Star Visa SERVICES

Medical Insurance order form.

Expected Entry Date	City	E-mail Address	Address	Post Code	Mobile No

Main Beneficiary

Please answer the following questions:

Date of Birth:	Gender:		
➢ Are you currently admitted to hospital or receiving emergency medical treatment? ➢ Have you been in accident that caused permanent injury or disability? ➢ Do you have any congenital disorders? ➢ Are you pregnant? ➢ Is your current pregnancy an outcome of assisted means of conception including but not limited to (IVF, hormonal induction)? ➢ Number of pregnancy Months?		☐ yes ☐ yes ☐ yes ☐ yes ☐ yes	☐ no ☐ no ☐ no ☐ no ☐ no

Full name: _____

Signature: _____

Date: _____

Please note that Star Visa Services will obtain the medical insurance on your behalf.