



CIC INSURANCE
We keep our word

CIC INSURANCE GROUP LTD.
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**CIC-MEDISURE FAMILY HEALTH PLAN
MEMBER APPLICATION FORM**

WRITE NAME AT THE BACK
OF EACH PHOTOGRAPH
AND ATTACH WITH A CLIP

(PLEASE, DO NOT USE STAPLE OR PIN)

A. PERSONAL PARTICULARS OF THE APPLICANT

TITLE: Mr. Mrs. Miss. Other _____ PROPOSAL COMMENCEMENT DATE

Day	Month	Year
DD	MM	YYYY

SURNAME _____ OTHER NAMES _____ ID/PASSPORT NUMBER _____

GENDER

M	F
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 MARITAL STATUS

M	S	D	W
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 DATE OF BIRTH

DD	MM	YYYY
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 MOBILE NUMBER _____ ALTERNATIVE PHONE NUMBER _____

POSTAL ADDRESS _____ POSTAL CODE _____ TOWN OF RESIDENCE _____ PHYSICAL ADDRESS _____

EMAIL ADDRESS _____ HEIGHT (CM) _____ WEIGHT (KG) _____ BLOOD GROUP

A	B	AB	O
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SPECIFIC OCCUPATION/DESIGNATION _____ NAME OF EMPLOYER/BUSINESS _____ STAFF PAYROLL NO. WHERE APPLICABLE _____

B. PARTICULARS OF THE APPLICANT'S DEPENDANTS TO BE INCLUDED ON COVER

1. FULL NAMES _____ GENDER

M	F
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 BLOOD GROUP

A	B	AB	O
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 ID/PASSPORT NUMBER. _____ DATE OF BIRTH

DD	MM	YYYY
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 Relationship: Child Spouse Living with you: Yes No
2. FULL NAMES _____ GENDER

M	F
---	---

 BLOOD GROUP

A	B	AB	O
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 ID/PASSPORT NUMBER. _____ DATE OF BIRTH

DD	MM	YYYY
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 Relationship: Child Spouse Living with you: Yes No
3. FULL NAMES _____ GENDER

M	F
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 BLOOD GROUP

A	B	AB	O
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 ID/PASSPORT NUMBER. _____ DATE OF BIRTH

DD	MM	YYYY
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 Relationship: Child Spouse Living with you: Yes No
4. FULL NAMES _____ GENDER

M	F
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 BLOOD GROUP

A	B	AB	O
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 ID/PASSPORT NUMBER. _____ DATE OF BIRTH

DD	MM	YYYY
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 Relationship: Child Spouse Living with you: Yes No
5. FULL NAMES _____ GENDER

M	F
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 BLOOD GROUP

A	B	AB	O
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 ID/PASSPORT NUMBER. _____ DATE OF BIRTH

DD	MM	YYYY
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 Relationship: Child Spouse Living with you: Yes No
6. FULL NAMES _____ GENDER

M	F
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 BLOOD GROUP

A	B	AB	O
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 ID/PASSPORT NUMBER. _____ DATE OF BIRTH

DD	MM	YYYY
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 Relationship: Child Spouse Living with you: Yes No
7. FULL NAMES _____ GENDER

M	F
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 BLOOD GROUP

A	B	AB	O
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 ID/PASSPORT NUMBER. _____ DATE OF BIRTH

DD	MM	YYYY
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 Relationship: Child Spouse Living with you: Yes No

NOTE: KINDLY INDICATE THE NATIONAL ID NUMBER FOR YOUR SPOUSE AND EACH CHILD ABOVE 18 YEARS OF AGE. (ATTACH COPIES)

FOR DEPENDANTS NOT LIVING WITH YOU, INDICATE THEIR TOWN OF RESIDENCE AND ALTERNATIVE ADDRESS _____

C. CONFIDENTIAL MEDICAL HISTORY OF THE APPLICANT AND DEPENDANTS LISTED

Please answer all the questions. Blank spaces are not acceptable.
You may attach an additional sheet if the space provided is insufficient.

1. Have you or any of your dependants been hospitalized in the last 3 years? Yes No
2. Have you or any of your dependants ever had an accident resulting in a permanent injury? Yes No
3. Are you or any of your dependants presently suffering from any disease that is recurrent in nature? Yes No
4. Are you or any of your dependants under any regular medication? Yes No
5. Do you or your dependants have any kind of physical disability? Yes No
6. Are there any circumstances in your(or your dependants) current or past medical history that may result in hospitalization or surgery in the near future? Yes No

Please state whether you or any of your dependants have ever been treated, received treatment or expect to receive treatment for any of the following conditions/illness:

7. Heart and blood vessels disorders e.g. high blood pressure, heart disease, stroke, congenital (inborn), heart conditions, chest pains, arterial disease. Yes No
8. Blood/ circulatory disorders e.g. Sickle cell anaemia, Varicose, Thrombosis, Kidney, Liver, Haemophilia, leukemia or any other blood disorder. Yes No
9. Respiratory disorders e.g. Bronchitis, Tuberculosis, Asthma, cigarette smoking disorder, any other respiratory related problem. Yes No
10. Neurological disorders e.g. Meningitis, stroke, brain or spinal cord disorder, epilepsy, any other neurological related disorder. Yes No
11. Ear, Nose and Throat related problem e.g. throat surgery, sinuses. Yes No
12. Eye disorders e.g. cataract, glaucoma, eye surgery, blindness. Yes No
13. Gynecological or genitor-urinary disorders e.g. Pelvic Inflammatory disease, menstrual irregularities. Yes No
14. Kidney disorders such as kidney failure, kidney stones, recurrent infections etc. Yes No
15. Musculoskeletal disorders e.g. arthritis, back problems, joints, gout, etc. Yes No
16. Endocrine diseases such as diabetes, thyroid disease, high cholesterol. Yes No
17. Surgical such as appendectomy, tonsillectomy or any other surgical procedure. Yes No
18. Other diseases/ disorders: cancer, alcohol/drug problem, hepatitis, ulcer, mental disorder, gall bladder disease, HIV infection. Yes No
19. Is there any other ailment or condition not listed above that you or your dependants may be suffering from? Yes No

If you answered YES to any of the questions 1 to 19 on the previous page, kindly give more details in the table below:

No.	Name of Applicant	Ailment/Disorder	Date Diagnosed	Doctor & Contact Address	Current Status

If the space is not adequate, fill in separate plain paper and attach to the form

20. a) Have you / your spouse ever delivered a child by Caesarean operation? Yes No
 b) Are you / your spouse currently pregnant? Yes No If yes please state number of weeks of pregnancy
21. Are you or any of your dependants allergic to drug(s)/ substances? Yes No
 If yes please give details _____
22. Have you been on medical insurance before? Yes No
 If yes please give name of the insurer/HMO, expiry date and any special exclusions _____
23. Any additional information not stated above, relating to your medical history _____

D. COVER BENEFITS SELECTED

1. Medical cover plan selected (please tick only one)

- CIC-Supreme Cover CIC-Prestige Cover CIC-Premier Cover
 CIC-Classic Cover CIC-Standard Cover CIC-Essential Cover

2. Optional rider covers selected (please tick). Each rider cover selected attracts additional premium:

- Emergency excess of loss Personal Accident Cover Life Cover

NEXT OF KIN (Must be over 18 years of age)

FULL NAMES			GENDER	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
DATE OF BIRTH		RELATIONSHIP	ID/PASSPORT NUMBER.	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
MOBILE NUMBER	POSTAL ADDRESS	POSTAL CODE	TOWN OF RESIDENCE	
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Important things to note:

- Cover is not effective until your application is assessed and accepted in writing and the full annual premium paid.
- Any pre-existing conditions for the applicant and his/her dependants must be declared on the application form, and cover confirmed by CIC in writing.
- Applicants aged 50 years and above will be required to go for specified medical test at their own cost.
- CIC Insurance will not be liable for medical expenses resulting from excluded conditions or exceeded benefits (as per Policy)

DECLARATION

I hereby apply to join the CIC-MEDISURE Family Health Plan. I understand to the best of my knowledge and belief that all the answers given above are true and complete, that I have not concealed or withheld any material information which the insurer ought to know in order to assess me or my family members for medical insurance.

I know that any misrepresentation of information could result in my policy being rendered null and void.

I hereby authorize the hospitals, medical or dental practitioners who have treated me or any of my dependants to disclose to CIC Insurance the records relating to such current or previous hospitalizations or medical treatment and to allow CIC Insurance to receive extracts from such records, and I undertake to assist in obtaining such information

Signature of the Applicant

DATE / /

E. FOR OFFICIAL USE ONLY

POLICY NUMBER

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POLICY COMMENCEMENT DATE

Day		Month		Year					
D	D	/	M	M	/	Y	Y	Y	Y

GROUP (Where Applicable)

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AGENT SURNAME

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OTHER NAMES

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CIC BRANCH

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AGENT CODE

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CIC RELATIONSHIP OFFICER (NAME Where Applicable)

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POSTED BY (NAME)

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	Day			Month			Year			
DATE	D	D	/	M	M	/	Y	Y	Y	Y