

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.)	<input type="checkbox"/>	<input type="checkbox"/>
2 Respiratory disease or Allergy (asthma, bronchitis, emphysema, pneumonia, tuberculosis etc.)	<input type="checkbox"/>	<input type="checkbox"/>
3 Digestive disease (constipation, diarrhea, hepatitis, ulcers, pancreatitis etc.)	<input type="checkbox"/>	<input type="checkbox"/>
4 Renal or Urinary disease (nephritis, stones, renal colic, albuminuria, hematuria...)	<input type="checkbox"/>	<input type="checkbox"/>
5 Osteo-articular disease, disease of Hip or Vertebral column (scoliosis, rheumatism, slipped disc etc.)	<input type="checkbox"/>	<input type="checkbox"/>
6 Neurological, Cerebral, or Muscular disease (epilepsy, meningitis, aneurysm, paralysis etc.)	<input type="checkbox"/>	<input type="checkbox"/>
7 Endocrinal or Metabolic disease (goiter, nodules, diabetes, cholesterol, gout etc.)	<input type="checkbox"/>	<input type="checkbox"/>
8 Eye, Nose & Throat disease (glaucoma, retinopathy, dizziness, otitis, laryngitis, sinusitis etc.)	<input type="checkbox"/>	<input type="checkbox"/>
9 Blood, Ganglionic or Skin disease (anemia, hemophilia, adenopathy, eczema, herpes, purpura etc.)	<input type="checkbox"/>	<input type="checkbox"/>
10 Sexual disease (AIDS, gonorrhea, syphilis etc.)	<input type="checkbox"/>	<input type="checkbox"/>
11 Tumors or Swelling (fibroma, cyst, lipoma, cancer etc.)	<input type="checkbox"/>	<input type="checkbox"/>
12 Any other disease, past or future operation, Accident or Treatment not mentioned above	<input type="checkbox"/>	<input type="checkbox"/>
13 Psychical disease (nervous depression, fatigue, insomnia, psychosis etc.)	<input type="checkbox"/>	<input type="checkbox"/>
14 For female applicants, are you pregnant? If yes please state the expected due date?	<input type="checkbox"/>	<input type="checkbox"/>
15 Congenital anomalies, Hereditary/Genetic diseases	<input type="checkbox"/>	<input type="checkbox"/>

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 ASSUREX SAL and/or NEXTCARE SAL 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 Assurex SAL, in accordance with the Lebanese Code of Obligations and Contracts, Article 974, Paragraph 2.

Signature: _____ **Date (dd/mm/yyyy):** / / Broker Name