الوطنية للتأمين على الحياة والعام
NATIONAL LIFE & GENERAL INSURANCE
Ominvest Group
مجموعة أومينفست

Ver-2/09/2020

Group Medical Declaration form

Before you begin

- To be completed by the HR or Authorized person of the company
- This form is for Groups who are applying Group Medical Insurance via NLGIC Group Medical Insurance
- You must make sure the details about your employees and their dependents are correct.
- Please take good care to answer all the questions honestly and to the best of your knowledge.

To be filled and signed by the authorized personnel in the Human Resource Department of the Company (Group} Applying for Group Medical Insurance

1. Company Name:

2. No of employees who availed continuous sick leave for 15 days or more in the past 12 months

Name of Employee	Date of Birth	Gender	No of Sick Leave Availed	Reason for Sick Leave

3. Is there any employees or their dependents that you are aware of, who were diagnosed with or undergoing treatment for a critical illness in the past 5 Years?

Name of the Member	Relationship (Employee,Spouse,Child)	Passport No	Date of Birth	Date of Diagnosis	Critical illness

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Note: The below illnesses, procedures and/or diseases or conditions are considered as CRITICAL by National Life and General Insurance. Any of these illnesses will be subject to additional exclusions and/or sub limits according to the medical policy documentation provided and may incur additional premiums for cover

- Any heart related condition where in surgery has been performed or advised,
- Any cancerous condition (benign or malignant) whether diagnosed, on treatment, post treatment, remission or any radiotherapy or chemotherapy.
- Any organ failure or end stage organ disease diagnosed, on treatment or treated
- Any organ transplant performed prior to inception of the policy
- Vascular diseases such as but not limited Stroke, Paralysis, Cerebral Aneurism.
- Heart Attack/Stroke
- Any High cost treatments like immunomodulator

4) Ongoing Maternity cases (Kindly fill the pregnancy questionnaire)

Declaration on behalf of the company:

I declare to the best of my knowledge and belief the information supplied is correct as declared above. I agree that this questionnaire shall form part of my group application for cover. I am aware that any violation of the duty of disclosure can result in a reduction or refusal of benefits and that compensatory damages may be claimed.

Authorized Signatory (with Name, Date & company Stamp)