Medical Application Form

Date : **Policy No :**
Contractual Period From **To** **Broker No:**

Personal Information

First Name : **Country :**
Father's Name : **City :**
Family Name : **Cell No :**
Status : **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐

Family Members	Name	Nationality	D.O.B.	Sex	Blood Type
Husband / Wife					
Children					

Programs Type **Silver** ☐ **Gold** ☐ **Diamond** ☐

Riders **Ambulatory** ☐ **Doctor's Visit** ☐ **Prescription Medicine** ☐

Is There Any Family Member Who Is Not Insured ? If Yes, Please Specify The Reason **Yes** ☐ ☐ **No**

Did You Have Any Medical Insurance Coverage? **Yes** ☐ **No** ☐

If Yes Please Specify The Preceding Insurance Company And Policy Expiry Date

Would You Like To Receive SMS Regarding Your Claims Status? **Yes** ☐ **No** ☐

Would You Like Your Broker To Receive SMS **Yes** ☐ **No** ☐

In Case Your Claim Is Rejected Or Partially Approved?

Application Form

1-Diseases of the cardiovascular system(hypertension, cardiomyopathies, coronary, vascular valvular)	Yes ◯ No ◯	10-Malignant tumors, lymphomas and leukemias disease arrythmias, etc.)	Yes ◯ No ◯
2-Diseases of the respiratory system other than cancer (asthma, chronic obstructive pulmonary disease,)	Yes ◯ No ◯	11-Sexually transmitted diseases, AIDS and HIV fibrosis etc.)	Yes ◯ No ◯
3-Diseases of the digestive system other than cancer pancreatitis, replacement, endoscopic procedures,	Yes ◯ No ◯	12-Other diseases, accidents, surgeries, prosthetic diagnostics…	Yes ◯ No ◯
4-Kidney & urinary tract diseases other than cancer (kidney stones, insufficiency, cysts, etc)	Yes ◯ No ◯	13-Have you or any of the applicants taken or currently No take any medications or have followed or will follow no any kinds of treatment	Yes ◯ No ◯
5-Orthesis and limb transplants, osteoarticular or muscular diseases other than cancer	Yes ◯ No ◯	14-Females only: are you currently pregnant?	Yes ◯ No ◯
6-Diseases of the nervous system other than cancer (polio, depression, epilepsy, multiple sclerosis, etc)	Yes ◯ No ◯	15. Congenital disorders and diseases	Yes ◯ No ◯
7- Diabetes or diseases of the endocrine glands other than cancer	Yes ◯ No ◯	16. Psychiatric disorder (depression, anxiety, etc.)	Yes ◯ No ◯
8--Diseases of the eye, ear, nose and throat other than cancer	Yes ◯ No ◯	17. Do you suffer from any symptoms related to the disease mentioned here above? (backache, chest pain, pain in joint, etc.)	Yes ◯ No ◯
9-Hematological diseases other than leukemia anemia, etc)	Yes ◯ No ◯		

In case the answer is yes to any of the Diseases/Conditions, above please specify full details in the table below

Name	Disease No.	Diagnoses Status	Treatment	Date	Hospital / Dr. Name

I hereby declare that the abovementioned information is complete, real and adequate, waiving, fully and irrevocably, the medical confidentiality on all the past and current medical files, documents and prescriptions related to any of us and those that will develop during the policy contract, in favor of the medical committees and doctors, requesting from them, and other insurance companies or any other risk carrier which we had contracted with for medical and/or life insurance, to provide the insurance company and/or GlobeMed Iraq with all the information and documents available at their side on our medical condition and of copies thereto, permitting GlobeMed Iraq, within its capabilities, to inform our treating physician with the information available at its side on our medical condition, in addition to the rejection or approval of coverage decisions at all healthcare providers and pharmacies, with all possible means, either through e-mail, or SMS or any other available means.I also declare that I have read the provisions of the policy with its general conditions and exceptions, and upon it I request the benefit from the health insurance for me and for my family members defined above. This declaration is final and irrevocable;

I signed it on____/____/ on one original copy to be kept with the Insurance Company to act upon it or upon a copy of it when necessary.