



GROUP LIFE APPLICATION (Individual Enrollment)

American University of Beirut

Agent : _____

Policy Holder: American University of Beirut

With Medical questions

A. PERSONAL DETAILS (Please use a pen and write in Block letters. Any corrections made must be approved by the applicant by signing next to it)

1- Full Name of proposed insured (as shown in Identification Document)

AUB ID: _____

Female Male Age: _____ Place & Date of Birth: _____ / ____ / ____ Nationality: _____

Single Married Widowed Divorced Number of Children: _____ Identification / Passport No.: _____ Registration No.: _____

2- Current Residence Address:

Bldg. & Floor: _____ Street or Quarter: _____ City / Town: _____

Country: _____ Telephone: _____ Mobile: _____ P.O. Box: _____

3- Occupation: _____ Daily Duties: _____

B- DETAILS OF INSURANCE APPLIED FOR

Benefits	Sum Insured
Natural Death Benefit	<input checked="" type="checkbox"/> 2 X annual salary *
Accidental Death Benefit	<input checked="" type="checkbox"/> 3 X annual salary *
Accelerated Permanent Total Disability due to Accident (Own or Similar Occupation)	<input checked="" type="checkbox"/> 3 X annual salary *
Permanent Partial Disability due to Accident	<input checked="" type="checkbox"/> 3 X annual salary *
Passive War Risk (Death, PTD Own or Similar Occupation, PPD)	<input checked="" type="checkbox"/> 2 X annual salary *

Beneficiary		
Name	Age	Relationship

* Subject to policy limitations

Currency: _____ USD _____

C- GENERAL QUESTIONS

- | | No | Yes |
|--|--------------------------|--------------------------|
| 1- Has any Life or Personal Accident or Health or Reinstatement application for you ever been declined, postponed, rated with sub-standard premium or in any way modified or cancelled? If yes, give details below | <input type="checkbox"/> | <input type="checkbox"/> |
| 2- Are you a member of any armed forces, or do you participate or intend to participate in any kind of racing, under water diving, sky diving, or any other hazardous sport or hazardous hobby, or fly in an aircraft other than as a fare-paying passenger on regularly scheduled airlines? If yes, please fill the relevant questionnaire. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3- Do you plan or intend to travel within the next 12 months and live outside your current country of residence? If yes, please give the details as requested below: | <input type="checkbox"/> | <input type="checkbox"/> |

Country: _____ Approximate date of travel: _____ Reason: _____ Length of stay: _____

D- MEDICAL DECLARATIONS

1- Name and address of personal physician or family doctor if any: _____

Date of last visit : _____

Reason : _____

Height: _____ cm

Advice given : _____

Weight: _____ kgs

2- Have you had any medical or surgical treatment, or had any medical tests whether out or in hospital, or have you been advised to undergo any diagnostic tests, hospitalization or surgery which was not done? No Yes

3- Have you ever been diagnosed or treated or had any surgical operation for rheumatic fever, heart attack, chest pain, brain stroke or any disorder of the cardiovascular system, cancer, tumor, liver disorder, kidney or ureter or urinary disorder, diabetes or any endocrine disorder and its secretions, gastrointestinal or reproductive disorder, blood or respiratory disorder, paralysis or any other nervous disorder, alcohol or drug abuse or any sickness not listed above? No Yes

4- Have you ever had any consultation or treatment for AIDS, AIDS Related Complex, or sexually transmitted disease or been told to have any of these or to had tested positive for AIDS or to have unexplained fatigue, weight loss, diarrhea, or unusual skin lesions? No Yes

5- Has any member of your immediate family suffered from diabetes, high blood pressure, heart disease, tuberculosis, mental disease or any AIDS related condition? No Yes

6- Have you smoked cigarettes or any other form of tobacco within the past 12 months? If yes, state how many per day: _____ No Yes

7- **For females:** Have you ever had complications at childbirth or are you now pregnant? If currently pregnant, how many months? _____ No Yes

IF THE ANSWER WAS "YES" TO ANY OF THE ABOVE QUESTIONS PLEASE GIVE THE DETAILS AS SHOWN BELOW

Question No.	Date	Names of Doctors/Hospitals, Reason for consultation/Test, Test Results, Prognosis, Treatment, Current health condition

E- DECLARATIONS

I hereby declare that all statements and answers in this application together with those in any required medical examination, questionnaire or amendments are full, complete and true and bind all parties in interest under the policy herein applied for.

I understand that incorrect answers or statements, or failure to disclose any material fact, may invalidate and cancel the insurance.

I hereby exonerate any Physician and/or Hospital and/or Clinic and/or Insurance Company and/or any other Organization that has any records or information about me from professional secrecy and hereby authorize such person and/or entities to give to Fidelity Assurance and Reinsurance Company S.A.L all information about me and copy of records with reference to health and/or medical history and/or any hospitalization, medical advice, diagnosis, treatment disease and/or ailment. I also authorize FIDELITY to obtain, from any source it deems appropriate, any information concerning my financial and/or professional and/or personal status, as well as any information related to my driving history. Any photocopy of this authorization shall be valid as the original.

IMPORTANT: Before signing this application please make sure that all your answers are correct and complete and that any incomplete answer may invalidate and cancel the insurance.

_____ Date

_____ City / Country

_____ Full Name & Signature of Proposed Insured

_____ Signature & Seal of Policy Holder