OMAN UNITED INSURANCE CO SAOG

MEDICAL INSURANCE

(To be completed by the person to be insured)

The statements given below will form the basis of the insurance contract. This is the responsibility of the life to be assured to provide complete and correct information. Any FALSE declaration in this form would invalidate the insurance cover / insurance benefits.

PLEASE STATE TRUTHFULLY:

Name of Life to be Assured:		Company Name:
ID Card No.:		Date of Birth:
Address : PO Box : PC No :	Location : Phone :	
Employer:	Occupation & Nature of duties :	
Annual Benefit Limit:	Cover Type: IP, OP or IP + OP:	
Optional Cover – Optical, Dental, Maternity, Psychiatric	Territorial Limit:	
Pre Existing & Chronic Limit:	Network:	
Deductible/Excess	Co-Insurance	
Name of Current Insurer:	Claim History:	
Height (in cm):	Weight (kg):	BP Reading (if known):

1. I have never suffered from any form of heart disease, high blood pressure, high cholesterol, circulatory disease, lung diseases including asthma, neurological diseases, ulcer, cancer, tumor, stroke or cyst whether benign or malignant, diabetes, kidney disease, mental or nervous disorders, liver disease including hepatitis, HIV infection or AIDS, ear or eye disease.
2. I have never suffered from any other chronic or long term medical condition not mentioned in point number 1 above.
3. I have not taken any form of medication for more than 10 consecutive days during last 2 years to treat any illness or disease.
4. I have never been absent from work or taken leave on health grounds for more than 10 days during last 12 months.
5. During last 5 years, I have never consulted any medical practitioner for any condition other than minor illness (such as cold or flu) or have never been hospitalized or had no surgical operation.
6. My application for life, disability or health insurance has never been declined, postponed or accepted with special terms / extra premiums or restrictions.
7. I do not smoke/consume alcohol.
8. I do not have any physical or mental impairment and I am in good health.
9. Applicable for females only – I am not pregnant at present and I do not have any history of gynecological problems.

If any of the above mentioned statement in points numbered 1 to 9 is not true, please share relevant details:

10. I declare that to the best of my knowledge and belief that above statements are true and correct and that statements together with any forms, reports, or other information completed or supplied by me shall form the basis of this contract. I am aware that giving full and correct information is my responsibility. If I do not provide complete and correct information, no claim would be payable in the event of my permanent total disability or death.
11. I am aware that the insurer accepts the above declaration in good faith and if this declaration is proved to be wrong or if any material information regarding my health has been withheld, the insurer would not be liable to pay any of the claim amounts.
12. I authorize any doctor, hospitals, medical Institutions, statutory authorities or Insurance companies to disclose information related to my physical or mental health and history including results of any tests to the Insurance Company and I agree that this authorization shall remain in force after my death.

I am fully aware that any omission or any incorrect statement in this Health Declaration Form would invalidate this Insurance Cover

Date **Signature of Life to be Assured** **Witness**