_____

Marital Status : _____ **Nationality:** _____

Passport No. : _____

EID Number : _____

UID Number : _____

Visa file number : _____

Visa Issued Emirate : _____

Relationship (EMPLOYEE/SPOUSE/CHILD):   _____

Signature: _____   **Date :** _____

FOR OFFICE USE ONLY

Reference No. : _____ **Date of Submission:** _____

Signature : _____

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MEDICAL INSURANCE – GENERAL UNDERTAKING

I, the undersigned, being aware of the Health Insurance Policy offered to me, hereby confirm I am aware that:

1. Any malpractice or misuse of this Health Insurance policy is closely monitored by the authority concerned.

2. If any malpractice/misuse is identified and proved to be genuine, the policy will be suspended with immediate effect and the policy holder involved shall be put in black list by the Insurance Provider as per the legal right vested in them.

3. In such an event, proper documented evidence shall be made available for the perusal of the policy holder.

4. As an after effect or consequence thereof, medical policy to the party/parties involved in future may be affected unfavorably.

This undertaking is collected with a view to ensure uninterrupted, eligible services to all the policy holders by the Insurance provider. You are requested to read and understand the significance of the above points and accept to abide by the set of rules concerned.

Name of Applicant **:** _____
(As per Passport)

IAS Member or Staff ID No. _____ **FAMILY** ☐

If Family, please mention relation_____

Mobile: _____**Gender: M/F**_____

Marital Status: _____ **Nationality:** _____

Signature: _____ **Date :** _____

Medical Application Form

Insured Name: _____   Inception Date: _____

Required Plan: _____   Policy No.: _____

NAME please specify Employee (E), Child (C) or Spouse (S) First Name / Middle Name / Family Name	Relation E/S/C	D. O. B. DD/MM/YY	Nationality	Sex M/F	Height CM	Weight KG	Photo card Yes/No	UAE Resident

Has DIC previously covered any of the above applicants?   Yes ☐ No ☐

Is there a member in your family that is not proposed for Insurance? Yes ☐ No ☐ If Yes, please explain under section Comments

Marital Status: _____   No. of Children: _____   Active at work since: _____

Street: _____   City: _____

P.O. Box: _____   Tel. No: _____

I hereby declare and agree, with respect to both, myself and to my Dependants, that I am aware of the general terms of this insurance and I accept them. With the above, I authorise my doctor, health institution or other organisation or person that has any information about my health and/or activities (and those of my **Dependants**) to provide the **Insurer** with the said information. This shall include hospital and any other records pertaining to medical advice, diagnosis, treatment or disturbances. A photocopy of this authorisation has the same validity as the original.

Have you ever been diagnosed or received any treatment (including hospital or surgery) or felt any disorder or pain or had any symptoms indicating:

(Please tick relevant box)

	Yes	No
1. Infectious and parasitic diseases		
2. Neoplasms/Cancer (benign or malignant)		
3. Diseases of the endocrine system, nutritional-, metabolic diseases and immunity disorders, diabetes		
4. Diseases of blood and blood forming organs		
5. Mental-/psychiatric disorders		
6. Diseases of the nervous system and sense organs (ears, eyes, nose)		
7. Diseases of the cardiovascular system incl. hypertension		
8. Diseases of the respiratory system		
9. Cirrhosis/ Hepatitis / Wilson's disease / Pancreatitis/ Liver disease / Crohn's disease / Ulcerative Colitis /Piles or any other disease of Mouth , Oesophagus , Liver , Gall bladder , Stomach or Intestines or any other part of Digestive System?		
10. Kidney stones/ Renal Failure/ Dialysis/Chronic Kidney Disease/Prostate Disease or any other disease of Kidney, Urinary tract or reproductive organs?		

	Yes	No
11. Pregnancy, complications of pregnancy, child birth and the puerperium incl. abortions		
12. Disease of the skin and subcutaneous tissue		
13. Diseases of the musculoskeletal system and connective tissue		
14. Congenital anomalies, hereditary/genetic diseases		
15. Certain conditions originating in the perinatal period		
16. Injury and poisoning		
17. Previous medical/surgical hospitalisations, procedures and operations		
18. Any (chronic) disease(s), symptoms and complaints not mentioned above		
19. Any Pre-existing disease(s), symptoms and complaints within the last ten years		
20. Motor Neuron Disease / muscular dystrophies/ Myasthnia Gravis or any other disease of Neuromuscular system (muscles and/or nervous system)		
21. Stroke/ Paralysis/ Transient Ischemic Attack / Multiple Sclerosis/ Epilepsy/ Parkinsonism/ Alzheimer's Depression /Dementia or any other disease of Brain and Nervous System?		
22. Smoke, consume alcohol, or chew tobacco or use any recreational drugs? If Yes please then provide the frequency and amount consumed		

In case the answer is YES to any of the conditions/diseases above please specify full details (preferably by a Medical Physician) on the additional questionnaire (Personal Information), which will be found attached to this application form.

In case medication is required on a regular basis please specify the full details such as genuine name, brand name and daily/weekly quantity on the additional questionnaire (Personal Information), which will be found attached to this application form.

Comments:

Only to be filled out if you have answered "Yes" in the question of any family members, who is not proposed for Insurance.

I agree that no indemnity will be paid under the proposed insurance policy for medical expenses arising from disorders which were declared prior to completion of this Application and which were not disclosed to the insurer at the date of this application. Failure to disclose material information to the insurer will invalidate the proposed insurance policy.

I hereby agree, with this in respect to both, myself and my Dependants that I am aware of the general terms of this insurance and I accept them for myself and on behalf of my dependants. I the undersigned declare that all of the above information as well as all declarations on the additional questionnaire (personal information) are true and complete. This information shall be considered as an integral part of the insurance policy.

Date: _____   **Signature:** _____

Medical Conditions

Name of applicant	Age:	Sex:
Date of application: / / (dd/mm/yyyy)		
Medical condition/diagnosis: (if more than one sickness, please complete a separate form for each)		
Date of last treatment/symptoms: / / (dd/mm/yyyy) ongoing treatment = current date		

Diagnosis Status:

	Yes	No
• Cured/ no symptoms	☐	☐
• Ongoing symptoms	☐	☐
• Ongoing hospitalization	☐	☐
• Pending hospitalization	☐	☐
• Ongoing treatment	☐	☐
• Pending treatment	☐	☐

In case of any *Diagnosis Status* the applicant was treated as:

	Yes	No
• Outpatient	☐	☐
• Hospitalized	☐	☐
• Treated both ways	☐	☐
• Operated on: / / (dd/mm/yyyy)		

How often do the symptoms occur?
Or can the illness be described as follows?

	Yes	No
• Acute	☐	☐
• Chronic	☐	☐
• Recurrent	☐	☐

	Yes	No
Did you have any bone fractures or injuries to bones or tendons?	☐	☐
Has any material used for osteosynthesis etc. been removed?		

In case medication is required on a regular basis please specify the genuine name, the brand name as well as the daily/weekly quantity below.

In case you are suffering from hypertension please specify your Systolic and Diastolic readings below.

Systolic:
Diastolic:

	Yes	No
In case of diabetes please specify whether insulin dependent.	☐	☐

	Yes	No
Are you currently pregnant?	☐	☐

- If Yes, have there been any complications to date?
- Last Menstrual period date -
- Are you currently trying to get pregnant?
- Are you undergoing any form of fertility treatment?

MEDICAL PRACTITIONER(S) MOST FREQUESNTLY VISITED IN THE LAST 2 YEARS:

- Name:

- Address:

- Telephone No.:

I understand and acknowledge any pregnancy not declared at the time of this application's coverage will be at the sole discretion of the insurer. The insurer has the right to not cover any maternity claims to any undeclared pregnancy. I also acknowledge and understand any pregnancy, which arises within forty calendar days from the date of this application; coverage will also be at the discretion of the insurer.

Date: _____   **Signature:** _____