INDIAN ASSOCIATION SHARJAH

P.O Box No-2324, Sharjah. UAE.
Telephone- 06-5610845, Fax- 06-5610805
Email: mail@iassharjah.com, admin@iassharjah.com

MEDICAL INSURANCE – APPLICATION FORM

Name of Applicant (As per Passport) : _____

IAS Member ☐ **Staff** ☐ **FAMILY** ☐

IAS Member or Staff ID No. _____

If Family, please mention IAS Member or Staff, ID No & Relation_____

Address in U.A.E : **P.O Box No.**_____ **Emirate:** _____

Telephone : **Residence:** _____

: **Mobile:** _____

E-mail : _____

Date of Birth : _____ **Gender: M/F**_____

Marital Status : _____ **Nationality:** _____

Passport No. : _____

EID Number : _____

UID Number : _____

Visa file number : _____

Visa Issued Emirate : _____

Relationship (EMPLOYEE/SPOUSE/CHILD): _____

Signature: _____ **Date :** _____

FOR OFFICE USE ONLY

Reference No. : _____ **Date of Submission:** _____

Signature : _____

INDIAN ASSOCIATION SHARJAH

P.O Box No-2324, Sharjah. UAE.
Telephone- 06-5610845, Fax- 06-5610805
Email: mail@iassharjah.com, admin@iassharjah.com

MEDICAL INSURANCE – GENERAL UNDERTAKING

I, the undersigned, being aware of the Health Insurance Policy offered to me, hereby confirm I am aware that:

1. **Any malpractice or misuse of this Health Insurance policy is closely monitored by the authority concerned.**
2. **If any malpractice/misuse is identified and proved to be genuine, the policy will be suspended with immediate effect and the policy holder involved shall be put in black list by the Insurance Provider as per the legal right vested in them.**
3. **In such an event, proper documented evidence shall be made available for the perusal of the policy holder.**
4. **As an after effect or consequence thereof, medical policy to the party/parties involved in future may be affected unfavorably.**

This undertaking is collected with a view to ensure uninterrupted, eligible services to all the policy holders by the Insurance provider. You are requested to read and understand the significance of the above points and accept to abide by the set of rules concerned.

Name of Applicant (As per Passport) : _____

IAS Member or Staff ID No. _____ FAMILY ☐

If Family, please mention relation_____

Mobile: _____Gender: M/F_____

Marital Status: _____ **Nationality: _____**

Signature: _____ **Date : _____**

MEDGULF

Medical Application Form

NAME	RELATION (E/S/C)	D. O. B	SEX (M/F)	MARITAL STATUS	HEIGHT (CM)	WEIGHT (KG)	Nationality	EMIRATES (VISA)
	PRINCIPLE							
	SPOUSE							
	CHILD							
	CHILD							
	CHILD							
	If any member has a Medical Condition to declare, please fill separate form for each Individual							

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 ☐

Has 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 ☐ No ☐
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 ☐ No ☐
3.	Are you taking any medication (pharmaceutical/alternative medicine) or have been advised?	Yes ☐ No ☐
4.	Do you have any physical problems/ disability for which you are undergoing physiotherapy or have been advised for?	Yes ☐ No ☐
5.	Have you been admitted in the hospital in the last 10 years?	Yes ☐ No ☐
6.	Are you currently pregnant or show signs and symptoms of pregnancy or planning to get pregnant? (This question apply only to married females) **For Married Females – When was your last Menstrual period date:___/__/ _** ***If the answer to above is YES, kindly fill the attached supplementary maternity questionnaire (page 4)***	Yes ☐ No ☐
7.	Do you have any previous surgical history or are you advised to undergo any kind of surgeries in the near future?	Yes ☐ No ☐
8.	Have you been ever diagnosed/treated and cured or undergoing treatments for cancer?	Yes ☐ No ☐
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 ☐ No ☐

- ***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 (NEXTCARE, MEDNET, NAS) 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:
  - Systolic: _____
  - 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 with full authorization to review my medical records across all hospitalsand/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 Third party administrator to approve or deny the case as per the audit findings.

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 (40) calendar days from the date of this application; coverage will also be at the discretion of the insurer. If an undeclared pregnancy arises whether intentionally or not,

Option 1: Policy will be re-underwritten with risk of undeclared pregnancy or,

Option 2: Exclude this pregnancy.

The final choice on the options will be made by the member.

Date: _____ **Signature:** _____

Supplementary Pregnancy Questionnaire

If you are currently pregnant, please answer the below questions.

Name of the Pregnant Female:

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 ☐ No ☐
Autoimmune Diseases	Yes ☐ No ☐
Diabetes/gestational diabetes	Yes ☐ No ☐
Thyroid Diseases	Yes ☐ No ☐
Kidney Diseases	Yes ☐ No ☐
Any placenta problems with the current pregnancy	Yes ☐ No ☐
Any episode of vaginal bleeding with this pregnancy	Yes ☐ No ☐

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: _____