

Credit Life

Gulf International Bank – Saudi Arabia
Medical Questionnaire

1.Particulars Of Life To Be Insured

| | | | |
|-------------------------|---|--------------------|-------------|
| Name | | | |
| Gender | <input type="checkbox"/> Male <input type="checkbox"/> Female | | |
| Date of Birth | DD /MM /YYY | Present Occupation | |
| ID Number | | Employer Name | |
| Finance Account Number | | Finance Date | DD /MM /YYY |
| Amount of Finance (SAR) | | | |
| Finance Duration | | | |

2.Medical & Lifestyle Questionnaire

| | | |
|----|--|--|
| A. | Height in Cms _____ cm | Weight in Kgs _____ kg |
| B. | If you smoke/ chew tobacco in any form, please state type and frequency of tobacco intake per day Note: State as Nil for non-smokers | Type and Number of units per day |
| C. | Have you ever been treated for diabetes mellitus or history of raised blood sugar, High or low blood pressure, Cholesterol, rheumatic fever, chest pain, myocardial infarction or any other disease or disorder of the heart or arteries or blood vessels? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| D. | Have you ever suffered from any disorder of the digestive system, gall bladder or liver? e.g. actual or suspected gastric or duodenal ulcer, bleeding from the bowel, recurrent indigestion, hepatitis, gallstones | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| E. | Have you ever suffered or treated for Asthma, bronchitis, pleurisy, tuberculosis, persistent cough or any other disease or disorder of lungs? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| F. | Have you ever suffered or treated for Paralysis, epilepsy, fits or any kind of nervous breakdown or any other disease related to the brain or the nervous system or ever had an anxiety state, depression or any mental or neurological disorder? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| G. | Do you have any disease or disorder of ear, nose, eyes or throat, including defective sight or hearing and discharge from ears? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| H. | Have you ever had cancer, rheumatism, gout, enlarged glands, lumps, tumors or cyst? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| I. | Have you ever suffered from any disease, disorder or infection of the kidneys, bladder or reproductive organs e.g. albumin in urine, stones, prostatitis, venereal disease? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| J. | Have you ever suffered from any illness or disorder which is not mentioned above? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| J. | Do you suffer or have suffered from any medical condition that had led to disability or could lead to disability, for which you intend to file or have filed disability assessment with the Public Authority for Social Insurance or any similar government authority (ies)? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Signature of the life assured

Date

Place

| | | |
|----|--|--|
| L. | Has any of your immediate family members (parents / brothers / sisters etc.) Suffered from or died of heart disease, stroke, high blood pressure, diabetes mellitus, any form of eye disease, cancer, kidney disease or paralysis before the age of 65 years and/or suffering /suffered any other hereditary/familial disorders? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| M. | Are you involved or do you intend to involve in any hazardous occupation or avocation? (for e.g. flying other than a fare paying passenger, diving, mountaineering, working at heights, underground or offshore, using explosives or any other dangerous activity). | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| N. | Have you ever had an application for life, accident, medical, health related insurance or riders refused, withdrawn, declined, postponed or offered with restricted benefits or with an increased premium or made any claim under any such policy? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

If any above-mentioned questions were answered with “Yes”, please mention the details below

Declarations:

I declare that:

1. The declarations stated above are true and correct and I have not withheld any information that may affect the Insurance Company/Takaful Operator’s or the Bank’s decision.
2. I am currently in active employment and not restricted by injury or illness from carrying out all of the duties of my current and usual occupation.
3. I authorize any hospital, doctor or other person who has treated or examined me, or who may do so hereafter, to give to the Bank or the Insurance Company/Takaful Operator on demand any information on my illness or injury, medical history, consultation, prescription or treatment or copies of all hospital or medical reports.
4. I have read and understood and agree to be bound by the summary of terms and conditions of Insurance/Takaful Cover (copy of this document provided to me) and any future changes that might be introduced from time to time.
5. I understand that all benefits that might become due under the insurance cover are payable by the Insurance Company/Takaful Operator to Gulf International Bank to be used against repaying my debt to the bank.

I confirm that all of the above answers and statements are true and that no material facts concerning my past and present state of health, occupation and habits have been withheld or omitted. I confirm that I clearly understand that in case of any misstatement, misrepresentation and/or suppression of any data, the Insurance Company/Takaful Operator has the right to repudiate any and all claim(s) under any coverage if issued based on this questionnaire. I acknowledge that in the event it becomes evident to the Bank or the insurance company that any of the information provided herein are not true, the Bank will have the right not to release my financial liability under the finance.

Signature of the life assured

Date

Place

Name of Bank Official

Signature & Employee ID

Date/Place