PROPOSAL OF INSURANCE FOR MEDICAL PLAN _____

E-mail

POLICY NO:

Please complete the proposal form in **BLOCK LETTERS.** No corrections or crossing out will be accepted without the initials of the applicant or the proposer

Applicant's Particulars

Name			Surname		
Gender	I.D./Passport No.	Date of Birth	Place of Birth	Permanent Residence	
Nationality		Full name and telephone no. of Doctor /Specialist		Height	Weight
Occupation		Employer		Type of Work	

Correspondence Address	Number	City	Postal Code

E-mail

Telephone No. - Residence	Telephone No. - Office	Mobile No.	Fax No.

Method of Payment

☐ Yearly
☐ Half - Yearly
☐ Quarterly

Family Condition

Married ☐ Single ☐ Divorced ☐ Widowed ☐

Are there other members of your family for which you do not ask medical cover? If YES, explain the reasons: YES ☐ NO ☐

_____

_____

Effective Date

Expiry Date

Signature of Applicant
(Stamp in the case of legal person)

Date

_____ _____

Head Office: 15 Esperidon Str., 2001 Strovolos. ***Mailing Address***: P.O.Box 24579, 1301 Nicosia.
Tel: +357 22886000. ***Fax***: +357 22886111. ***Email***: atlantic@atlantic.com.cy. ***Website***: www.atlantic.com.cy

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Occupation		**Employer**	**Type of Work**	

Note

The questions below must be answered with **YES** or **NO** by all Proposed Persons and on behalf of every dependant member (if the answer is **YES** please explain with details at the end of the questionnaire).

A. Previous Insurance Coverage

1. Have you ever applied for life insurance, personal accident or health insurance and the application remains outstanding?
2. Have you ever been rejected by an insurance company for life insurance and /or medical insurance or have you been accepted on special conditions?
3. Has ever a life, personal accident or medical insurance policy been cancelled or not renewed by any Company?
4. Are you presently covered under any other medical insurance? If **YES**, name the company, plan etc.

B. Dangerous Activities

1. Do you practise or intend to practise any kind of dangerous sport or activity?
   - Airplane piloting
   - Scuba-diving
   - Car or motorcycle racing
   - Horse racing
   - Parachuting or hang gliding
   - Mountaineering
   - Other air sports
   - Others
2. If you replied **YES** to question B1 state if the activity or sport is on a professional basis.

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C. Health condition and Family History

As far as you know

1.	Have you ever been diagnosed or operated or received treatment either as outpatient or inpatient?
2.	Have you ever been diagnosed or operated or received treatment, including medication either as outpatient or inpatient or have you felt any pain or had any symptoms that may be related to:
2.1	Cardiovascular system, (ischemic heart condition, cardiomyopathies, arrhythmias, valvular heart diseases, high blood pressure)
2.2	Cancer of any type , leukemia or blood disorders)
2.3	Diabetes Mellitus (type I or insulin dependent, type II or not insulin dependent)
2.4	Central nervous system disorders, mental or cognitive disorders (epilepsy, palsy, vertigo, blackouts, depression)
2.5	Cerebrovascular accidents (stroke)
2.6	Drug dependence or other substances abuse
2.7	Contagious or infectious diseases (e.g. AIDS)
2.8	Urogenital system disorders (e.g. kidney disorder, genital male/female disorders, fibroadenomas, recto cystocele, prostate hypertrophy)
2.9	Gastro-intestinal disorder (oesophageal, stomach, colon, liver, gall bladder, pancreas disorder)
2.10	Myosceletal system (spine, joints, muscles, bone disorders, bunions)
2.11	Nose/ear disorders (nasal scoliosis, hypertrophic tonsillae, adenoids, hypertrophic conchae, sinusitis , ear disorders)
2.12	Pulmonary system disorder (bronchial asthma, COPD, Pulmonary fibrosis)
2.13	Endocrine diseases (thyroid, lymph glands, ovaries, pituitary disorders)
2.14	Benign neoplasms (lipomas)
2.15	Coccyx cysts, hemorrhoids, hernias, anal fissures, varicose veins.
2.16	Eye disorders (cataract, retinopathies)
2.17	Other diseases (allergies, autoimmune, blood, skin disorders)
2.18	Congenital disorder, or malformations
2.19	Hyperlipidaemia (high cholesterol or triglycerides)
2.20	WOMEN ONLY. Are you pregnant YES / NO? Have you ever had problems with menstrual, hormonal or any other gynecological disorder?
2.21	MEN ONLY. Have you been granted postponement of enrollment, exemption or release from the National Guard on medical grounds?
3.	Did you have any symptoms during the last 10 years but failed to consult a doctor?