GROUP HEALTHCARE INSURANCE UNDER ILA PROGRAM

MEDICAL PROPOSAL AND QUESTIONNAIRE

I – Personal Information

Group name :

Principal's name :

First name *Father's name* *Family name*

Occupation : **Nationality:**

Address in the African country :
(Country of residence)

Address in country of origin :

Phone(s): *fixed line* *mobile* **Email(s):**

II – Insurance coverage requested and family members to be insured

	Name	Sex M / F	Coverage *	DOB DD – MMM - YY
Principal	:			
Spouse	:			
Child	:			
Child	:			
Child	:			
Child	:			
Child	:			

** For the Coverage, please choose A, B or SK (for Class A, Class B and Class SK), AMB for the Ambulatory coverage and DV for Doctors Visits. e.g. A + AMB + DV.*

III – Medical Questionnaire *(to be completed for all the family members to be insured)*

Have you, or any of your family members applying for the cover, ever been diagnosed or received any treatment (including hospital or surgery) or felt any disorder or pain or had any symptoms indicating:

	Yes	No		Yes	No
1 - **Circulatory or heart diseases** (*High blood pressure, arrhythmia, murmur, infarction, etc.*)			8 - **Blood, ganglionic or skin diseases** *(Anemia, hemophilia, adenopathy, eczema, herpes, etc.)*		
2 - **Respiratory diseases or allergy** (*Asthma, bronchitis, emphysema, pneumonia, tuberculosis, etc.*)			9 - **Eye, Nose & Throat diseases** (*Glaucoma, retinopathy, dizziness, laryngitis, sinusitis, etc.)*		
3 - **Digestive diseases** (*Constipation, diarrhea, hepatitis, ulcers, pancreatitis, etc.*)			10 - **Sexually Transmitted Diseases** *(AIDS, HIV, gonorrhea, syphilis, etc.)*		
4 - **Renal or urinary diseases** *(Nephritis, stones, renal colic, albuminuria, hematuria, etc.)*			11 - **Tumors or swelling** *(Fibroma, cyst, lipoma, cancer, etc.)*		
5 - **Osteoarticular diseases, disease of hip or vertebral column** *(Scoliosis, rheumatism, slipped disc etc.)*			12 - **Any other disease,** *past or future operation, accident or treatment not mentioned above*		
6 - **Neurological or metabolic diseases** *(Epilepsy, meningitis, aneurysm, paralysis, etc.)*			13 - **Psychical diseases** *(Nervous breakdown, depression, fatigue, insomnia, psychosis etc.)*		
7 - **Endocrinal diseases** (*Goiter, nodules, diabetes, cholesterol, gout, etc.)*			14 - **Congenital anomalies, hereditary/genetic**		

For female proposed insured: are you actually pregnant: Yes □ No □
If Yes, what is the expected delivery date?

In case the answer is YES to any of the conditions/diseases above or in case any medication is required on a regular basis, please specify full details on the back of this sheet.

I authorize my doctor, health institute or any other organization or person(s) that has any information about my health and/or activities (and those of my family members listed above) to provide the Insurance Company and/or the Third Party Administrator with the said information. This shall include hospital and any other records pertaining to medical advice, diagnosis, and treatment. A photocopy of authorization has the same validity as the original.

I declare that my answers to the above questions are true to the best of my knowledge and belief, that I have disclosed all particulars affecting the assessment of the risk. I agree that this proposal and declaration shall be the basis of the contract between me and the Insurance Company, in accordance with the applicable laws.

Date / / **Name and Signature**

If you have answered **YES** to any of the Medical Questionnaire questions above, please give full details here:

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4	
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Applicant's Name **Signature**