

## GROUP LIFE MEDICAL QUESTIONNAIRE

Please complete this form using black or blue ink. Write in BLOCK LETTERS and tick the relevant items. If your application is incomplete it might cause a delay. Kindly ensure that you submit a fully filled form together with the signed illustration. The proposed life assured and policy owner are required to disclose all information requested. Please retain a copy of this proposal form and other correspondences with us for your future reference.

### 1. General Details

A. Name

B. Gender

Male  Female

C. Date of Birth

D. Job Description

### 2. Medical Questionnaire

For all questions answered 'Yes', please provide more details in Section 3.

A. What is your Height  cms Weight  Kgs

B. Has any of your parents, brothers or sisters had any hereditary disorders, high blood pressure or diabetes prior to 60 years of age? Yes  No

C. Are you at present not in good health and not capable of doing daily tasks? Yes  No

D. Has your weight changed in the last 12 months? Yes  No

E. During the past five (5) years, have you been unable to work for more than 30 consecutive days? Yes  No

F. Have you smoked in the last 12 months? If yes, please state the type of smoke (cigarettes / shisha etc) and how many per day. Yes  No

G. Do you drink alcohol? If yes, please state type & amount per day. Yes  No

H. During the past five (5) years, have you consulted or been examined or been treated by any physician or health practitioners, had an X-ray, ECG or any laboratory tests, had observation or treatment in any hospital or other medical facility or been advised to have surgical operation? Yes  No

I. Have you ever had or been told you had Epilepsy, nervous breakdown or any disorder of the brain or nervous system, high blood pressure, chest pain, stroke or heart disorder; asthma, chronic cough, or any lung problem, Indigestion, ulcer, colitis, chronic or recurrent diarrhea or any disorder of the digestive system, diabetes, or any disorder of the kidneys, liver or urinary system; rheumatic fever, arthritis, gout, or any joint or bone disorder, Cancer, tumor, enlarged gland or blood disorder, unexplained recurrent or persistent fever, weight loss or any skin disorder, any sexual transmitted disease (e.g. syphilis, gonorrhoea) or viral disease (e.g. Hepatitis B, AIDS), any other illness, injury, disability, deformity or physical defect in any part of your body not mentioned above? Yes  No

J. Have you ever received treatment with any blood products or undergone blood transfusion or are you currently receiving any form of medical treatment or intend to seek medical advice, treatment, or any medical tests or surgical operation in the near future? Yes  No

K. Have you ever taken drugs other than for medical purposes? Yes  No

L. Do you or are you likely to pilot an aircraft or engage in any private flying, sky/skin/scuba diving, motorcycle/car/motorboat racing, mountain/rock climbing, bungee jumping, parachuting, or similar hazardous activities? Yes  No

M. Do you have any existing Life or Critical illness cover (approved, postponed, declined or not accepted on normal terms)? Yes  No

### 3. Additional Details

### 4. Declaration

I declare that I have answered all the questions in this questionnaire after clearly understanding them and that I have duly signed this form at required places. I confirm to have fully understood the nature of the questions and the importance of disclosing all information while answering such questions. I declare that the answers given by me to all questions in the questionnaire are true and complete in every respect and that I have not withheld any material information or suppressed any material fact. I confirm that I clearly understand that in case of any misstatement, misrepresentation and/or suppression of any data and/or information and/or where I do not inform the Company of any changes in information provided in this questionnaire, the Company has the right to repudiate any and all claim(s) under any policy if issued based on this questionnaire and/or at sole discretion of the Company to consider any issued policy based on this questionnaire as void. I hereby authorize Oman Insurance Company("Sukoon") to contact me anytime and through any medium (phone, email, sms etc.) for purpose of obtaining more information about this proposal form and/or for keeping me informed about their other products and/or promotion activities. I hereby also authorize my past/present employer/business associates, medical practitioner(s)/hospitals/laboratories/medical providers, insurance companies, financial institutions to release to Oman Insurance Company all details, records, facts and information (including medical details, KYC records, AML-CTF & FATCA details) as required anytime by Oman Insurance Company("Sukoon") for assessment of risk and/or for processing of claims if subsequently an insurance policy is issued based on this proposal form. This proposal form shall be a part of the insurance policy in case of its acceptance by the Company. I further unconditionally consent and authorize you to store, process and/or disclose/transfer my personal information as may be required to issue/ underwrite/ administer / process my proposal/policy/ claims, etc. (as may be applicable) including but not limited to third party administrators, medical providers, reinsurers, service providers etc. whether within or outside the UAE.

Name

Date (dd/mm/yy)

Signature