

**Damaan Islamic Insurance Company (Beema)**  
**Health Questionnaire**



Name \_\_\_\_\_

Civil ID (QID) \_\_\_\_\_

1. Have you ever had, or been told to have or been treated for, or will be receiving medical advice, counseling, or treatment in connection with the following conditions:		
	<b>No</b>	<b>Yes</b>
a) Raised cholesterol, blood pressure, chest pain, diseases of or any disorders of the heart or blood vessel disease?	<input type="checkbox"/>	<input type="checkbox"/>
b) Diabetes mellitus, thyroid disorders or any other endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>
c) Cancer, tumors, growth, lump, cyst, of any kind?	<input type="checkbox"/>	<input type="checkbox"/>
d) Diseases or disorders of kidney (e.g. blood, sugar in urine), stomach, intestines, liver, gall bladder, or blood?	<input type="checkbox"/>	<input type="checkbox"/>
e) Ear(s), eye(s), nose, throat, asthma, persistent cough, breathing discomfort or any other lungs disorders?	<input type="checkbox"/>	<input type="checkbox"/>
f) Fits, paralysis, stroke, weakness of the limbs, depression, or any other nervous or mental disorders?	<input type="checkbox"/>	<input type="checkbox"/>
g) Arthritis, rheumatism, gout, joint, back or other bones and joints problems, loss of use of limb, physical deformity or disability?	<input type="checkbox"/>	<input type="checkbox"/>
h) HIV and/or AIDS related condition or any infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>
i) Any other illness or disease not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past two years, have you suffered from a sickness or involved in an accident for which you were admitted to hospital or medical center or undergone an operation?	<input type="checkbox"/>	<input type="checkbox"/>

**DECLARATION**

I declare, to the best of my knowledge, that the above declarations I made are complete and true and I have not willfully attempted to avoid disclosing information which would have a bearing on the terms of the Cover applied.

I also agree that, if it is proven that there is non-disclosure of material fact that I know or ought to know, the Cover effected will automatically be voided or cancelled.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

POLICY NO:

EXPIRY DATE:

MAIL ID:

MOBILE NO: