Arab Orient Insurance Company

Global Knowlege .. Local Approach

Crown MEDICAL PLAN

Medical Insurance Application Form (Group)

Crown Medical Plan

Policy Holder Name : ..... **Policy No :** .....

Effective Date Of Insurance : ..... **Social Security No. :** .....

List of Proposed Insured Member

Name and Nationality I.D.	Family Name	Date of Birth	Relation	Class	Sex	Height	Weight	Occupation	Nationality	Residency

Married Status : ..... **No. of Children :** ..... **Employment Date :** .....

N.B. The answers of the below questions should be by the applicant on behalf of each of his/her dependents.

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

Yes	No		Yes	No	
☐	☐	1- Infectious and parasitic diseases .	☐	☐	8- Disease of respiratory system .
☐	☐	2- Neoplasm .	☐	☐	9- Disease of the digestive system .
☐	☐	3- Diseases of the endocrine system Nutritional, Metabolic . Diseases and immunity Disorders .	☐	☐	10- Disease of the genitourinary system, kidney diseases and breast disorder .
☐	☐	4- Disease of blood and blood forming organs .	☐	☐	11- Pregnancy and complication,or any gynecological disorder .
☐	☐	5- Mental Disorder .	☐	☐	12- Congenital anomalies, hereditary disease .
☐	☐	6- Disease of nervous system and sense organs .	☐	☐	13- previous medical surgical hospitalization, procedures and operation .
☐	☐	7- Disease of the cardiovascular system	☐	☐	14- any disease, symptoms and complaints not mentioned above .

The concealing and/or changing of any medical information shall render the medical insurance policy cancelled even if it's issuance has already been approved

If the reply is yes to any of the questions above, please specify the name and write down full details .

Details : .....

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Declaration :

I declare that to the best of my knowledge and belief the statements on this application form are full, true and correct, and I agree that the acceptance of my application shall be on the basis of these statements.

I hereby authorize Arab Orient Ins. Co. or any of its representatives to approach my doctor or any hospital that is declared in this application for any medical information that might be helpful to them .

Date : / /

Applicant's signature :

Stamp of Policy Holder :

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