Assurex s.a.l.
Insurance and Reinsurance

assuHEALTH®

HEALTH INSURANCE APPLIATION FORM

First Name | **Father's Name** | **Family**

Marital Status: Married ◯ Single ◯ Divorced ◯ Widow ◯ — ◯ **assuHEALTH**

Full address of Applicant — ◯ **assuHEALTH Plus**

Phone Number (s): *Fixed* | *Mobile -* | *Email -*

Class of Coverage: *A* ◯ *B* ◯ *SK* ◯ *SK Excl.* ◯ — **Riders**: *AM85%* ◯ *AM100%* ◯ *PM* ◯ *DV* ◯

Family Members	Name	DOB	Nationality	Nssf	Sex	Height	Weight	Smoker	Occupation
Subscriber									
Spouse									
Child									
Child									
Child									
Child									

If a Dependent of yours is not applying for coverage, please state the reason

#		Yes	No
1	**Circulatory or Heart diseases** (high blood pressure, arrhythmia, murmur, infarction, etc....)	◯	◯
2	**Respiratory diseases or allergy** (asthma, bronchitis, emphysema, pneumonia, tuberculosis, etc..)	◯	◯
3	**Digestive diseases** (constipation, diarrhea, hepatitis, ulcers, pancreatitis, etc….)	◯	◯
4	**Renal or Urinary diseases** (nephritis, stones, renal colic, albuminuria, hematuria, etc….)	◯	◯
5	**Osteo-articular diseases, disease of Hip or Vertebral Column** (scoliosis, rheumatism, slipped dic. etc)	◯	◯
6	**Neurological or Metabolic disease** (epilepsy, meningitis, aneurysm, paralysis, etc….)	◯	◯
7	**Endocrinal or Metabolic disease** (goiter, nodules, diabetes, cholesterol, gout, etc….)	◯	◯
8	**Blood, Ganglionic or Skin diseases** (anemia, hemophilia, adenopathy, eczema, herpes, etc…)	◯	◯
9	**Eye, Nose & Throat diseases** (glaucoma, retinopathy, dizziness, otitis, laryngitis, sinusitis, etc…)	◯	◯
10	**Sexually Transmitted diseases** (AIDS, HIV, gonorrhea, siphilis, etc …..)	◯	◯
11	**Tumors or Swelling** (fibroma, cyst, lipoma, cancer, etc….)	◯	◯
12	**Any other disease, past or future operation, Accident or Treatment not mentioned above**	◯	◯
13	**Psychical diseases** (nervous breakdown, depression, fatigue, insomnia, psychosis etc…)	◯	◯
14	**For Female applicants,** are you pregnant? If Yes please state the expected due date	◯	◯
15	**congenital anomalies, Hereditary/Genetic diseases**	◯	◯

If you answered Yes to any of the above questions, please give full details here below:

#	Name	Date	Hospital	Details

I authorize my doctor, health institute or other organization or person that has any information about my health and/or activities (and those of my Dependants) to provide ASSUREX SAL and/or NEXTCARE SAL with the said information. This shall include hospital and any other records pertaining to medical advice, diagnosis, and treatment. A photocopy of authorization has the same validity as the original.
I declare that above questions are true to the best of my knowledge and belief, that I have disclosed all particulars affecting the assessment of the risk. I agree that this proposal and declaration shall be the basis of the contract between me and Assurex SAL, in accordance with the Lebanese Code of Obligations and Contracts, Article 974, Paragraph 2.

Signature: **Date (dd/mm/yyyy)**