



Aram Ghannadzadeh <aram.ghannad@gmail.com>

## RE: GIG Insurance Smart Health Quote QMS3025736089 QMS7025794434

Aram Ghannadzadeh <aram.ghannad@gmail.com>  
Norlyn Mae Mendoza <Norlyn.Mendoza@gig-gulf.com>

Mon, Apr 28, 2025 at 9:47 AM

Dear Norlyn,

Thank you for your feedback.

For iv) I found that they had given me the report in paper, so please find it attached.

So then only I, ii, iii left to provide.

On Mon, Apr 28, 2025 at 9:18 AM Norlyn Mae Mendoza <Norlyn.Mendoza@gig-gulf.com> wrote:

CONFIDENTIAL

Dear Aram,

Good morning.

I've verified the points to our medical underwriters along with all the reports shared.

Team has confirmed that below is pending:

i Statement of treating orthopedic specialist on the attached GIG medical examination form

ii Statement of treating pulmonologist on the attached GIG medical examination form

iii. Current within 30 days pulmonary function test, chest X ray, PT, INR, D-dimer, KUB ultrasound and Doppler ultrasound Venous duplex ultrasound report of BOTH lower extremities

iv Copies of previous colonoscopy report. What was received is biopsy report (file name: ARAM Report), please share colonoscopy report if done before

Thank you.

Yours sincerely,

Applicant's Name:	MR. ARAM GHANNADZADEH		Date of Birth:	04/5/1984	
Height(cm):	173	Weight(kg):	79	Blood Pressure(mmHg):	127/79
Clinical features:	NIL SIGNIFICANT				

Diagnosis (please state cause & duration of the diagnosed conditions):

NO CURRENT MEDICAL ISSUES.

Kindly state the past medical history:

H/O BILATERAL DVT & PULMONARY EMBOLISM IN 2022  
 (DUE TO FREQUENT AIR TRAVEL)  
 THROMBOPHILIA SCREENING WAS NEGATIVE

Kindly state the past surgical history - procedure and outcome (if applicable):

NIL SIGNIFICANT

Does the applicant have any complication related to the diagnosed conditions. If Yes, please specify:

Yes  No

Please specify the current and proposed treatment (kindly include dosage and duration):

NO ACTIVE TREATMENT  
 NO PENDING PROPOSED TREATMENT

Kindly attach a copy of the latest blood tests/investigation reports

Declaration continued:

**For the medical practitioner use only**

Physician's name, signature & stamp:



Date: DD MM YYYY

06 / 05 / 2025

**To be completed by the applicant**

I, the undersigned, declare that the details given in the above questionnaire are true and correct, to the best of my knowledge and belief. I also hereby declare that I have not withheld any material information that may influence the assessment or acceptance of this application and understand and agree that this form will constitute part of my application for insurance and that failure to disclose any material fact known to me may invalidate the contract.

Signature of the applicant:

Date: DD MM YYYY