fidelity
ASSURANCE & REINSURANCE CO. S.A.L.

Individual Healthcare Insurance Application

Entered in the insurance companies register under No. 121 - subject to Legislative Decree No. 9812 dated 4/5/1968 - CR 19345 Beirut.

kindly complete the present application clearly in capital letters with an ink pen. The Proposer should also sign near any alteration or erasure done on the present document.

Details:	currency:	Payment: cash ☐ ____ installments ☐	Additional coverages: Yes ☐ No ☐

Family name Father's name name	Male ☐ Female ☐	**Date of Birth**	**NSSF**	**Length**	**Weight**
			Yes ☐ No ☐		

Mailing Address: Resid ☐ Work ☐	City:	Street:	Bldg.	Floor/
Tel. No.	Cel. No.	P.O Box	Residential area	

Do you, or any of your relatives travel outside Lebanon? Yes ☐ No ☐	name of the Person:	Yearly Frequency	Where?

Marital Status: Single ☐ Married ☐ Divorced ☐ Widower ☐ o. of Children	Med. Program: Normal ☐ ECO ☐	Class:

Medical Care: (with Medical Report)	Ambulatory (Lab & X-rays) Yes ☐ No ☐	(Prescription Drugs) Yes ☐ No ☐

1. Will all of your family members that are under your dependance benefit from the present cover? Yes ☐ No ☐
2. Were all of your family members previously insured Yes ☐ No ☐ In case the answer is yes, where & for how many years?
3. In case the Subscriber is the wife, does your husband benefit from any other insurance? Yes ☐ No ☐ Where?

Passport or Identity No.	Nationality:	Occupation:

Employer (Co.'s name):	Daily Work:	Work hours:

Family & Dependents names in full	**Birthdate D M Y**	**Male**	**Female**	**son/ daught.**	**husb/ Wife**	**Additional coverages**	**Occup.**	**Lgth/Wght**
		☐	☐	☐	☐	PA ☐ SI ___		
		☐	☐	☐	☐	PA ☐ SI ___		
		☐	☐	☐	☐	PA ☐ SI ___		
		☐	☐	☐	☐	PA ☐ SI ___		
		☐	☐	☐	☐	PA ☐ SI ___		
		☐	☐	☐	☐	PA ☐ SI ___		

Cover for Personal Accident (PA): Death following Accident (Provided the age of the Insured at time of accident is not less than5 years old), Permanent Total & Partial Disablement following accident.

Comments:

Broker/Agent's name:	Code No. (1) ☐☐☐☐☐ (2) ☐☐☐☐☐

THIS SECTION IS FOR COMPANY USE ONLY - PREMIUM CALCULATION

IN CO-NIL	**IN CO-NSSF**	**OUT**	**TTL: IN+OUT**	**ADD: O/W**	**FAMILY DISCOUNT:**	**CASH DISC.**
TOTAL: IN+OUT, O/W - AFTER DISCOUNT			**LIFE**	**PA**	**UNDERWRITERS' COMMENTS**	
TOTAL PREMIUM IN US$		**PAID WITH APPLICATION (US$)**		**U/W DECISION: STANDARD ☐ EXCL. ☐ EXTRA PREMIUM ☐**	**U/WRITER'S SIGNATURE:**	

IMPORTANT: PLEASE READ CAREFULLY THE ISSUING CONDITIONS OF THE TEMPORARY NON-BINDING RECEIPT ATTACHED.

Did you, or any of your Family or Dependants mentioned herein suffer any of the ailments or diseases described hereunder? Kindly affix a (X) mark in the appropriate check box.

Withholding any information could lead to acceptance by the Company of the Proposal at the conditions set therein but will lead to the cancellation of the policy in case it is discovered later on.

1	Hypertension or Hypotension, Rheumatic fever, Cardiac Failure, Insufficiency or any Heart or Coronary Disease,	**Yes** ☐	**No** ☐	**12**	Any Congenital Malformation or Disablement, any previous Health Problems or any Physical Disability	**Yes** ☐	**No** ☐
2	Asthma,Bronchitis, Tuberculosis and/or any other Lungs Disease.	**Yes** ☐	**No** ☐	**13**	Fractures, Arthrosis, Rhumatism & related Diseases in the Vertebral Column. Any other Bone or Ligament or Muscle Disease.	**Yes** ☐	**No** ☐
3	Cancer, Tumors, Blood aneamia & any other Blood and/or skin Disease	**Yes** ☐	**No** ☐	**14**	Diseases of the Reproductive System, Venereal Diseases, Infertility, Sexually Transmittable Diseases.	**Yes** ☐	**No** ☐
4	Kidneys, Calculus, Kidney Stones, Bladder, Urinary Tract & Prostate.	**Yes** ☐	**No** ☐	**15**	Thyroid, Diabetes and/or any other Lymphatic Disease.	**Yes** ☐	**No** ☐
5	Ear or Throat Disease, Nose Deviation or Disease.	**Yes** ☐	**No** ☐	**16**	Drug use and/or Liquor abuse.	**Yes** ☐	**No** ☐
6	Cataract and/or any other eye Disease.	**Yes** ☐	**No** ☐	**17**	Bodily Injury consequent to an accident for the last 10years? If yes, please give details.	**Yes** ☐	**No** ☐
7	Epilepsy, Hemiplegia, Nervous Breakdown and/or any other Brain or Nervous disorder.	**Yes** ☐	**No** ☐	**18**	Do you suffer from any Disease not listed herein? Are you now under any type of medication?	**Yes** ☐	**No** ☐
8	Stomach, Bowels, Gall-Bladder, Liver, Ulcer, Hernia, Hemorroids &/or any other Digestive system Disease.	**Yes** ☐	**No** ☐	**19**	Did any of your close family (Parents, Brothers, Sisters) ever suffer from any Disease listed herein or from any other Disease?	**Yes** ☐	**No** ☐
9	Did any of you or your family ever undergo any type of Surgery	**Yes** ☐	**No** ☐	**20**	Females only: Irregular or Heavy Periods, Breast Disease or any other Female Disease.	**Yes** ☐	**No** ☐
10	Did any of You or your Family gain or lose weight during the past 12 months? If yes, who?	**Yes** ☐	**No** ☐	**21**	Females only: Are you presently pregnant? If yes when is the expected date of delivery?	**Yes** ☐	**No** ☐
11	AIDS, Related Complex (ARC), Human Immuno Deficiency Virus Seropositive (HIV+)	**Yes** ☐	**No** ☐	**22**	**Additional Info:**	**Yes** ☐	**No** ☐

IN CASE YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE GIVE DETAILS AS FOLLOWS:

Person's name	Quest. #	Diagnosis	Treatment & Date	name & address of Dr. & Hosp.

General Info:

1. What is the name of your family Doctor?
2. Does any of your family members visit regularly a doctor? Yes ☐ No ☐ If yes, who?..... How many times a year? ……
3. does any of the Applicants practice any kind of Sport? Any dangerous Sport or Hobby, or the driving of Motorcycle? Yes ☐ No ☐ In case yes, who ..... and what kind of Sport or Hobby? .....
4. Does any of the Applicants smoke? Yes ☐ No ☐ . In case yes, who?..... how many cigarettes a day? .....
5. Does any of the Applicants drink alcohol? Yes ☐ No ☐ . In case yes, who?..... how many drinks a day? .....
6. Has any of the Proposers' Applications ever been rejected by an Insurer? Has a similar Application been suspended for further enquiry or been rated sub-standardor has been altered in any way or cancelled? Yes No . In case yes, who? ..... What is the name of the insurance Company? .....

Empowerment:

I the undersigned, hereby authorize any Hospital or Doctor or any other person that treated me or any of my family members, to provide the treating physician of **Fidelity Assurance & Reinsurance Co. S.A.L.** or their representative any information in his possession for any treatment or consultation, including any personal history and diagnosis. I also confirm that all answers in this Application are true and that I answered them myself. For the purpose of an accurate study of my Application, I hereby waive all legal rights for myself & on behalf of all persons concerned by an insurance policy issued on the ground of this Application. Thus, and in as much as the Law allows it, any person or physician may in full authority, upon request of the Company, have access to all information in this concern.

Witness/Broker name:	Signature:	date: / /
Registration No. near the Ministry of Economy:	Licence valid till: / /	
I paid with the present Application a sum of:……		
NAME & SIGNATURE OF THE APPLICANT: