Health Declaration

To be completed by the Applicant

Policy No. [ ]

▶ Please complete all relevant information completely and legibly.

Gulf Operations
P.O. Box 371916, Dubai, UAE - Tel. 04 415 4555, Fax 04 415 4445

Health Details Questions pertain to all Proposed Insured/s under this application. Please provide complete and correct answers irrespective of how important they might appear. If a question is answered 'yes', please provide complete details below.

	Yes	No
1. **Do you have any personal or family doctor?**	☐	☐

If 'yes', please state details on the table below:

	Doctor's Name	Address / Phone No.	Date Last seen	Reason / symptoms	Any diagnosis	Advice given
Proposed Insured						
Joint Insured						
Applicant						

2. **Proposed Insured** Height [ ] ft. [ ] in. or [ ] cm. Weight [ ] lbs. or [ ] kg.

	Yes	No
3. **Do you use or smoke any type of tobacco, cigarettes, pipe, shisha, e-cigarette, vape, or chew tobacco?**	☐	☐

If 'yes', [ ] quantity [ ] per day

	Yes	No
If, currently, you are not using or smoking a tobacco product, have you ever smoked or used any type of tobacco (cigarettes, pipe, shisha, e-cigarette, vape, or chew tobacco)?	☐	☐

What type you used to smoke? [ ]

What is the quantity you used to smoke per day? [ ]

For how long did you smoke? [ ]

When did you stop? [ ]

Why did you stop? [ ]

	Yes	No
4. **Have you had any medical or surgical treatment, or investigative medical tests or hospitalizations or have you been advised to undergo any diagnostic tests, hospitalization or surgery which was not done?**	☐	☐
5. **Have you ever had indication of, diagnosis of, treatment or surgery for:**		
a) Rheumatic fever, high blood pressure, murmur, stroke, chest pain, heart attack, or any disorder of heart, blood, or blood vessels?	☐	☐
b) Any form of cancer, tumor, or cyst?	☐	☐
c) Diabetes, high blood sugar, thyroid disorder, or any endocrine disorder?	☐	☐
d) Hepatitis or any other liver, pancreas, gallbladder, stomach, or intestinal disorder?	☐	☐
e) Any kidney, urinary, or reproductive disorder?	☐	☐
f) Epilepsy, paralysis, or any other nervous disorder?	☐	☐
g) Any form of blood disorder or disease?	☐	☐
h) Asthma, Tuberculosis, Respiratory, or lung disease?	☐	☐
i) Mental or psychiatric illness including anxiety and depression?	☐	☐
j) Any disease or disorder of the muscles, spine, joints, and limbs including loss of feeling or tremor?	☐	☐
k) Excessive consumption of alcohol, alcoholism, and drug abuse?	☐	☐
l) Any disorder of sight, speech, or hearing?	☐	☐
m) Any hereditary or congenital condition?	☐	☐
n) Any chronic condition, infirmity, or injury not mentioned above?	☐	☐

		Yes	No
6.	**Have you ever been treated for AIDS, Auto-immune Disease, AIDS Related Complex, or sexually transmitted disease or been told you have any of these OR that you had tested positive for AIDS (please state reason and results) OR have you had unexplained fatigue, weight loss, diarrhoea, or unusual skin lesions?**	☐	☐
7.	**Has any member of your immediate family ever suffered or died from any of the conditions stated above?** .... **If "Yes", please state details on the table below:**	☐	☐

Name of Insured	Family Members	Age if Living	State of Health	Age of diagnosis	Age at Death	Cause of Death

***Details to any "Yes" answers to above questions, include name of Proposed Insured, Joint Insured, and Applicant, dates, names of doctors, hospitals, reason for consultation, tests, results, diagnosis, treatments, and current condition**

Question No.	Name of Insured	Date	Name of doctors, Hospitals	Reason for consultation	Outcome	Age at time of diagnosis	Treatment	Current Condition

Additional information:

Signatures

Name of Applicant / Proposed Insured	Full Name in his/her own handwriting	X Signature
Name of Joint Insured	Full Name in his/her own handwriting	X Signature
Name of Witness / Representative	Full Name in his/her own handwriting	X Signature

Signed at [Place] City/Country [ ] on this [D][D] day of [M][M] 20[Y][Y]

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