MEDICAL CARE INSURANCE FOR ALIENS

PROPOSAL FORM

ALIEN'S PERSONAL DETAILS

Full Name:

Single: ☐ Married: ☐ Divorced: ☐ Widow/er: ☐

Date of Birth: MP No (Envelope No) / ARC:

Height: Weight: Sex:

Business Address: Post Code:

Telephone:

Occupation:

EMPLOYER'S GRANTEE DETAILS

Full Name: I.C. No:

Employer's Register No:

If Grantee is a Company – Reg. No

Mailing Address: Post Code:

Telephone:

Relationship to Life to be Assured:

DETAILS OF REQUIRED COVER (STANDARD) **PREMIUM:**

PERIOD OF INSURANCE:

From: …… To: …….. Annual Premium: €

FOR INTERNAL USE ONLY:

Name of Agent: Agent Code:

Underwriting Decision: Received :

Asfalistiki Eteria I "Kentriki" Ltd
33 Clementos str, 1061 Nicosia, P.O.Box 25131, 1307 Nicosia, Cyprus
Tel: 22745710, Fax: 22769051, e-mail: info@kentriki.com.cy, website: kentriki.com.cy

PROPOSER'S MEDICAL HISTORY

Please tick in the appropriate box and give all relevant information in case where you have ticked the box marked "YES"

1. Do you suffer from any disability, slip disk, hernia, varicose veins, sight or hearing problems or any other Chronic illness? YES ☐ NO ☐

2. Have you undergone any surgical operation or have you an illness or medical condition for which you Have consulted a doctor or have been advised that an operation may be necessary in the future?
   YES ☐ NO ☐

3. Do you suffer from any illness or disease or have any such symptoms?
   YES ☐ NO ☐

4. (a) Please give the name and address of your doctor:
   (b) How long have you been under his/her care?

5. In the last five years
   (a) Have you been admitted in a hospital or Clinic as an in-patient? YES ☐ NO ☐
   (b) Have you consulted a specialist? YES ☐ NO ☐
   (c) Have you consulted a General Practitioner? YES ☐ NO ☐

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FURTHER INFORMATION

1. Have you ever been refused or been accepted with special terms for Life Assurance or Accident or Health Insurance or has any Company cancelled, refused to renew or impose special terms to your policy?

   YES ☐ NO ☐

2. Have you submitted a claim under a Personal Accident or Health Insurance Policy?

   YES ☐ NO ☐

3. Are you currently insured under a Personal Accident or Health Insurance in relation with medical expenses?

   YES ☐ NO ☐

4. Are you entitled for medical expenses reimbursement from your employer or any other medical fund?

   YES ☐ NO ☐

5. Please give full details of your trips abroad, frequency and length of stay of each trip.

6. Please give full details of sports that you engage in.

DECLARATION

I hereby declare that all answers are true and correct. I am in good health and I have not concealed any material fact that will affect the assessment or acceptance of this application. I agree that this application together with this declaration shall form the bases for the insurance contract between me and Kentriki Insurance Co Ltd (hereinafter called the Company) and I shall accept the contract with its terms, conditions and exceptions described there in. I authorise the Company to seek information regarding my medical condition from any doctor whom I consulted concerning my physical or mental condition and to collect any information from any insurance company from which I sought medical insurance cover authorising at the same time the aforesaid entities to give any information that will be asked for and I agree that such information (together with any information given by me to Kentriki Insurance Co Ltd in writing) shall form integrall part of this Application. The Company will have no liability till this application has been accepted and the first premium has been paid. I agree that any amount paid will be refunded to me if this application is not accepted by the Company.

Applicant's Signature …… Date. ……

Grantee's Signature …… Date ……

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EXCLUSIONS

1. The Company has no liabilities arising out of or connected in any way to:

   (a) Expenses directly or indirectly resulting from or consequent upon congenital defects and deformities.
   (b) Acquired Immune Deficiency Syndrome (A.I.D.S)
   (c) Rest cures, cure in a sanatorium or custodian care of periods of quarantine or isolation.
   (d) Cosmetic or plastic surgery unless necessitated by an Accidental Bodily Injury occuring while insured.
   (e) Dental examination, dental X-rays, extractions, root canals, fillings except as a result of an accidental injury to sound natural teeth that can be proved beyond reasonable doubt with the aid of X-rays or an independent examination or other medical evidence. Prostheses, corrective devices and medical appliances and false teeth, crowns, inlays and bridges, orthodontic, endodontic, periodontic and general dental care.
   (f) Refractive error or optical abnormalities and or fitting or optical or hearing aids.
   (g) Examinations for check-up purposes not incidental to, or necessary for the diagnosis of the illness or Accidental Bodily Injury.
   (h) General Health Examinations.
   (i) Inoculations and vaccinations.
   (j) Contraceptives and/or the fitting of contraceptive devices.
   (k) Expenses incurred for the treatement of rheumatism, arthriti, lumbago, neck pain and ischialgia except hospital (or clinic) treatment as an in-patient in which case the above mentioned conditions are covered.
   (l) Infertility treatment.
   (m) Physiotherapy except in cases where it is necessary to cure an injury.
   (n) Pre-existing conditions or any complcations directly attributable to these conditions.
   (o) Expenses for gunecological problems either before or during the first six months from the inception date of the policy or the reinstatement date of the policy.
   (p) Nervous or mental disorder or epileptic attacks or psychological illnesses or therapy in psychiatric hospitals or institutions.
   (q) Expenses for medical treatment that is not performed or recommended by a legally registered, qualified medical practitioner or which takes place at a physiotherapy clinic or health spa or a similar institution or during quarantine.
   (r) Expenses incured outside Cyprus.
   (s) Expenses which the Insured is entitled to compensation from funds or medical funds or other insurance policies. Any amount payable under this insurance policy will be restricted to the difference that may exist between the benefits under those other insurance coverage or funds and will be calculated from the benefits chart of the aforementioned policy, whichever amount is less.
   (t) Expenses for medical treatment caused by a work related accident whithin the framework of the Employment Law which are covered by the Social Insurance Fund.

2. Additionally no claims are reimbursed for expenses on illnesses or accidents that are caused by or are the direct or indirect result of:

   (a) War, invasion, act or foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution Insurrection or overthrowing of government by force or military or usurped power or participation of the insured person to any illegal actions.
   (b) Ionizing radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel.
   (c) The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assemply or nuclear component thereof.
   (d) Naval or military or air force or police force operations.
   (e) Self inflicted injury, suicide, attempted suicide, drug abuse, alcoholism, sexually transmitted diseases, illnesses or conditions which are the cause of chronic alcoholism.
   (f) Pregnancy, childbirth, ectopic pregnancy or termination of pregnancy or any other normal or other complications which are the direct cause of this.
   It is noted that, not withstanding anything to the contrary of the terms of this exclusion, in case or childbirth (normal or caesarian section) benefit 3 “Pregnancy Benefit”, as described in the Schedule of Benefits, is activated.
   (ζ) Participation in professional athletics or any dangerous sports, driving or participating in any kind of racing or competition or participation in Illegal activities.