AXA COOPERATIVE INSURANCE
STANDARD INDIVIDUAL APPLICATION FORM

Please note: The application form must be completed and signed by the member (for him and his family) in writing , using block CAPITALS LETTERS and by ticking the relevant boxes.

1. Your Details – *One Application Form Per Member*

First Name: .....
Family Name: .....
Date of Birth: ___ / ____ / _____ (dd/mm/yyyy)
Nationality .....

Gender: Male ☐ Female ☐
Marital Status: Single ☐ Married ☐
Employer: .....
Job Occupation: .....

Employee ☐ Spouse ☐ Child ☐

2. Your treating medical practitioner contact details or the name of the clinic / hospital you usually go to:

Name: ..... Telephone: ..... Address/ Hospital .....

3. Your Confidential medical history

Please note (Very Important):

- No liability will be accepted for any medical condition which originated before the date of enrollment or which was foreseeable at the time of application unless such

Part A	**Please answer each question by clearly marking one of the corresponding boxes**	
Your Weight ..... **Your Height** ..... **Do you smoke ?** ..... **, If "yes" How many cigarettes a day?**		
1. In the last 2 years have you experienced (or are you now experiencing) any symptoms or discomfort such as but not limited to; fever, pain, migraine, headache, cough, vomiting, diarrhea, fatigue, dizziness, bleeding, itching, toothache?	**yes** ☐	**No** ☐
a) If you have answered 'yes' to the question above, have you treated yourself or been treated by anybody else?	**yes** ☐	**No** ☐
b) Have any of those symptoms or discomfort come back?	**yes** ☐	**No** ☐
c) Name the physician most familiar with your family history?		
2. In the last 2 years or at present have you noticed any lumps or other mass, changes in moles or other skin problems or have you had any loss of function such as but not limited to; movement, hearing, vision or speech?	**yes** ☐	**No** ☐
a) If you have answered 'yes' to the question above, have you treated yourself or been treated by anybody else?	**yes** ☐	**No** ☐
3. In the last 2 years have you had or do you now have any medical condition requiring treatment lasting longer than seven days?	**yes** ☐	**No** ☐
4. In the last 2 years have you or are you now taking any medication for more than seven days, whether you have been advised to or not?	**yes** ☐	**No** ☐
5. In the last 12 months or at present have you been advised by a medical practitioner or another expert to change your diet, undertake more physical exercise or change your lifestyle in other way?	**yes** ☐	**No** ☐
6. Have you ever been diagnosed with any form of cancer and/or undergone or been advised to undergo any screening to rule out a potential cancer diagnosis?	**yes** ☐	**No** ☐
1. Do you suffer from any of the below, if yes, then please provide medical reports: a) Diabetes b) Blood vessel (Veins and arteries) diseases/disorders c) Chronic obstructive pulmonary disease (COPD) d) Cancer of any type e) Nervous system surgeries f) Diseases of the brain's veins and arteries	**yes** ☐	**No** ☐
8. In the last 5 years have you been hospitalized or undergone surgery of any kind?	**yes** ☐	**No** ☐

9. For female applicants: - Are you pregnant? If yes, When is the Effective Due Date? - Have you recently been (within the last 12 months) - Are you planning to become pregnant (in the coming 12 months)?	yes ☐ __/__/__ yes ☐ yes ☐	No ☐ No ☐ No ☐
10. Have you ever had any complications associated with conception, a pregnancy and/or given birth by caesarean section?	yes ☐	No ☐
11. Do you foresee any need to visit any medical practitioner or therapist of any kind in the coming year for a follow-up visit, planned hospitalization, health screening / checkups or because you have any symptoms/discomfort of any kind?	yes ☐	No ☐
12. Please declare If there is any major condition that we should know about (In good faith you must declare it).	yes ☐	No ☐

Part B	**This applies if you have indicated "yes" replies in part A**					
Question number in Part A	Nature of illness/disability and treatment received	Period of illness/disability Month	Year	Duration	Need for any further treatment or consultation	Present state of health in this respect

• In case you need additional space, please use a separate sheet of paper to be enclosed together with this Individual Application Form.

Declaration: I declare that to the best of my knowledge and belief that all information /statements provided on this Application Form are full, true and correct. I shall read the AXA Healthcare Standard Guide and Policy Wordings when received and I will be bound by it. In the event of a dispute, I agree to follow the AXA

Signature of policy holder:	.....	**Print name:**	.....	**Date (dd/mm/yyyy):**	__ / __ / _____

• Please send original only by courier to your insurance representative.
• Please make sure that this form is signed and dated before sending it to your insurance representative.