تكافل شركة أبوظبي الوطنية للتكافل ش.م.ع
Takaful Abu Dhabi National Takaful Co. P.S.C

Individual Medical Enrollment Form

Policy Holder Name:	Takaful Use Only
Required Plan Type:	Approved:
Applicant Occupation & Address:	Declined:
Email Address:	Pending:
Mobile No.:	Documents to be attached: copy of Emirates ID, passport copy & the visa copy for each member, and copy of your last insurance certificate or your last insurance membership card along with continuity certificate if available.
Marital Status: Married □ Single □ Widow □ Divorced □	
Are you a Politically Exposed Person (PEP): Yes □ No □	

1.Who is to be covered under this policy?

Full Name of Members	Gender (M/F)	Date of birth DD/MM/YY	Height cm	Weight Kg	Smoker Y/N (Quantity)	Alcohol details Average intake per week

All family members must be enrolled under the plan

2. Medical History

Please answer all the following questions either "Yes" or "NO" in respect of yourself and your listed dependents. If any answer is yes, please provide full details. Do not leave any answers blank as the form will need to be returned to you to be fully completed and this will delay your application.

Any applicant who is above 60 years of age should mandatorily submit a medical health certificate from a UAE based Registered Medical Practitioner even if there are no medical declarations to be made on this form.

Have you, or any person to be covered by this policy, ever suffered from, visited a doctor or taken any medication for any of the following medical conditions?

No.	Medical Details	YES	NO
1	Has there been any Loss/Gain of weight in the last 12 months? If yes, please provide the details.		
2	Heart, blood vessels and circulatory system: e.g. high blood pressure, high cholesterol, chest pain or tightness in chest, coronary artery disease or heart attack, stroke, rheumatic fever, irregular heartbeat, heart valve defects, poor circulation, cramps during exercise or walking, swelling of legs, congenital heart conditions		
3	Blood disorders: e.g. anaemia, bleeding disorders, haemophilia, leukaemia		
4	Respiratory system or lungs: e.g. asthma, chronic bronchitis, pneumonia, persistent cough, emphysema or cigarette smoking disorders, allergies, coughing up blood, chronic sinusitis		
5	Gastro-intestinal or liver disorders: e.g. recurrent indigestion or heartburn, ulcers in the digestive system, gall bladder disease, ulcerative colitis, Crohn's disease, hepatitis, jaundice, hiatus hernia, persistent diarrhoea		
6	Cancers, growths: e.g. any types of cancers or growths, whether benign or malignant, including melanoma, Hodgkin's disease, breast cancer		

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No.	Medical Details	YES	NO
7	Gynaecological disorders: e.g. ovarian cysts, any conditions of the cervix, endometriosis, hysterectomy, miscarriages, pregnancy related problems, abnormal pap smear, fibroids, cysts, fertility treatment, normal or cesarean delivery, premature delivery or premature babies. Or any other complications related to maternity, till date		
8	Male genito-urinary system: e.g. prostate disorders, testicular tumours		
9	Kidney or bladder disorders: e.g. kidney stones, kidney failure, recurrent urinary infections, blood in the urine, nephritis, difficulty passing urine		
10	Musculo-skeletal system: e.g. osteo or rheumatoid arthritis, back pain, abnormal spinal curvature or other spinal disorders, back or neck operations, hip disorders, joint problems or replacement, osteoporosis, chronic gout, bunions		
11	Psychological disorders: e.g. depression, anxiety or stress related disorders, psychotic disorders, anorexia/bulimia, panic attacks, attempted suicide, alcohol or drug dependency		
12	Endocrine disorders: e.g. diabetes, including diabetic complications or dialysis, sugar in urine, thyroid disorders, nutritional disorders, adrenal disorders, abnormal growth disorders		
13	Skin disorders: e.g. eczema, psoriasis, skin cancers, cellulitis		
14	Neurological disorders: e.g. epilepsy, multiple sclerosis, paralysis, Alzheimer's disease, Parkinson's disease, dizziness, fainting, chronic fatigue		
15	Eye related disorders: e.g. glaucoma, blindness, eye surgery, retinitis pigmentosa, cataracts, lens implants, refractive or laser surgery		
16	Ear, nose or throat disorders: e.g. hearing impairment, recurrent ear infections, recurrent tonsillitis		
17	Muscular disorders: e.g. muscular dystrophy, myasthenia gravis, bursitis, muscle wasting disorders		
18	Has any close blood relative of you or your dependents ever been diagnosed with heart disease, high cholesterol, diabetes, or any other hereditary disease?		
19	Do you or any of your dependents have any hereditary disorders or birth defects?		
20	Have you or any of you dependents ever sought counselling or treatment for HIV or AIDS related infections or ever tested positive for HIV, AIDS?		
21	Have you or any of your dependents received medical advice or treatment for any infectious or tropical disease e.g. tuberculosis, bilharzia, malaria, cholera, or any sexually transmitted disease?		
22	Have you or any of your dependents ever received medical advice, counselling or treatment to reduce alcohol consumption, or for alcohol abuse or alcoholism?		
23	Are you or your dependents currently taking any prescription medication?		
24	Are there any existing conditions, or any other conditions or symptoms, which are not detailed above, for which medical advice, diagnosis, care or treatment has already been recommended or received. Or did you go through any previous medical/surgical hospitalizations, procedures and operations?		
25	Have you or any of your dependents ever been rejected or subjected to any waiting periods, exclusions or penalties on any other health insurance plan?		
26	**Have you been diagnosed as COVID-19 (Novel Coronavirus) patient? if yes when:……**		
	Did you, in the past 14 days, come in close contact with someone who has been diagnosed with COVID-19		
	Have you had any fever or respiratory symptoms "coughing, sneezing, trouble breathing" in the past 3 days		
	Have you travelled to any other country in last 14 days? If yes, please specify……		
	Have you volunteered for a COVID 19 vaccine clinical trials?		
	Have you received the vaccine dose?		

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No.	Medical Details	YES	NO
27	For Females only (Applicant or Dependent) : Are you pregnant? If Yes, please give the expected delivery date.		
	Have there been any complications to date?		
	If No, Last Menstrual period date:		
	Are you currently trying to get pregnant?		
	Are you undergoing any form of fertility treatment?		
Disclaimer: I understand and acknowledge any pregnancy not declared at the time of this application's coverage will be at the sole discretion of the insurer. The insurer has the right to not cover any maternity claims to any undeclared pregnancy. I also acknowledge and understand any pregnancy, which arises within forty calendar days from the date of this application; coverage will also be at the discretion of the insurer.			
28	Do you or your dependents have any active medical insurance / Takaful cover? If yes, kindly provide us with a copy of the valid medical card.		

If you have answered "yes" to any of the questions above, please supply full details below

Question No:	Name of Applicant	Details (including full details of the medical condition, dates of diagnosis and treatment, treatment undertaken and the name and address of the doctor(s) consulted)

If space provided is insufficient, please use another application form.

Is additional information attached	Yes □	No □

Based on above declarations, insurer reserves the right to request for additional medical report/documents to complete the assessment of medical conditions.

DECLARATION

I, the undersigned, on my behalf and on behalf of my legal dependents listed above, do hereby declare that, to the best of my knowledge, all the answers are full, complete and true Otherwise, **the Takaful coverage will be considered null & void with immediate effect in case of false declaration or non-disclosure or misrepresentation or concealment of material facts. Any medical health development after signing this form till the date of confirmation of cover should be notified to ADNTC for risk assessment and to avoid later services rejection**. I further, on my behalf and on behalf of my legal dependents listed above, give full and irrevocable authorization to my hospital, physician or other person who attended us or any member of my family to give (Abu Dhabi National Takaful Company), or its representative all information pertaining to our stat of health; and I hereby waive our right of medical confidentiality to the benefit of Abu Dhabi National Takaful Company and its representative. I also authorize ADNTC to share my medical records with healthcare providers and third parties as and when needed. I hereby agree that this form and declaration shall be the basis of the coverage of the medical policy. I declare that I read the Sharia Introduction, terms, conditions, exclusions, Policy Schedule and Additional coverages of the Insurance Policy and I accept it.

Name of Applicant Signature of Applicant Date