الشركة اللبنانية السويسرية للضمان
LIBANO-SUISSE
Insurance Company
Since 1959
THE SIGNATURE THAT PROTECTS YOU

GlobeMed
Qatar

INDIVIDUAL/FAMILIY MEDICAL-APPLICATION FORM

Date ______________________

Contractual Period From	To	**Broker No.**	**Policy No.**

For Administration only

PERSONAL INFORMATION

First Name ______________________ Family Name ______________________

Father's Name ______________________ Civil ID No. ______________________

Country ______________________ City ______________________

Street ______________________ Bldg. ______________________

Cell No. ______________________ Home No. ______________________

P.O. Box ______________________ Email ______________________

APPLICATION DETAILS

SPECIALIZED RIDERS PLANS ◯ Optical ◯ Dental

POLICYHOLDER'S FAMILY STATUS ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Family Members	Name	Nationality	D.O.B.	Sex M/F	Height CM	Weight KG	Smoker Y/N	Profession	Blood Type
Policyholder									
Spouse									
Children									

Is there any family member who is not insured? If yes, please specify. ______________________

Did you have any medical insurance coverage? If yes, please specify the preceding insurance company & policy expiry date. ______________________

Would you like to receive SMS regarding your claims status? ◯ Yes ◯ No

Would you like your broker to receive SMS in case your claim is rejected or partially approved? ◯ Yes ◯ No

APPLICATION DETAILS

Kindly identify any disease related to your medical condition "over the last 10 years", by putting the sign (x) next to the medical condition:

1. Diseases of the cardiovascular system (hypertension, coronary, vascular disease, valvular, cardiomyopathies, arrythmias, etc.) — Yes ◯ No ◯
2. Diseases of the respiratory system other than cancer (asthma, chronic obstructive pulmonary disease, fibrosis etc.) — Yes ◯ No ◯
3. Diseases of the digestive system other than cancer (Crohn, other intestinal inflammation, pancreatitis, diverticulitis, gall bladder or liver disease, etc) — Yes ◯ No ◯
4. Kidney & urinary tract diseases other than cancer (kidney stones, insufficiency, cysts, etc) — Yes ◯ No ◯
5. Orthesis and limb transplants, osteoarticular or muscular diseases other than cancer — Yes ◯ No ◯
6. Diseases of the nervous system other than cancer (polio, depression, epilepsy, multiple sclerosis, etc) — Yes ◯ No ◯
7. Diabetes or diseases of the endocrine glands other than cancer — Yes ◯ No ◯
8. Diseases of the eye, ear, nose and throat other than cancer — Yes ◯ No ◯
9. Hematological diseases other than leukemia (anemia, etc) — Yes ◯ No ◯
10. Malignant tumors, lymphomas and leukemias — Yes ◯ No ◯
11. Sexually transmitted diseases, AIDS and HIV — Yes ◯ No ◯
12. Other diseases, accidents, surgeries, prosthetic replacement, endoscopic procedures, diagnostics tests that you had or you are aware of — Yes ◯ No ◯
13. Have you or any of the applicants taken or currently take any medications or have followed or will follow any kind of treatment — Yes ◯ No ◯
14. Females only: are you currently pregnant? — Yes ◯ No ◯
15. Congenital disorders and diseases — Yes ◯ No ◯
16. Psychiatric disorder (depression, anxiety, etc.) — Yes ◯ No ◯
17. Do you suffer from any symptoms related to the disease mentioned here above? (backache, chest pain, pain in joint, etc.) — Yes ◯ No ◯

In case the answer is yes to any of the Diseases/Conditions, above please specify full details in the table below

Name	Disease No.	Diagnoses Status	Treatment	Date	Hospital / Dr. Name

I hereby declare that the abovementioned information is complete, real and adequate, waiving, fully and irrevocably, the medical confidentiality on all the past and current medical files, documents and prescriptions related to any of us and those that will develop during the policy contract, in favor of the Medical committees and doctors, requesting from them, and other insurance companies or any other risk carrier which we had contracted with for medical and/or life insurance, to provide the insurance company and/or MedNet with all the information and documents available at their side on our medical condition and of copies thereto, permitting MedNet, within its capabilities, to inform our treating physician with the information available at its side on our medical condition, in addition to the rejection or approval of coverage decisions at all healthcare providers and pharmacies, with all possible means, either through e-mail, or SMS or any other available means.

I also declare that I have read the provisions of the policy with its general conditions and exceptions, and upon it I request the benefit from the health insurance for me and for my family members defined above. This declaration is final and irrevocable; I signed it on ____/_____/_____ on one original copy to be kept with the Insurance Company to act upon it or upon a copy of it when necessary.

Policyholder Signature ____________________

First Beneficiary Signature ____________________

Second Beneficiary Signature ____________________

Third Beneficiary Signature ____________________

Fourth Beneficiary Signature ____________________