BANKERS ASSURANCE SAL
NASCO KARAOGLAN GROUP

Insurance Application Form and Medical Questionnaire
(Individual/Family)

For Administration Use
Contractual Period:
From: …… To: ……
Account Manager: ……
Policy Number: ……

This proposal from includes a medical questionnaire and constitutes the basis of the decision of the company to contract with me or to refrain thereof. It also constitutes the basis of the terms, conditions and exclusions of the policy. Any concealment or misstatement may void the policy pursuant to section 982 of the code of obligations.

First Name: …… Middle Name: …… Last Name: ……

ID Number: …… Gender: ☐ male ☐ female

Address: ……
Building/Floor *Street*

……
City *Region/Mouhafaza*

E-mail Address: ……

Telephone: …… …… …… ……
Tel. 1 *Tel. 2* *Mobile* *Fax*

IN-HOSPITAL PROGRAMS *(Please choose one program only)*

Program	Excess Deductible	Network	Class
☐ Basic Individual Program	☐ 100 ☐ 200 ☐ 300	☐ Full Network	☐ Lux ☐ A ☐ B ☐ C ☐ SP
	☐ 400 ☐ 500 ☐ 600	☐ North regional ☐ South regional	☐ A ☐ SP
	☐ 750 ☐ 1000	☐ Reduced Network	☐ A ☐ B ☐ C
☐ Syria Program			☐ A ☐ B
☐ Syria Plus Program			☐ A ☐ B
☐ HAX Program		☐ Full ☐ Limited	☐ C ☐ N
☐ Ambulatory for HAX			
☐ Abroad Worldwide Emergency (R)			

Nationalities carried by the Insured Person: ……

ADDITIONAL PROGRAMS

☐ Ambulatory coverage	☐ Daily Income I	☐ 1	☐ 2	☐ 3	☐ Abroad Emergency International (SA)
☐ Medications coverage	☐ Daily Income II	☐ 1	☐ 2	☐ 3	☐ Abroad Emergency International (SA, 40 000$)
☐ Doctor's Visit coverage	☐ Individual Conversion Option				☐ International Healthcare

Marital Status: ☐ single ☐ married ☐ widowed ☐ divorced

Family Members	Name	Sex	Date of Birth	Nationality	With NSSF?	Weight	Height	Blood Group	Smoker?	Profession
Insured			……/……/……		☐ yes ☐ no				☐ yes ☐ no	
Spouse			……/……/……		☐ yes ☐ no				☐ yes ☐ no	
Children			……/……/……		☐ yes ☐ no				☐ yes ☐ no	
			……/……/……		☐ yes ☐ no				☐ yes ☐ no	
			……/……/……		☐ yes ☐ no				☐ yes ☐ no	
			……/……/……		☐ yes ☐ no				☐ yes ☐ no	
			……/……/……		☐ yes ☐ no				☐ yes ☐ no	
			……/……/……		☐ yes ☐ no				☐ yes ☐ no	

Is there a family member that will not be insured? ☐ No ☐ Yes, please specify reason: ……

If any of the persons was treated or had an operation during the past 10 years due to any of the below diseases, please mark it with an (x)

1. Cardio-vascular diseases (hypertension, myocardial infarction…)	☐ yes	☐ no	9. Hematological diseases (anemia)	☐ yes	☐ no
2. Respiratory diseases (asthma, tuberculosis…)	☐ yes	☐ no	10. Malignant tumors (cancer, leukemia…)	☐ yes	☐ no
3. Diseases of the digestive system (ulcer, liver diseases…)	☐ yes	☐ no	11. Sexually Transmitted Diseases & AIDS (positive serology or disease)	☐ yes	☐ no
4. Kidney & urinary tract diseases	☐ yes	☐ no	12. Congenital malformation or disablement	☐ yes	☐ no
5. Osteo-articular & muscular diseases or transplants	☐ yes	☐ no	13. Other diseases, accidents, previous or future operations you already know about	☐ yes	☐ no
6. Diseases of the nervous system (depression, multiple sclerosis, epilepsy…)	☐ yes	☐ no	14. Are any of you following or have ever followed a medical treatment?	☐ yes	☐ no
7. Endocrine glands & diabetes diseases (triglyceride, thyroid diseases…)	☐ yes	☐ no	15. Does any of you have an allergy against a drug, food or other?	☐ yes	☐ no
8. ENT or eye diseases	☐ yes	☐ no	16. For women: are you currently pregnant? Expected date of delivery: ……	☐ yes	☐ no

If the answer for one of the above listed questions is yes, kindly specify the name of the individual affected by or treated from a disease, the correspondent number in the above table as well as all the relevant details.

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Name	Disease Nr.	Diagnosis	Treatment	Date	Physician/Hospital Name

The undersigned asserts that the information provided in this proposal in respect of myself and of my family is complete, precise and true. I hereby authorize the insurance company and to its Third Party Administrator or to any party they may duly appoint to inquire about my medical situation and that of my family members and request that they be provided with al information connected to our medical history from doctors, hospitals and other medical providers or insuring parties and recognize that they are entitled to access our medical files. This authority is given for the purposes of this proposal form and of the insurance contract which may be issued as a result thereof. I hereby waive the right to the medical confidentiality in respect of myself or of the members of my family to the extent necessary for the insurance company to investigate the accuracy of the information provided in this document and to assess the truth of my medical situation.

Date: …….. *Signature: ……..*