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?

4.	Do you have a family history of:
	4.1 Heart condition
	4.2 Hypertension
	4.3 Diabetes mellitus
	4.4 Congenital disorder or malformation
	4.5 Cancer
	4.6 Neurological or mental disorder
	4.7 Kidney's disorder (polycystic kidney, nephrolithiasis)
	4.8 Hemophilia
	4.9 Muscular dystrophy

D. Way of Living

1.	Do you smoke? If YES specify the quantity
2.	Do you consume alcohol? If YES specify the quantity
3.	Do you work for more than 40 hours per week?
4.	Do you sleep less than 8 hours per day?
5.	Do you travel abroad more than 6 times per year?

If the answer to any of the above questions is **YES** please give full details. State the patient's name, nature of illness or injury. State the names and addresses of the attendant physicians, hospitals, etc.

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The Processing of Personal Data (Protection of Individuals) Law 138 (I) of 2001

In accordance with the provisions of the above Law, **Atlantic Insurance Company Public Ltd,** in its capacity as Controller within the meaning of the Law, wishes to advise the Proposer that in order to issue the Insurance Contract, it is necessary to collect and process personal data, including sensitive data. The personal data will be recorded in an electronic or any other form to the personal data filling system(s), within the meaning of the Law, maintained **Atlantic Insurance Company Public Ltd** or by any other company or person with which co-operation exists and/or and agreement is in force. In addition to the primary purpose of processing the personal data, which is the execution and administration of the Insurance Contract, such data will also be processed for the purpose of research and statistical analysis, promoting new products of the Company as well as maintaining high service standards. The recipients of the personal data shall be the dully authorised personnel of the Company and of any other company or person with which co-operation exists and/or and agreement is in force. The processing of such data is confidential and shall be carried out only by persons acting under the authority of the Controller. The Proposer has the right of access to and rectification of the data relating to him as well as the right of objection to the processing of such data. The right of access and objection shall be exercised by the submission of an application to the Controller and the payment of the sum prescribed by the Regulations issued under this Law. In the event that the Proposer refuses to authorize or objects to the processing of the data relating to him the Company reserves the right not to accept the Proposal for Insurance or to terminate the Insurance Contract or to reject any Claim for compensation.

Declaration

All information included in this document represent the notification that the Company action as the Controller has an obligation, in accordance with the Law, to provide me with and by signing this Proposal I acknowledge and declare that the Company has informed me of the provisions of this Law. Furthermore, by signing this Proposal I hereby grant my express consent to **Atlantic Insurance Company Public Ltd** to collect and process data relating to myself, which may also include sensitive data, and to maintain such data in the Company's personal data filling system(s), within the meaning of the Law.

Declaration

I hereby declare that to the best of my knowledge and belief, that whatever is stated in this Proposal is absolutely true and that I have not concealed, distorted or misrepresented any fact. I also agree that this proposal and declaration shall be absolutely binding upon me, shall form the basis of this Policy between myself and **Atlantic Insurance Company Public Ltd** and will be considered as forming part of the Policy to be issued.

Authorisation

I hereby authorise, any Medical Institution or Medical Practitioner or any other relevant professional who has extended to me or any other of the proposed for insurance persons of my family any medical treatment or services, to furnish to **Atlantic Insurance Company Public Ltd** or any other authorized company any information that may be requested concerning my person or any of my dependants. I also authorize any other insurance company where I have submitted an insurance proposal or claim for compensation, to communicate to **Atlantic** any information that they may request.

Signature of Proposer

Date

Underwriting Instructions (exclusions, endorsements etc)

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