Gateway International Assurance L.L.C.

Agents for **ARABIA** Insurance Company s.a.l

Medical Health Questionnaire

Full Name of Applicant:

Date of Birth: / /

Occupation (Please state if you are employed or self-employed):

Sum Insured Amount:
Monthly Installments: Mode of Payment:
Inception Date: / / Expiry Date: / /

Beneficiary:

1. a) What is your occupation?

   b) Please give an exact description of your occupation:

2. Do you, or do you intend to, take part in any hazardous activities in the course of your work or leisure pursuits (e.g. private aviation, height work, motor racing)? If so, please give details

3. Do you intend to travel or reside outside of (*home country)* other than for normal holidays or have you done so in the past 10 years? If so, please give details

4. What is the name, address and telephone number of your usual doctor:

5. a) What is your height?

   b) What is your weight?

   c) Has your weight changed during the last year? If so, please state reason and the amount of increase or decrease

6. a) Do you smoke? If so, please state type of tobacco and amount smoked per day.

   b) Do you drink any alcohol? If so, please state type of alcohol and quantity consumed per week.

   c) Did you ever regularly drink or smoke more in the past or have you received medical advice to reduce or discontinue your alcohol or tobacco consumption?

7. Are you disabled? If so, please give details?

8. Have you consulted any doctor within the last 5 years? If so, please give details.

9. Have you ever had or been told you had or been treated for:

   a) Nervous, mental or neurological complaints (e.g. fits, epilepsy, blackouts, dizziness, persistent headaches, paralysis, anxiety or depression)?

   b) Heart or circulatory disorders (e.g. high blood pressure, stroke, chest pains, heart murmur, palpitations, rheumatic fever)?

c) Disorders of the digestive system, gastric or duodenal ulcers, colitis, hepatitis, other disorders of the liver, gall bladder, stomach or intestine?

d) Disorders or infections of the kidneys, bladder or reproductive organs (e.g. blood in the urine, kidney stones, prostates…)?

e) Diabetes, sugar in the urine, goitre or any other diseases or abnormality of the endocrine system?

f) Cancer, tumours, cysts or any growths?

g) Disorders of the muscles, bones, joints, limbs, spine, e.g. rheumatism, arthritis, gout, slipped disc or other back or neck troubles?)

h) Diseases of the eyes, ears, nose (including nose bleeding) or throat?

10. Have you ever received medical advice, counselling or had a test in connection with hepatitis, HIV, AIDS or any sexually transmitted condition? If so, please give dates, circumstances and results

11. In the past 5 years, have you had any:

a) Diagnostic tests such as X-ray, mammography, electrocardiogram, CT scanning, echo or ultra-sonogram, blood or urine studies?

b) Illness, injury, operation, medical advice, hospital treatment or physical check-up not mentioned above?

12. Do you regularly take any medication? If so, please give reasons and type of treatment taken

13. To the best of your knowledge and belief, has any of your immediate family (father, mother, siblings) ever had or died from diabetes, heart or circulatory diseases, stroke, kidney disease, cancer, multiple sclerosis, mental disease or any heredity disease?

Please specify:

14. Has any application for insurance ever been declined, deferred or have you been offered special terms by any life assurance company?

DECLARATION:

I, the undersigned, whose life is proposed for life assurance, whether in my own handwriting or not, do hereby declare that the above statements in this proposal are true and complete to the best of my knowledge and belief and that such disclosures, proposal plus any related statements will form part of the basis of this Contract of life assurance. Failure to disclose material information may invalidate the policy. I consent that should Arabia Insurance is seeking information from any doctor who at any time has attended me concerning anything which affects my physical or mental health or seeking information from any insurance office to which a proposal has been made for insurance on my life and I authorize the giving of such information.

Signature of Proposed Insured _____ *Date* _____

Signature of Applicant _____ *Date* _____