Medical Questionnaire

Credit Family Takaful Scheme

All fields are mandatory. Write in BLOCK LETTERS and tick the relevant items. If the form is incomplete it might cause a delay. Kindly ensure that you submit a fully filled form together with the signed annexes, if applicable. Please retain a copy of this form and other correspondence with us for your future reference.

1. General Details		
A. Name		☐ Male ☐ Female
B. Date of Birth		
C. Job Description		

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

A. What is your height (cm)? Weight (kg)?	Yes ☐ No ☐
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, gonorrhea) 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. Authorization

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 Sukoon Takaful PJSC 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 Sukoon Takaful PJSC all details, records, facts and information (including medical details, KYC records, AML-CTF & FATCA details) as required anytime by Sukoon Takaful PJSC for assessment of risk and/or for processing of claims if subsequently a Takaful insurance policy is issued based on this proposal form. This proposal form shall be a part of the Takaful 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, Retakaful operators/ reinsurers, service providers etc. whether within or outside the UAE.

Name		Signature		Date	