



# Healthcare Insurance Proposal Form

**This proposal form must be duly completed and signed**

**POLICY NO: MAZMED\_\_\_\_\_**



**PART A**

**HEALTH STATEMENT – PLEASE COMPLETE IN BLOCK LETTERS**

**INFORMATION MUST BE SUPPLIED IN RESPECT OF ALL THE QUESTIONS BELOW. PLEASE INDICATE YOUR ANSWERS WITH AN ‘X’ IN THE APPROPRIATE BLOCK AND PROVIDE FULL DETAILS. ALL QUESTIONS IN THIS SECTION MUST BE COMPLETED OR APPLICATION WILL BE CONSIDERED INCOMPLETE.**

**GENERAL PRACTITIONER’S NAMES**

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**HAVE YOU (OR ANY OF YOUR DEPENDANTS) EVER BEEN DIAGNOSED WITH OR RECEIVED TREATMENT OR ADVICE FOR ANY CONDITION OR ILLNESS RELATING TO ONE OF THE FOLLOWING CATEGORIES LISTED? INDICATE SPECIFIC CONDITION BY UNDERSCORING THE SPECIFIC CONDITION. AS THIS IS NOT AN ALL INCLUSIVE LIST, IF YOUR PARTICULAR CONDITION DOES NOT APPEAR IN THE LIST OF EXAMPLES, IT IS IMPERATIVE THAT YOU INSERT THE CONDITION IN THE RELEVANT BLOCK (OTHERS).**

**SECTION A**

<b>A1</b>	<b>HEART, BLOOD VESSELS, OR CIRCULATORY SYSTEM</b>	e.g. cardiac murmurs, high blood pressure, chest pain, tightness of chest, palpitations, coronary circulatory system thrombosis, valve defects, shortness of breath, stroke, high cholesterol, cramps during light exercise, or walking, varicose veins, cardiac irregularities, swelling of the legs, or leg ulcers	YES	NO
If yes, please give details:				
<b>A2</b>	<b>RESPIRATORY SYSTEM OR LUNGS</b>	e.g. asthma, tuberculosis (tb), chronic bronchitis, pneumonia, persistent cough, coughing up blood, emphysema/COPD or broncho-spasm	YES	NO
If yes, please give details:				
<b>A3</b>	<b>DIGESTIVE SYSTEM OR LIVER</b>	e.g. ulcers of the stomach or duodenum, chronic indigestion, jaundice, liver disease, hepatitis B, bleeding from the rectum, any related hernia, ulcerative colitis, ‘gall stones’, heartburn, persistent abdominal pain, loss of weight (not due to diet), persistent diarrhoea, or persistent constipation	YES	NO
If yes, please give details:				
<b>A4</b>	<b>KIDNEYS, BLADDER</b>	e.g. kidney stones, infections, blood or protein in the urine, difficulty in passing urine or urological condition	YES	NO
If yes, please give details:				
<b>A5</b>	<b>NERVOUS SYSTEM</b>	e.g. depression, anorexia, anxiety or stress-related disorders, nervous tension, frequent headaches, psychological disturbances, migraine, fits, fainting, blackouts, multiple sclerosis, epilepsy, paralysis, brain impairment, Alzheimer, or dizziness	YES	NO

If yes, please give details:			
<b>A6</b>	<b>EYE, EAR, NOSE OR THROAT</b>	e.g. defective sight, glaucoma, retinitis pigmentosa, hearing impairment, recurrent ear infections, balance disturbance, vocal problems, impaired speech, allergies, cataracts, chronic sinusitis, and/or strabismus	YES NO
If yes, please give details:			
<b>A7</b>	<b>SKELETON, VERTEBRAL COLUMN, JOINTS, MUSCLES, OR SKIN</b>	e.g. back pain, displacement, of the vertebrae or discs, any other back or neck trouble or operations, arthritis or arthritic pain, chronic gout, rheumatism. e.g. eruptions or diseases of the skin, psoriasis, dermatitis, acne-vulgaris, nodular cystic or eczema. e.g. any physical disability, any chiropractic treatment or sciatica.	YES NO
If yes, please give details:			
<b>A8</b>	<b>REPRODUCTIVE SYSTEM (MALE &amp; FEMALE)</b>	e.g. ovarian cysts, hysterectomy, venereal diseases, any condition of the cervix, prostatitis, testicular tumours, endometriosis, fertility treatment, prosthetic hypertrophy or prostatitis, undescended testis or phimosis	YES NO
If yes, please give details:			
<b>A9</b>	<b>BREAST</b>	e.g. breast cancer, symptomatic excessive enlargement/ reduction of breast....	YES NO
If yes, please give details:			
<b>A10</b>	<b>DENTAL SYSTEM</b>	e.g. poor closure of the jaws, implants, orthodontic, periodontal or maxillo-facial surgery	YES NO
If yes, please give details:			
<b>A11</b>	<b>TROPICAL AND INFECTIOUS DISEASES</b>	e.g. malaria, typhoid fever, HIV and AIDS etc.	YES NO
If yes, please give details:			
<b>OTHERS</b>			

<b>SECTION B</b>			
<b>B1</b>	Have you (or any of your dependants) been treated/admitted as an Inpatient in a clinic/hospital?		YES NO
If yes, please give details:			
<b>B2</b>	Are you (or any of your dependants) currently pregnant? If so, please specify the expected date of delivery?		YES NO

If yes, please give details:			
B3	Have you or any of your dependants had cancer, growths, or any other kind of tumours, lumps (benign or malignant)?	YES	NO
If yes, please give details:			
B4	<b>Have you or any of your dependants had diabetes, sugar in the urine, leukaemia, haemophilia, bleeding disorders, anaemia, thyroid gland or other glandular or blood diseases and/or any related endocrine disorder?</b>	YES	NO
If yes, please give details:			
B5	<b>Have you or any of your dependants had dialysis for renal failure?</b>	YES	NO
If yes, please give details:			
B6	<b>Has any application by you (or any of your dependants) for life, medical or disability ever been declined, postponed, withdrawn, or accepted with special terms, or at a special premium? Or have you ever submitted a disability, accident or trauma benefit claim to any insurer or fund?</b>	YES	NO
If yes, please give details:			
B7	<b>Are you (or any of your dependants) receiving any treatment for a medical or other problem?</b>	YES	NO
If yes, please give details:			
B8	<b>Are you (or any of your dependants) currently taking any prescribed medication?</b>	YES	NO
If yes, please give details:			
B9	<b>Are you (or any of your dependants) a smoker?</b>	YES	NO
If yes, how many per day:			
B10	<b>Do you (or any of your dependants) consume alcohol?</b>	YES	NO
If yes, what is your/their daily consumption:			
B11	<b>Has any member of your (or your spouse's) immediate family, e.g. parents, brothers, sisters, suffered from breast cancer or any other cancer, diabetes, heart disease, high blood pressure, raised cholesterol, mental disease or any hereditary disease? If 'YES', please state which relative, his/her age and type of disease.</b>	YES	NO
If yes, please give details:			
B12	<b>Is there any known or foreseeable need for you (or any of your dependants) to consult a medical practitioner, dentist or optometrist?</b>	YES	NO
If yes, please give details:			
B13	<b>Do you (or any of your dependants) practise any physical exercise?</b>	YES	NO

If yes, please give details and how often:			
<b>B14</b>	<b>The above questions are not all inclusive. Should you (or any of your dependants) have any condition that is not covered by these questions, you must provide us with such information.</b>	YES	NO
If yes, please give details:			
<b>B15</b>	<b>Please ensure that you fully disclose any known or suspected conditions and symptoms experienced by anybody included in this application, even if professional advice has not been sought. Typical examples are varicose veins, allergies, bunions, piles, or any pains, swelling.</b>	YES	NO
Please give details:			
<b>B16</b>	<b>OTHERS:</b>		
<b>B17</b>	<b>Are you presently insured under any medical insurance?</b>	YES	NO
If yes, please give details:			

**SIGNATURE OF PRINCIPAL MEMBER**

**DATE SIGNED**

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**IMPORTANT NOTE**

- 1) Completion and/or submission of a proposal form does **NEITHER** entail the company to automatically accept the proposal **NOR** that cover is triggered as from the date of submission of this proposal.
- 2) Confirmation of acceptance /cover by our underwriting section will be forwarded within a delay of 14 days as from the date of receipt of such proposal by our company.
  - i) In case there is an alteration in your health condition from the time the proposal form is submitted to our company and the acceptance thereof by our underwriting section, you should immediately inform the company accordingly.
  - ii) Any withholding, concealment or wilful non-disclosure of any material fact shall entail that this proposal form will be disregarded and/or that this condition will equally be deemed to be considered as a pre-existing one

## DECLARATION

I, the undersigned, hereby declared that:

The scheme or its agents may from time to time do the following in respect of me (and any of my dependants):

- > Request and receive any medical and medically related information that is relevant to consider this application and any claim-related benefits for me (and any of my dependants for whom this application is accepted). Such information may be obtained from any healthcare provider or healthcare facility.
- > Communicate any medical and medically related information from any healthcare provider or healthcare facility to the scheme's contracted healthcare management company. The purpose of this exchange is to ensure that the most cost-effective and high quality medical care is obtained for all members of the scheme.
- > I further acknowledge that, the scheme or its agents may from time to time, and without notice to me, do the following in respect of me (and any of my dependants):
  - > Conduct investigations into any claim submitted by me or on behalf of my dependants; current medical condition, including but not limited to, obtaining copies of my or my dependents medical records
  - > Conduct medical investigations of any kind and at any time, into my or my dependants medical history and/or information regarding
  - > My or their medical history and results of any medical tests and examinations
  - > Instruct me or my dependant to undergo any medical testing and examinations as are deemed by the scheme or its agents to be a necessary part of such investigations
- > Access any/all results of such tests and examinations carried out at the instance of the scheme or its agents without my consent
- > Request that I furnish to them copies of all my or my dependants medical records and any information regarding my or their medical history as well as any results of medical tests and examinations, immediately upon request thereof.

By my signature below I expressly authorise the scheme to do all things necessary to carry out the above mentioned investigations.

I hereby declare that all the statements and answers given above are true and correct and that I have not withheld or concealed any information that might influence the acceptance of this proposal.

I further agree that this proposal and declaration shall be the basis of the contract between SACOS Insurance Company Limited and myself, and I agree to accept a Policy in the company's usual form for this class of Insurance.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_