

Medical Application Form

Insured Name: _____
Required Plan: _____

Inception Date: _____
Policy No.: _____

NAME please specify Employee (E), Child (C) or Spouse (S)			Relation	D. O. B.	Nationality	Sex	Height	Weight	Photo card	Bahraini Resident
First Name	Middle Name	Family Name	E/S/C	DD/MM/YY		M/F	CM	KG	Yes/No	

Has MedNet previously covered any of the above applicants? Yes ☐ No ☐
Is there a member in your family that is not proposed for insurance? Yes ☐ No ☐ If Yes, please explain under section Comments

Marital Status: _____ No. of Children: _____ Active at work since: _____

Street: _____ City: _____

P.O. Box: _____ Tel. No: _____

I hereby declare and agree, with respect to both, myself and to my Dependants, 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 (and those of my **Dependants**) 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.

Have you ever been diagnosed or received any treatment (including hospital or surgery) or felt any disorder or pain or had any symptoms indicating:

(Please tick relevant box)	Yes	No
1. Infectious and parasitic diseases	<input type="checkbox"/>	<input type="checkbox"/>
2. Neoplasms/Cancer (benign or malignant)	<input type="checkbox"/>	<input type="checkbox"/>
3. Diseases of the endocrine system, nutritional-, metabolic diseases and immunity disorders, diabetes	<input type="checkbox"/>	<input type="checkbox"/>
4. Diseases of blood and blood forming organs	<input type="checkbox"/>	<input type="checkbox"/>
5. Mental-/psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>
6. Diseases of the nervous system and sense organs (ears, eyes, nose)	<input type="checkbox"/>	<input type="checkbox"/>
7. Diseases of the cardiovascular system incl. hypertension	<input type="checkbox"/>	<input type="checkbox"/>
8. Diseases of the respiratory system	<input type="checkbox"/>	<input type="checkbox"/>
9. Diseases of digestive system	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
10. Diseases of genitourinary system, kidney diseases and breast disorders	<input type="checkbox"/>	<input type="checkbox"/>
11. Pregnancy, complications of pregnancy, child birth and the puerperium incl. abortions	<input type="checkbox"/>	<input type="checkbox"/>
12. Disease of the skin and subcutaneous tissue	<input type="checkbox"/>	<input type="checkbox"/>
13. Diseases of the musculoskeletal system and connective tissue	<input type="checkbox"/>	<input type="checkbox"/>
14. Congenital anomalies, hereditary/genetic diseases	<input type="checkbox"/>	<input type="checkbox"/>
15. Certain conditions originating in the perinatal period	<input type="checkbox"/>	<input type="checkbox"/>
16. Injury and poisoning	<input type="checkbox"/>	<input type="checkbox"/>
17. Previous medical/surgical hospitalisations, procedures and operations	<input type="checkbox"/>	<input type="checkbox"/>
18. Any (chronic) disease(s), symptoms and complaints not mentioned above	<input type="checkbox"/>	<input type="checkbox"/>

In case the answer is YES to any of the conditions/diseases above please specify full details (preferably by a Medical Physician) on the additional questionnaire (Personal Information), which will be found attached to this application form.

In case medication is required on a regular basis please specify the full details such as genuine name, brand name and daily/weekly quantity on the additional questionnaire (Personal Information), which will be found attached to this application form.

Mediclinic Application Forms

Josef Woodman

A red circular graphic with a gradient, appearing as a partial circle or a thick arc, located to the right of the name bar.

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