MEDICAL EXPENSE INSURANCE
INDIVIDUALS AND FAMILY INSURANCE APPLICATION

I.- APPLICANT PERSONAL INFORMATION

1.1.- Full Name (person or entity): _____

1.2.- Home Adress:

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.- Employer Company: _____

1.8.- Activity or Field of the Entity: _____

1.7.- Other occupations: _____

II.- INSURANCE INFOTMATION

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.- 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

IV.- 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	

V.- 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)

VI.- MEDICAL QUESTIONARY

Declare por cada Asegurado

Suffered Illness before or present	Date	Frequency of suffer, diagnosis, treatment, result and grade of recuperation	Name
☐ High Blood or coronary arteries affections			
☐ Dyspnea			
☐ Tuberculosis			
☐ Pleurisies			

☐ Gotha			
☐ Rheumatism			
☐ Vertigoes, convulsions or dismays			
☐ Epilepsies			
☐ Mental Illness or del nervous system			
☐ Diabetes			
☐ Albumin, glucose or blood in urine			
☐ Tumors or cancer			
☐ Ulcers			
☐ Tuberculosis			
☐ Pleurisies			
☐ Gotha			
☐ Hernia			
☐ Suspenders			
☐ Varicose veins			
☐ Phlebitis			
☐ Physical defect			
☐ Pregnancy complications			
☐ Heart			
☐ Lungs			
☐ Stomach			
☐ Bowels			
☐ Appendix			
☐ Rectum			
☐ Liver			
☐ Vesicle			
☐ Prostate			
☐ Nose			
☐ Throat			
☐ Spine			
☐ Ear			

☐ Eyes			
☐ Kidneys			
☐ Bones and articulations			
☐ Female breasts and organs			
☐ Surgery			
Pregnancy			
RX			
Electrocardiograms			
Others			

V.- 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 whish 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: _____