



MEDICAL EXPENSE INSURANCE  
GROUP INSURANCE APPLICATION

Group of 10 person over

**I.- APPLICANT PERSONAL INFORMATION**

- 1.1.- Full Name (person or entity): \_\_\_\_\_
- 1.2.- Home Address:  
Street: \_\_\_\_\_ No. \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_  
Phone: \_\_\_\_\_ Mail: \_\_\_\_\_ Post Code: \_\_\_\_\_
- 1.3.- Representative Name (just for legal person): \_\_\_\_\_
- 1.4.- Current Job: \_\_\_\_\_
- 1.5.- Job description: \_\_\_\_\_
- 1.6.- Profession: \_\_\_\_\_
- 1.7.- Activity or Field of the Entity: \_\_\_\_\_

**II.- DATOS DEL SEGURO**

- 2.1.- Maximun Amount of Indemnization: CUP 2,400,000.00
- 2.2.- Validity of the requested insurance: From 24:00 h of \_\_\_\_/\_\_\_\_/\_\_\_\_ To 24:00 h of \_\_\_\_/\_\_\_\_/\_\_\_\_  
(The Policy would be contracted by a year or at least for a period of 180 days. This insurance shall have effect from the first 72 hours after acceptance of the Insurance Conditions)

**III.- STATEMENT**

Concerned to all effects of this application, every answer gave for the person are complete and in the truth. The Insurer and the Applicant are agreeing in the veracity of the answer and every one is necessary to get the insurance contract. Every declaration and answer Will be the support of the existence of this contract.

The Applicant allow to the physician from which get assistance that offers all the pertinent information about illness or accident to the Seguros Internacionales de Cuba, S.A. (ESICUBA), in this case, the Applicant exempts to the physician referent to the professional secret that could be incurred, in virtue to this contract.

Name: \_\_\_\_\_

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

The Signing of this Application does not oblige the Insurer to conclude the insurance contract.

**JUST EXCLUSIVE USE FOR INSURANCE PRODUCER**

INSURANCE PRODUCER: \_\_\_\_\_  
(Producer name and entity that represents)

RECEIPT DATE: \_\_\_\_\_



MEDICAL EXPENSE INSURANCE  
GROUP INSURANCE APPLICATION  
INSURANCE LIST

Group of 10 person over

I.- PERSONAL INFORMATION TO APPLICANT

Main Insurer

Full name	Family grade	Born date	Nationality	No. Passport	Sex	Weight (kg)	height (m)	Civil status

Other Insurers (for each one could be offering all information asking here)

Full name	Family grade	Born date	Nationality	No. Passport	Sex	Weight (kg)	height (m)	Civil status

II.- ANOTHER SAME INSURANCE ASKING BEFORE, PENDING OR CURRENT

Insurance Agency	
Country	
Benefit limits	
Rejection, modification, cancellation, postponement, rate increase from any application of the same kind of insurance like this.	[ ] Yes [ ] No
Name of Company	
Date	



Reason	
Information about claims fulfilled in policy of accident, illness or lifetime disability	

**III.- OTHER INFORMATIONS**

For each one Insured

Sports or high-risk activities	[ ] Yes [ ] No	Name(s)
Which	[ ] Mountaineering [ ] Water skiing [ ] Diving [ ] skydiving [ ] Motorcycling	Name(s)
Frequency	[ ] Weekly [ ] Quarterly [ ] Monthly [ ] occasional	Name(s)
Competition	[ ] Yes [ ] No	Name(s)

**V.- MEDICAL QUESTIONARY**

For each one Insured

Suffered Illness before or present	Date	Frequency of suffer, diagnosis, treatment, result and grade of recuperation	Name(s)
<input type="checkbox"/> High Blood or coronary arteries affections			
<input type="checkbox"/> Dyspnea			
<input type="checkbox"/> Tuberculosis			
<input type="checkbox"/> Pleurisies			
<input type="checkbox"/> Gotha			
<input type="checkbox"/> Rheumatism			
<input type="checkbox"/> Vertigoes, convulsions or dismays			
<input type="checkbox"/> Epilepsies			
<input type="checkbox"/> Mental Illness or del nervous system			
<input type="checkbox"/> Diabetes			
<input type="checkbox"/> Albumin, glucose or blood in urine			
<input type="checkbox"/> Tumors or cancer			



<input type="checkbox"/> Ulcers			
<input type="checkbox"/> Neurasthenia			
<input type="checkbox"/> Syphilis o gonorrhea			
<input type="checkbox"/> Asthma or Hay fever			
<input type="checkbox"/> Hernia			
<input type="checkbox"/> Suspenders			
<input type="checkbox"/> Varicose veins			
<input type="checkbox"/> Phlebitis			
<input type="checkbox"/> Physical defect			
<input type="checkbox"/> Pregnancy complications			
<input type="checkbox"/> Heart			
<input type="checkbox"/> Lungs			
<input type="checkbox"/> Stomach			
<input type="checkbox"/> Bowels			
<input type="checkbox"/> Appendix			
<input type="checkbox"/> Rectum			
<input type="checkbox"/> Liver			
<input type="checkbox"/> Vesicle			
<input type="checkbox"/> Prostate			
<input type="checkbox"/> Nose			
<input type="checkbox"/> Throat			
<input type="checkbox"/> Spine			
<input type="checkbox"/> Ear			
<input type="checkbox"/> Eyes			
<input type="checkbox"/> Kidneys			
<input type="checkbox"/> Bones and articulations			
<input type="checkbox"/> Female breasts and organs			
<input type="checkbox"/> Surgery			
Pregnancy			
RX			
Electrocardiograms			
Others			