Medical Application Form

Please note that:

- The application should accompany the following documents:
  a. Copy of passport with valid visa page
  b. Copy of both sides of Emirates ID
  c. Certificate of Continuity (COC)
- Any alteration/ overwriting in the application must be signed by the applicant.
- This Medical Assessment form is valid for 1 month (30 days) from the date of completion and the form being signed by the applicant
- **Any applicant who is 60 years of age and above 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**

Name of Main Applicant (exactly as appearing in the passport - IN CAPITAL LETTER):

First Name Middle Name Last Name

Mailing Address:

Street/ Road P.O. Box Postal Code City Country

Gender: _____ **Marital Status:** _____ **No. of Children:** _____ **Nationality:** _____

Contact Details: (a) Mobile: _____ **(b) E-mail:** _____

Visa Issuance Emirate: _____ **Industry/Occupation:** _____

All Family Members (Main Applicant as the first name)

NAME Please specify Employee (E), Child (C) or Spouse (S) First Name Middle Name Family	**Relation** E / S / C	**D. O. B.** DD/MM/YYYY	**Nationality**	**Sex** M / F	**Height** CM	**Weight** KG	**Blood Type**	**UAE Resident**

(Please tick relevant box)	**Yes**	**No**
Chapter A Insurance History (in case answer is "Yes," specify reason)		
1. Have you ever been accepted for health insurance on sub-standard terms?		
2. Have you ever been declined for health insurance?		
3. Are the proposed persons, already insured under a plan with NEXTCARE or any other insurance company?		
Chapter B Specific Medical History (if "Yes," specify diagnostic details, treatment received & recovery status. If you are in any doubt as to whether a fact is material, then it should be disclosed.)		
1. Have you ever been diagnosed, treated or felt any disorder, pain or had any symptoms related to the following:		
a. **Musculoskeletal and/or Connective Tissue System**? (i.e. fractures, joint or cartilage problems, back problems, deformities, bone infections, osteoporosis, arthritis, rheumatism, etc.)		

Date: _____ **Applicant's Signature:** _____

(Please tick relevant box)	Yes	No
b. **Cancer, Neoplasms, Tumours?** (specify below the type, location, treatment, whether malignant or benign)		
c. **Blood & Blood Forming Organ Systems?** (i.e. anaemia, thalassemia, bleeding disorders, blood cell disease, spleen problems, lymph node problems, etc.)		
d. **Digestive System?** (i.e. Reflux, ulcers, diverticula, bleeding-infection-obstruction-perforation of the oesophagus, stomach, intestines or colon, problems of the teeth/gums/mouth/jaw, problems with the liver, gallbladder or pancreas, anal/rectal polyps, etc.)		
e. **Endocrine, Nutritional, Metabolic and/or Immunity System? (**i.e. diabetes, thyroid or pituitary gland problems, adrenal gland, ovary or testes problems, hormone problems, gout, multiple sclerosis, cystic fibrosis, metabolic disorders, immune problems, etc.)		
f. **Nervous System or Sense Organs?** (i.e. ear injury/infection, vertigo, hearing problems, eye injury/disease, retina problems, glaucoma, vision problems, muscular dystrophy, brain/nerve degeneration, meningitis, paralysis, seizures, epilepsy, neuralgia, etc.)		
g. **Genitourinary System?** (i.e. Kidney/bladder infections, renal failure, kidney stones, endometriosis, menstrual cycle problems, salpingitis, ovarian cysts, prostate problems, impotence, testicle infections, sperm abnormalities, fertility problems, etc.)		
h. **Respiratory System?** (i.e. Sinusitis, allergies, tonsillitis/laryngitis, bronchitis, emphysema, pneumonia, etc.)		
i. **Skin-Subcutaneous Tissue?** (i.e. dermatitis, acne, seborrhoea, puritis, etc.)		
j. **Cardiovascular System? (**i.e. stroke, cerebral ischemia, rheumatic fever, atherosclerosis, aneurysm, embolism, peripheral vascular disease, hypertension, heart valve disease, irregular heartbeat, pulmonary embolism, phlebitis, varicosities, etc.)		
k. Any (chronic) disease(s), symptoms and complaints **not** mentioned above		
2. Have you ever undergone surgery to remove a body organ or structure? (Specify body organ/Structure, date & place of surgery?)		
3. Have you been tested or treated for Hepatitis A or C?		
4. Are you HIV positive or have any medical condition or symptom indicative of HIV infection or AIDS?		
Chapter C **Maternity/ History of Conception** (if answer Yes is selected, specify details and numbers)		
1. Are you currently pregnant? If Yes, have there been any complications to date?		
2. Last Menstrual period date (dd-mm-yyyy)		
3. Are you currently trying to get pregnant?		
4. Are you undergoing any form of fertility treatment?		

Date: _____ **Applicant's Signature:** _____

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Details of Answer "Yes"

In case the answer is YES to any of the conditions/diseases or medication is required on a regular basis above please specify full details.

Continue on a separate sheet if necessary for further detailed information:

Chapter and Question Number	Name of Person Affected	Diagnosis	Date of Onset dd-mm-yyyy	Medication

In case of diabetes please specify whether insulin dependent please specify the generic name / brand name as well as the daily / weekly quantity below:

In case currently on immunomodulator or immunotherapy kindly specify the generic name / brand name as well as how often administration is required:

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.

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 declare and agree, with respect to, myself 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 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.

All Declarations must be made in writing on this application verbal declarations WILL NOT be accepted.

Date: _____ **Applicant's Signature:** _____