MEDICAL APPLICATION FORM FOR INDIVIDUALS & FAMILIES MUTUAL UPGRADED PROGRAM

Olivier
La Caisse Mutuelle d'entraide Liban

GlobeMed
Lebanon

Date _____

Contractual Period From	To	**Delegate**	**Cover** No.

PERSONAL INFORMATION

First Name _____ Family Name _____

Father's Name _____ Civil ID No. _____

Country _____ City _____

Street _____ Bldg. _____

Cell _____ Home No. _____

P.O. Box _____ Email _____

APPLICATION DETAILS

Network	○ Full Network	○ Limited Network

*Refer to Mutual fund for details regarding the Network Variation Options

RIDERS PLANS ○ Ambulatory Limited Network ○ Ambulatory Full Network ○ Doctor's Visit ○ Prescription Medicine

COVER HOLDER'S FAMILY STATUS ○ Single ○ Married ○ Divorced ○ Widowed

Family Members	Name	Nationality	D.O.B.	Sex M/F	Height CM	Weight KG	Smoker Y/N	NSSF Y/N	Profession	Blood Type
Cover holder										
Spouse										
Children										

Is there any family member who is not insured? If yes, please specify the reason.

Did you have any medical insurance coverage? If yes. please specify the preceding insurance guarantor expiry date.

Would you like to receive SMS regarding your claims status? ○ Yes ○ No

Would you like your delegate to receive SMS in case your claim is rejected or partially approved? ○ Yes ○ No

APPLICATION DETAILS

Kindly identify any disease related to your medical condition "over the last 10 years", by putting the sign (x) next to the medical condition:

1. Diseases of the cardiovascular system (hypertension, coronary, vascular disease, valvular, cardiomyopathies, arrhythmia, etc.) Yes ◯ No ◯
2. Diseases of the respiratory system other than cancer (asthma, chronic obstructive pulmonary disease, fibrosis etc.) Yes ◯ No ◯
3. Diseases of the digestive system other than cancer (Crohn, other intestinal inflammation, pancreatitis, diverticulitis, gall bladder or liver disease, etc) Yes ◯ No ◯
4. Kidney & Urinary tract diseases other than cancer (kidney stones, insufficiency, cysts, etc.) Yes ◯ No ◯
5. Orthesis and limb transplants, osteoarticular or muscular diseases other than cancer Yes ◯ No ◯
6. Diseases of the nervous system other than cancer (polio, depression, epilepsy, multiple sclerosis, etc.) Yes ◯ No ◯
7. Diabetes or diseases of the endocrine glands other than cancer Yes ◯ No ◯
8. Diseases of the eye, ear, nose and throat other than cancer Yes ◯ No ◯
9. Hematological diseases other than leukemia (anemia, etc) Yes ◯ No ◯
10. Malignant tumors, lymphomas and leukemias Yes ◯ No ◯
11. Sexually transmitted diseases, AIDS and HIV Yes ◯ No ◯
12. Other diseases, accidents, surgeries, prosthetic replacement, endoscopic procedures, diagnostics tests that you had or you are aware of Yes ◯ No ◯
13. Have you or any of the applicants taken or currently take any medications or have followed or will follow any kind of treatment Yes ◯ No ◯
14. Females only: Are you currently pregnant? Yes ◯ No ◯
15. Congenital disorders and diseases Yes ◯ No ◯
16. Psychiatric disorder (depression, anxiety, etc) Yes ◯ No ◯
17. Do you suffer from any symptoms related to the disease mentioned here above? (backache, chest pain, pain in joint, etc) Yes ◯ No ◯

In case the answer is yes to any of the Diseases/Conditions, aboved please specify full details in the table below

Name	Disease No.	Diagnosis Status	Treatment	Date	Hospital / Dr. Name

I hereby declare that the abovementioned information is complete, real and adequate, waiving, fully and irrevocably, the medical confidentiality on all the past and current medical files, documents and prescriptions related to any of us and those that will develop during the contract, in favor of the Medical committees and doctors, requesting from them, and other mutual funds and insurance companies or any other risk carrier which we had contracted with for medical and/or life insurance, to provide the mutual fund and/or GlobeMed Lebanon, with all the information and documents available at their side on our medical condition and of copies thereto, permitting GlobeMed Lebanon, within its capabilities, to inform our treating physician with the information available at its side on our medical condition, in addition to the rejection or approval of coverage decisions at all healthcare providers and pharmacies, with all possible means, either through e-mail, or SMS or any other available means.

I also declare that I have read the provisions of the contract with its general conditions and exceptions, and upon it I request to benefit from the health insurance for me and for my family members defined above. This declaration is final and irrevocable: I signed it on / / . on one original copy to be kept with the mutual fund to act upon it or upon a copy of it when necessary.

Cover holder Signature _____ First Beneficiary Signature _____ Second Beneficiary Signature _____

Third Beneficiary Signature _____ Fourth Beneficiary Signature _____