APPLICATION FOR MEDICAL INSURANCE

Applicant full name	الاسم الكاملا
Expected date of entry	تاريخ الدخول المتوقع
P.O.BOX	صندوق البريد
City where you live in Canada	اسم المدينة الذي تسكن بها في كندا
Zip code	الرمز البريدي
Email address	البريد الالكتروني
Your mobile #	رقم الجوال
Your passport #	رقم الجواز
Date & place of birth	تاريخ و مكان الميلاد
Gender	الجنس : -- ذكر -- انثى
Are you currently admitted to hospital or receiving emergency medical treatment? -----Yes ------NO	هل هناك حالة تنويم في المستشفى حاليا او تتلقى علاج الطوارئ؟ نعم ----- لا------
Have you been in an accident that caused permanent injury of disability? -----Yes ------No	هل تعرضت لحادث أدى الى اصابتك بعلة او اعاقة؟ نعم----- لا-----
Do you have any congenital disorders ? -----Yes ------NO	هل لديك حالات ضعف او تشوه؟ نعم ----- لا -------
Are you pregnant -----Yes ------NO If yes how many months	هل يوجد حمل : نعم -------- لا------- اذا كان الجواب نعم كم عدد اشهر الحمل

***Fees for insurance will vary according to health,age, type & visa validity & duration of stay in SA**

*** رسوم التأمين تعتمد حسب الحالة الصحية ـ العمر – مدة الاقامة و صلاحية التأشيرة**

Note that there is no cancelation or refund once the documents are received and processed by our office. This office is not responsible for any loss, damage, negligence or delays in issuance of visas due to circumstances and causes beyond its control due to an act of any other party. The applicant must acknowledge that the decision to have the visa granted or denied is to the discretion and decision of the embassy applying for. If visa is denied our office will not endure expenses or refunds, responsibility, liability for rejection, loss or damage. Applicant acknowledges the responsibility for the information provided & accepts all fees required.

The information you provide is only shared with the authority you are appointing and will be kept confidential.

The form will only be accepted if it is fully completed , dated and signed

DATE: SIGNATURE: _____