AMANAH INSURANCE
MEDICAL MEMBER APPLICATION FORM

PERSONAL PARTICULAR OF THE APPLICANT

Name of The Insured Company	Title	Proposal Commencement Date
	☐ MR. ☐ MRS. ☐ MISS.	Day Month Year _____/_____/_____

First Name	Middle Name	Last Name	ID/Passport

Gender	Marital Status	Date of Birth	Mobile Number	Alternative Mobile Number
☐ Male ☐ Female	☐ single ☐ Married	Day Month Year _____/_____/_____		

Blood Group	Height (Cm)	Weight (Cm)	Email Address

Specific Occupation/Designation	Date of Employment	Staff Payroll No.
	Day Month Year _____/_____/_____	

PARTICULARS OF DEPENDANTS TO BE INCLUDED ON COVER

No.	Full Name or Dependent (Surname First)	Dependent Type (Spouse/Child)	Gender (M/F)	Date of Birth	Blood Group	I.D No.

Health Questions (You Must Complete All Questions)

1.	Has any of you or your above dependents been hospitalized in the last 3 years?	Yes	☐	No	☐
2.	Have any of you or your above dependents ever had an accident resulting in a permanent injury?	Yes	☐	No	☐
3.	Do any of you suffer from any disease that is recurrent in nature?	Yes	☐	No	☐
4.	Are any of you on regular medication?	Yes	☐	No	☐
5.	Do any of you have any kind of physical disability?	Yes	☐	No	☐

Please state whether any of you proposed for inclusion on cover has ever been treated, received treatment or expects to receive treatment for any of the following conditions / illness:

6.	Heart and Blood vessels disorders e.g. high blood pressure, heart disease, stroke, congenital (inborn) heart conditions, chest pains, arterial disease.	Yes	☐	No	☐
7.	Blood/ circulatory disorders e.g. Sickle cell anemia, Varicose, Thrombosis, Kidney, Liver, Hemophilia, leukemia or any other blood disorder.	Yes	☐	No	☐
8.	Respiratory disorders e.g. Bronchitis, Tuberculosis, Asthma, cigarette smoking disorder, any other respiratory related disorder.	Yes	☐	No	☐
9.	Neurological disorders e.g. Meningitis, stroke, brain or spinal cord disorder, epilepsy, any other neurological related disorder.	Yes	☐	No	☐
10.	Ear, Nose and Throat related problem e.g. throat surgery, sinuses.	Yes	☐	No	☐
11.	Eye disorders e.g. cataract, glaucoma, eye surgery, blindness.	Yes	☐	No	☐
12	Gynecological or genitor-urinary disorders e.g. Pelvic Inflammatory disease, menstrual irregularities.	Yes	☐	No	☐
13.	Kidney disorders such as kidney failure, kidney stones, recurrent infections etc.	Yes	☐	No	☐
14.	Musculoskeletal disorders e.g. arthritis, back problems, joints, gout, etc.	Yes	☐	No	☐
15.	Endocrine diseases such as diabetes, thyroid disease, high cholesterol.	Yes	☐	No	☐
16.	Surgical such as appendectomy, tonsillectomy or any other surgical procedure.	Yes	☐	No	☐
17.	Other diseases/ disorders: cancer, alcohol/drug problem, hepatitis, ulcer, mental disorder, gall bladder disease, HIV infection.	Yes	☐	No	☐

If you answered YES to any of the questions 1 to 17, kindly give more details in the table below.

No.	Name of Applicant	Ailment/ Disorder	Date Diagnosed	Doctor & Contact Address	Current Status

If the space is not adequate, fill in a separate plain paper and staple it to the form

18. For female applicants / spouses only:
    a) Have you / your spouse ever delivered a child by Caesarean operation? If yes please give member name
    b) _____ YES ☐ NO ☐

    c) Is any member currently pregnant?
    If yes please state number of weeks of pregnancy _____ YES ☐ NO ☐

19. Is any of you allergic to drugs? If yes give details
    _____

20. Have you been on medical insurance before?
    If yes give the name of the Insurer/HMO, expiry date and special exclusions YES ☐ NO ☐
    _____

I hereby apply to join the above medical scheme. I understand to the best of my knowledge and belief that all the answers given above are true, that I have not concealed or withheld any material information which the underwriter ought to know in order to assess me or my family members for medical insurance. I hereby authorize the hospitals, medical or dental practitioners who have treated me or any of my dependants to disclose to Amanah Insurance. The records relating to such current or previous hospitalizations, medical treatment and to allow Amanah Insurance to receive extracts from such records, and I undertake to assist in obtaining such information.

Signature of Principal Member: _____ Date: _____

Agency Name & Stamp

_____

Note: Kindly indicate the National I.D number for your spouse and each child above 18 years of age. (Please attach copies)