redefining / cooperative insurance
رؤية جديدة / للتأمين التعاوني

DECLARATION OF HEALTH

Personal Details

First Name:		Middle Name(s):		Family Name:	
Gender:		Date of Birth:		Contact #:	

Health Details

[1] Name & Address of personal physician or family doctor:					
Date last seen:		Reason:			
What advice / treatment / medications has been given / prescribed?					
[2] Height (cm)		Weight (kg)			
Has your weight changed in the last 12 months?				□ Yes □ No	
If yes, state the amount and reason for the change.					
[3] Have you used any form of tobacco in the last 12 months?				□ Yes □ No	
If yes, state in what form and number of sticks smoked per day.					
[4] Are you currently receiving any treatment, medicaltion whether or not prescribed by a physician?				□ Yes □ No	
[5] Do you intend to seek medical advice / undergo medical investigations in the near future?				□ Yes □ No	
[6] Have you ever used any habit forming drugs except on the advise of a physician ?				□ Yes □ No	
[7] Have you ever suffered from or been diagnosed/treated for or been indicated to have:					
a. Mental or nervous disease/disorder, anxiety or depression?				□ Yes □ No	
b. Dizziness, fainting, headache, paralysis, stroke, brain haemorrhage, cerebrovacular accident, fits and seizures?				□ Yes □ No	
c. Heart problems including myocardial infarction or chest pain?				□ Yes □ No	
d. Disease/Disorder of eyes, ears, nose or throat? Any speech defect?				□ Yes □ No	
e. Respiratory disease/disorders - asthma, bronchitis, pneumonia, tuberculosis, pleurisy?				□ Yes □ No	
f. Disease/Disorder of the urinary tract - including kidney stones?				□ Yes □ No	
g. Disease/Disorder/Deformity of the joints/bones, muscular system (polio, rheumatism, dystrophies)?				□ Yes □ No	
h. Hearing or vision impairment?				□ Yes □ No	
i. Rheumatic Fever?				□ Yes □ No	
j. Diabetes, hypertension, hypercholesterolemia or hepatitis?				□ Yes □ No	
k. Cancer, leukemia, brain or spinal tumor?				□ Yes □ No	
l. Thyroid disorders or disorders of the digestive tract (ie Ulcerative Colitis, Crohn's disease)?				□ Yes □ No	
[8] a. Have you received any medical advice or treatment in connection with AIDS, AIDS related complex or STD disease?				□ Yes □ No	
b. Have you ever been told you have AIDS or AIDS related Complex?				□ Yes □ No	
c. Have you ever been told to have a positive blood test for antibodies of HIV?				□ Yes □ No	
[9] Do you have any of the following which are unexplained - weight loss, fatigue, diarrhea, enlarged lymph nodes, unusual skin lesions?				□ Yes □ No	
[10] Have you within the last 5 years had any mental or physical disease / condition / ailment not listed above, had a check up, consultation, illness, injury or surgery, been hospitalized or been advised to have any diagnostic test, consultations or examination?				□ Yes □ No	
[11] Is there a family history of diabetes, cancer, heart disease, high blood pressure, mental illness or suicide?				□ Yes □ No	
[12] Has any insurance company ever declined you for life, health or disability cover; raised an extra premium or applied any exclusion clause(s)?				□ Yes □ No	
[13] Has any insurance company ever cancelled your life, health or disability insurance/benefits?				□ Yes □ No	
[14] Have you ever been incapacitated / discharged from work for health reasons for more than one week?				□ Yes □ No	
[15] **FEMALES ONLY**					
a. Are you pregnant? (If yes then state the duration of pregnancy): _____				□ Yes □ No	
b. Any history of abortion, miscarriage, disease of the ovaries, uterus, genital tract or breasts?				□ Yes □ No	
c. Is your menstruation cycle regular and healthy? (If not then please state details below)?				□ Yes □ No	

If any of above questions is answered 'YES', please give details below:
(Question #, date, duration, physician/medical facilities details, diagnosis & degree of recovery):

I hereby confirm that I am the person named as the proposed insured on the Life application submitted to AXA Cooperative Insurance, and I confirm that I have read and answered above questions to the best of my knowledge, and acknowledge that this Health Declaration form part of the Insurance contract.
I hereby authorize any physician, medical facility or other institution or person, that has any records or knowledge of my health, to give any or all information about me with reference to my medical history, health, hospitalization, advice, diagnosis or treatment to AXA Cooperative Insurance or its representative.

Signed at:	

Signature of Applicant

Date:	

AXA Cooperative Insurance Company
C. R. No. 1010271203

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