



WEHBE INSURANCE SERVICES LLC

Ministry of Economy – Registration No 106 of Year 1997

MediCare Individual Application Form

E&OE

No. 501 – Oud Metha Offices, Oud Metha Road, P.O.Box 2550, Dubai-U.A.E T: +971 (4) 3242345 – F: +971 (4) 3244010
E: info@wisuae.com – www.wisuae.com – Associate Offices in Beirut – Cairo – Jeddah – Riyadh – Dammam

Medical Questionnaire (over 65 years only)

If you or your spouse are 65 years or older you must complete this form

PLEASE COMPLETE FULLY IN BLOCK CAPITALS AND TICK RELEVANT BOXES

Your personal details

Applicant's full name:

Spouse full name (if over 65):

Have you or any of the proposed Insured's who are 65 years or over had any surgical operation, been confined or treated in a hospital, sanatorium, nursing home or other medical institution within the last five (5) years or is any treatment currently being performed or any operation/hospital confinement scheduled?

Applicant
 Yes No

Spouse
 Yes No

Have you or any of the proposed Insured's who are 65 years or over had any treatment or tests performed by a general practitioner or specialist including the prescription of drugs within the last five (5) years?

Applicant
 Yes No

Spouse
 Yes No

Are you currently suffering from any medical condition or disability, or experiencing symptoms of any kind which might reasonably be considered to need medical treatment in the future?

Applicant
 Yes No

Spouse
 Yes No

If the answer to any of the above questions is 'YES' please give details including dates, nature of ailment, medical procedure(s) performed and name and address of physician and/or medical facility.

Applicant:

Spouse:

Please give name and address of your normal attending (family) physician. If none, so state:

Applicant:

Spouse (if different to applicant):

SHOULD THE INFORMATION YOU PROVIDE ON YOUR APPLICATION FORM RAISE FURTHER QUESTIONS CONCERNING YOUR OR ANY OF THE PROPOSED INSURED'S STATE OF HEALTH, A 'COMPREHENSIVE HEALTH DECLARATION FORM' (NO MEDICAL EXAMINATION REQUIRED) WILL BE SENT TO YOU FOR COMPLETION AND FURTHER EVALUATION UPON RETURN.

Declaration

I declare that the answers to the above details are accurately represented and are to the best of my knowledge and belief, full, complete and true, and that I do not have any knowledge of any circumstance that could affect the results of the evaluation by the Insurer related to my application for insurance.

I authorise any physician or practitioner who has observed me or any of the proposed Insured's for diagnosis, treatment, disease or ailment, to give to the Insurer full particulars of these, including any prior medical history. I waive in my name, and that of any other person who shall have or claim an interest in any policy issued as a result of the answers, all provisions of law forbidding such action.

The refusal to submit medical information by any Insured or doctor, clinic, hospital or institution, shall be considered as a waiver of benefits by such Insured and/or supplier of services and the Insurer shall have no further obligation towards such persons or entity.

I consent to the processing by MediCare International of any of the personal data I provide or which is provided to Medicare International about me by any other person.

Signature of applicant:

Date:

