SAICOHEALTH DAMANA

Individual Health Declaration

You must reveal all facts you know, or ought to know, which may affect the insurance cover you are applying for. Otherwise, the insurance policy may not be valid.

Name of company	
Nature of Business	
Effective date (dd/mm/yyyy)	

Details of insured(s)

	NAME	Sex	Date of birth (dd/mm/yyyy)	Height (meters)	Weight (kilograms)
Main insured		☐ Male ☐ Female			
Spouse		☐ Male ☐ Female			
Child 1		☐ Male ☐ Female			
Child 2		☐ Male ☐ Female			
Child 3		☐ Male ☐ Female			

Correspondence address

Office Address:	
Phone:	
Email:	

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Questions on health

Questions	Main insured	Spouse	Child 1	Child 2	Child 3
1. Has any application for life, medical or accident insurance been declined, postponed or accepted on special terms?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. In the past five years, have you had any medical leave of more than seven days continuously, any hospitalization (except normal pregnancy) or surgery?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you been investigated, diagnosed or treated by a doctor for any health condition relating to:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
a) Heart attacks or heart disorders, chest pain, stroke or hypertension	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Liver, hepatitis B or C, stomach or intestine disorders	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) Hereditary or congenital condition	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) Cancer or tumor , for women any breast disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) Lung or respiratory disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) Diabetes Or Hyperlipidemia	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) Thyroid disorders, kidney disorders or other reproductive system disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) Disorder of the brain, nervous system or blood disorder e.g. sickle cell disease or thalassemia HIV, AIDS or any autoimmune disorders, e.g. Multiple sclerosis or SLE (Systemic Lupus Erythematosus) but not limited to ?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you been advised to have any surgical operation?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. 6. Do you have any back/spine disorders or any other physical impairment, defect or deformity or mental condition or disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. Have you visited any General Practitioner(s) or Specialist(s) in the last six months. (For E.g. Medicare only)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Do you or are you likely to engage in an occupation or any activities which could be considered dangerous? If “Yes”, please state the activity	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8. Any other illness, injury or disability not mentioned above?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

9. Performed or pending Covid 19 test	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
a) Advised for self-isolation/ quarantine	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10. Are you currently pregnant? LMP Date : _ _ /_ _ /_ _ _ _	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
a) If yes, have there been any complications to date?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Are you currently trying to get pregnant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) Are you undergoing any form of fertility treatment?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If you have answered "Yes" to any of the above questions, please give full details including dates, name of hospital or insurer, reasons, descriptions, diagnoses, treatment, still on follow-up or fully recovered or cured and attach medical reports, if available. Please include the respective question number(s) for your answer.

Name:
Hospital, clinic or practice:
Phone:
Fax:
Email:
Address:
Postcode:

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Note to the applicant

Completing this application

Please make sure you complete all sections. The questions should be considered carefully and answered as fully as possible. We will not be able to process your application if information is missing.

Your duty of disclosure

The questions in this application and any other information we ask for are essential for us to underwrite and administer your plan. You must tell us about all material facts before we can accept an application or renew the plan. If you do not tell us all material facts or misrepresent any material facts, it may affect your rights or your defendants' rights under the plan. A material fact is information likely to influence us in assessing or accepting the insurance. If there is any doubt about whether a fact is material, for your own protection, you must tell us. Failure to answer all questions fully and honestly may invalidate your insurance. A copy of the completed application can be supplied on request, but you should keep a record of all information you supply to us, including copies of all letters.

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**.**

We must receive all outstanding information before we can process your application. If you do not complete this application in full it will cause delays. The claim settlements based on the declarations made will be the sole discretion of the insurance company.

Declaration by Inured

I hereby apply to be covered under the medical insurance, including the dependents listed in this application. I declare that the information given in this application is true and complete to the best of my knowledge and belief, it is agreed that the declaration and information supplied in this application shall form the basis of the contract between me, my dependents and the insurance company. After reading all the terms and conditions and documents provided to me I am satisfied that the selected medical benefits meet with my requirements at this time.

Signature of Employee	Name of the Employee	Date(dd/mm/yyyy)