Forward together

شركة عمان للتأمين
Oman Insurance Company

Proposal Form
Individual Enrollment - Healthcare Insurance

Please complete this form using BLOCK CAPITALS and by ticking the relevant items.

1. Client Details			
A. Name	First Name:		
	Last Name:		Ms. ☐ Mrs. ☐ Mr. ☐
B. Nationality		Date of Birth (dd/mm/yyyy)	
C. Marital Status		Number of Children	
D. Company		Designation:	
E. Address	Building:		
	Street:		
	PO Box:	City:	Emirates:
F. Contact Number	Mobile:	Tel:	
G. Email			

2. Existing or Previous Medical Insurance			
Do you currently have medical Insurance?	Yes ☐ No ☐		
If Yes, please select	OIC ☐ Others ☐		
If OIC: Policy number		Expiry Date	

3. Additional Family Members to be Covered

Title	Name	Nationality	Relationship (wife/husband/son/Daughter)	Date of Birth DD/MM/YYYY	Passport No	Living In	Visa Issued in

Oman Insurance Company (P.S.C.), Paid up Capital 461,872,125, C.R. No. 41952, Insurance Authority No. 9 dated 24/12/1984
Head Office: P.O. Box 5209, Dubai, United Arab Emirates. Tel.: +971 4 233 7777, Fax: +971 4 233 7775, www.tameen.ae

4. Medical History

Declarations must be made in writing on this application. Verbal declarations will not be accepted.

		Applicant	Member 1	Member 2	Member 3	Member 4
A.	Name					
B.	Height (cm)					
C.	Weight (kg)					
D.	Any symptoms of Discomfort experienced during the past 2 years	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	If Yes, please answer the below questions.					
D1.	Nature of symptoms /discomfort/medical conditions					
D2.	Nature of treatment received					
D3.	When did it start?					
D4.	How long did it last?					
D5.	Need for any further treatment	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
D6.	Present state of health					
E.	Any diagnosed medical conditions during the past 5 years?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	If Yes, please answer the below questions.					
E1.	Nature of symptoms/discomfort/medical conditions					
E2.	Nature of treatment received					
E3.	When did it start?					
E4.	How long did it last?					
E5.	Need for any further treatment	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
E6.	Present state of health					

- If there is any medical condition falling outside the 5 years period mentioned, in such cases you should declare it in good faith.
- Please give details overleaf.
- Please continue on a separate sheet if necessary for further detailed information.
- If you answered yes to any of the questions mentioned above, please provide us with the latest medical report for the related medical condition.

4. Medical History (cont.)

F. Have you or any person(s) you wish to insure ever suffered from any of the following?
Please answer 'Yes' or 'No' to all questions written below:

		Yes	No	Remarks
F1.	Heart ,blood vessel, hypertension and circulatory diseases			
F2.	Congenital and hereditary diseases			
F3.	Cancer and blood diseases			
F4.	Neurological, mental and psychological disease			
F5.	Kidney and calculus disease			
F6.	Digestive disorders			
F7.	Respiratory system diseases			
F8.	Skin and subcutaneous tissue diseases			
F9.	AIDS			
F10.	Bone and muscle diseases			
F11.	Genitourinary system disorders			
F12.	Lymphatic system diseases			
F13.	Your wife pregnant			
F14.	Endocrine and metabolic disorders like diabetes			
F15.	Rheumatoid and immunology			
F16.	Pre-operative and operation			
F17.	Back Pain			
F18.	Nervous system diseases			
F19.	Eye and Ear diseases			
F20.	Any sickness, medical complication, any condition not listed above			

If answer is “Yes” to any of the above question, please give the full details.

G. Has any member of your family (parents, brothers or sisters) had heart disease, high blood pressure, diabetes, congenital disease or deformity, cancer, nervous or mental disorders, kidney disease, hemophilia and/or muscular dystrophy? Yes ☐ No ☐

If you have answered 'Yes', please give the following information:

G1.	Name of the person	
G2.	Medical condition	

5. Pre-existing Medical Conditions & Previous Operation

Insured Name	Diseases Details	Date of diagnosis / treatment / operation	Name of the Hospital / Attending Physician

6. Current Medications

Insured Name	Medicine Name	Daily Dosage	Date from which medicines were started

7. Life Style

A. Do you or any person(s) you wish to insure is a professional sportsman or engage in any hazardous sports or activities? Yes ☐ No ☐

If you have answered 'Yes', please give details of your activities:

Do you or any person(s) you wish to insure:

B. Smoke Yes ☐ No ☐

C. Consume Alcohol Yes ☐ No ☐

D. Stay abroad for more than 60 days during this year Yes ☐ No ☐

If you have answered 'Yes', please give details of your activities:

8. Insurance History

Please answer 'Yes' or 'No' to all questions written below:

A. Are you presently insured under any other health insurance coverage? Yes ☐ No ☐

B. Are you currently making or do you intend to make any life, accident, critical illness or health Insurance proposals to any other insurance company? Yes ☐ No ☐

C. Has any of your application for life, accident, critical illness or health insurance been declined, Postponed or accepted on special terms? Yes ☐ No ☐

D. Has a company terminated or refused to renew your contract of life, accident, critical illness or health insurance? Yes ☐ No ☐

If you have answered 'Yes', please give the following information:

Name of the Company	Insurance Type	Coverage	Sum Insured / Limit	Year

9.	Medical Practitioner(s) Most frequently used in the last 5 years		
A. Name			
	Building:		
B Address	Street		
	PO Box:	City	Emirates:
C. Contact Number	Tel:		

10. Declaration

I hereby declare that to the best of my knowledge and belief the above particulars are true and complete and full information has been disclosed. I understand that non-disclosure or misrepresentation of any fact may lead to the refusal of any claim or the cancellation of any policy. I hereby agree that this proposal and declaration or any written statement made by me in reference to the proposal shall be the basis of the contract between the Company and me.

I understand that I should be having DHA compliant insurance policy if I or my dependents are holding Dubai visa and a HAAD compliant insurance policy if I or my dependents are holding an Abu Dhabi / Al Ain Visa. I hereby agree to notify the company incase my visa changes during a policy year to be enrolled under an Insurance policy that is compliant with respective regulator.

Proposer's Name		Proposer's Signature	
Emirates ID			
Date			

11. Declaration (continued)

Signature