

Medical Application Form

| NAME | RELATION (E/S/C) | D. O. B | SEX (M/F) | MARITAL STATUS | HEIGHT (CM) | WEIGHT (KG) | EMIRATES (VISA) |
|------|------------------|---------|-----------|----------------|-------------|-------------|-----------------|
| | PRINCIPLE | | | | | | |
| | SPOUSE | | | | | | |
| | CHILD | | | | | | |
| | CHILD | | | | | | |
| | CHILD | | | | | | |

| | | | |
|----------|--|---------------|--|
| Email ID | | Mobile number | |
|----------|--|---------------|--|

Have you ever tested positive for COVID-19 ? Yes No
 When is the last date you have tested negative for COVID ? _____(DD/MM/YYYY)

Is there any Post COVID complications under medical monitoring? Yes No

Have your health insurance request was ever declined or accepted on substandard terms?
 If yes, then please provide details. Yes No

Is there any eligible family member kept away from this insurance request?
 If yes, then please provide details Yes No

Please answer all questions mentioned below as either Yes or No:

| No. | Details | Declaration |
|-----|---|--|
| 1. | Are you under any medical observation/undergoing any medical/ surgical/ treatment or have been advised for the same? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. | Do you have any chronic illness? A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics: It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests. It needs ongoing or long-term control or relief of symptoms. It may require rehabilitation or the patient to be trained to cope with it. It continues indefinitely. Symptoms / medical condition may recur or likely to recur. | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. | Are you taking any medication (pharmaceutical/alternative medicine) or have been advised? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. | Do you have any physical problems/ disability for which you are undergoing physiotherapy or have been advised for? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 5. | Have you been admitted in the hospital in the last 10 years? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 6. | Are you currently pregnant or show signs and symptoms of pregnancy or planning to get pregnant? (This question apply only to married females) If the answer to above is YES kindly fill the attached supplementary maternity questionnaire. | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 7. | Do you have any previous surgical history or are you advised to undergo any kind of surgeries in the near future? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 8. | Have you been ever diagnosed/treated and cured or undergoing treatments for cancer? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 9. | Is there any other medical condition or disorder or any symptoms that you should be declared, and you are unable to relate to the above-mentioned Questions? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

❖ **Any applicant who is above 60 years of age should mandatorily submit a medical health certificate from a UAE based Registered Medical Practitioner even if there are no medical declarations to be made on the MAF.**

❖ **Have you availed insurance services under MedNet earlier? If yes please provide earlier policy/card numbers with last year of service:** _____

Please fill below details if you have answered any question as "YES" from above.

- Please specify name of the patient: _____

- Medical Condition / Diagnosis: _____
 (if we have more than one sickness please use another form)

- Diagnosis status: Cured / No Symptoms Ongoing Symptoms Ongoing Hospitalization Pending Hospitalization
 Ongoing treatment Pending treatment

- Treatment taken as: Out-Patient Hospitalization Treated both ways Operated on Date: _____

- Can the illness be described as follows? Acute Chronic Recurrent

- Please specify the medication generic names, the brand name as well as the daily/weekly quantity:

- In case you are suffering from hypertension, please specify your recent Systolic and Diastolic readings below:

- o Systolic: _____
- o Diastolic: _____

- In case of diabetes, please specify whether insulin dependent, also specify/attach latest HbA1c result. Yes No . HbA1c: _____

Based on above declarations, insurer reserves the right to request for additional medical report/documents to complete the assessment of medical conditions.

False declaration shall result in no coverage and cancellation of the insurance policy

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 Dependents that I am aware of the general terms of this insurance and I accept them for myself and on behalf of my dependents. I, the undersigned declare that all 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.

I hereby provide my Insurer and associated Third party administrator(MedNet) with full authorization to review my medical records across all hospitals and/or medical centers which I have ever visited whether before or after my insurance inception date. This includes all kinds of medical records whether related to services done on cash basis or under other insurance coverage. I acknowledge that the coverage decision for any service requested will be based on my records review and it is the sole authority of MedNet / Insurer to approve or deny the case as per the audit findings.

Date: _____

Signature: _____

Supplementary Pregnancy Questionnaire

If you are married female please answer the below questions.

Name :

Last Menstrual period date :

Do you have earlier history of Caesarean Section, Premature Delivery or Premature babies? Or any other complications related to maternity, till date?

Have you undergone any treatment or taken any medications for infertility to achieve this pregnancy?

Please send a copy of the latest ultrasound report and specify if there are any abnormal findings or more than one foetus seen.

Do you have any of the below conditions?

| Medical Condition | YES / NO |
|---|--|
| Any Heart Disease or hypertension | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Autoimmune Diseases | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Diabetes/gestational diabetes | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Thyroid Diseases | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Kidney Diseases | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Any placenta problems with the current pregnancy | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Any episode of vaginal bleeding with this pregnancy | Yes <input type="checkbox"/> No <input type="checkbox"/> |

If answer to any of the above is yes please support with relevant medical records and detailed information on the same.

Disclaimer: 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.

Name: _____

Signature: _____

Date: _____