

# Medical Application Form

Insured Name: \_\_\_\_\_  
Required Plan: \_\_\_\_\_

Inception Date: \_\_\_\_\_  
Policy No.: \_\_\_\_\_

| NAME please specify Employee (E), Child (C) or Spouse (S) |             |             | Relation | D. O. B. | Nationality | Sex | Height | Weight | Photo card | Bahrain Resident |
|-----------------------------------------------------------|-------------|-------------|----------|----------|-------------|-----|--------|--------|------------|------------------|
| First Name                                                | Middle Name | Family Name | E/S/C    | DD/MM/YY |             | M/F | CM     | KG     | Yes/No     |                  |
|                                                           |             |             |          |          |             |     |        |        |            |                  |
|                                                           |             |             |          |          |             |     |        |        |            |                  |
|                                                           |             |             |          |          |             |     |        |        |            |                  |
|                                                           |             |             |          |          |             |     |        |        |            |                  |
|                                                           |             |             |          |          |             |     |        |        |            |                  |

Has MedNet previously covered any of the above applicants? Yes ☐ No ☐  
Is there a member in your family that is not proposed for insurance? Yes ☐ No ☐ If Yes, please explain under section Comments

Marital Status: \_\_\_\_\_ No. of Children: \_\_\_\_\_ Active at work since: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_

P.O. Box: \_\_\_\_\_ Tel. No: \_\_\_\_\_

I hereby declare and agree, with respect to both, myself and to my Dependants, that I am aware of the general terms of this insurance and I accept them. With the above, I authorise my doctor, health institution or other organisation or person that has any information about my health and/or activities (and those of my **Dependants**) to provide the **Insurer** with the said information. This shall include hospital and any other records pertaining to medical advice, diagnosis, treatment or disturbances. A photocopy of this authorisation has the same validity as the original.

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

| (Please tick relevant box)                                                                             | Yes                      | No                       |
|--------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Infectious and parasitic diseases                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Neoplasms/Cancer (benign or malignant)                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Diseases of the endocrine system, nutritional-, metabolic diseases and immunity disorders, diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Diseases of blood and blood forming organs                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Mental-/psychiatric disorders                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Diseases of the nervous system and sense organs (ears, eyes, nose)                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Diseases of the cardiovascular system incl. hypertension                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Diseases of the respiratory system                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Diseases of digestive system                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |

|                                                                                           | Yes                      | No                       |
|-------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 10. Diseases of genitourinary system, kidney diseases and breast disorders                | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Pregnancy, complications of pregnancy, child birth and the puerperium incl. abortions | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Disease of the skin and subcutaneous tissue                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Diseases of the musculoskeletal system and connective tissue                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Congenital anomalies, hereditary/genetic diseases                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Certain conditions originating in the perinatal period                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Injury and poisoning                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Previous medical/surgical hospitalisations, procedures and operations                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Any (chronic) disease(s), symptoms and complaints not mentioned above                 | <input type="checkbox"/> | <input type="checkbox"/> |

In case the answer is YES to any of the conditions/diseases above please specify full details (preferably by a Medical Physician) on the additional questionnaire (Personal Information), which will be found attached to this application form.

In case medication is required on a regular basis please specify the full details such as genuine name, brand name and daily/weekly quantity on the additional questionnaire (Personal Information), which will be found attached to this application form.

# Mediclinic Application Forms

**Yi-Tong Ma**

A red circular graphic with a gradient, appearing as a semi-circle or a partial circle, located to the right of the name bar.

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