Global Plans
Plans created by William Russell

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DUBAI INSURANCE

Global Health Plans

Employee Application Form (Full Medical Underwriting)

Please complete this form in **BLOCK CAPITALS** using black ink, and return it to us by email, fax or post. You can find our contact details at the end of this form.

Your employment details

Employer: ..... Group plan number: .....

Date you started working for your employer: .....

Your personal details

First name: ..... Surname: ..... Title: .....

Address: .....

.....

Telephone number: ..... Mobile number: .....

Email: ..... Occupation: .....

Date of birth: ..... Nationality: ..... ☐ Male ☐ Female

Emirate where you will be living/working: ..... How long have you lived here? ..... years

Passport number: ..... Emirates ID number: .....

UID number (found on visa): .....

Dependants to be included

Please enter details of all dependants to be included in the plan. You may include your spouse or partner and your unmarried children (i.e. your son, daughter, step-son, step-daughter, adopted children and children subject to legal guardianship) provided the unmarried children are aged less than 18 years old, or less than 25 years old if in continuous full-time education. Children aged 18+ and not in full-time education must complete their own application form.

	Spouse	Child 1	Child 2	Child 3
First name				
Surname				
Date of birth				
Gender				
Relationship to you				
Country where they will be living				
Occupation				
Passport number				
Emirates ID number				
UID number (found on visa)				

Is your occupation and the occupation of your spouse 100% office-based? ☐ Yes ☐ No

If NO, please provide a job description, or full details of any non-office-based activities and how often they are participated in:

.....

Do you or your spouse participate in any hazardous activities? ☐ Yes ☐ No

If YES, please provide full details of any hazardous activities and how often they are participated in:

.....

If your employer's plan includes the personal accident optional benefit, this does not cover accidents as a result of hazardous activities/occupations. Cover for hazardous activities/occupations may be subject to a premium loading, special terms, or we may decline to offer cover.

Hazardous activities include off-piste skiing, scuba diving to a depth of more than 30 metres (or any unsupervised scuba diving), rock climbing or mountaineering, pot-holing, hang-gliding, parachuting (including tandem), bungee jumping, kite surfing/windsurfing, hunting on horseback, driving or riding in any kind of race or competition, flying other than as a passenger in a commercial aircraft, riding a motorcycle (or riding pillion), motor scooter, moped or quad bike, or any other activity that places you in a similar degree of danger as any of those mentioned here.

Previous/current insurance

Have you, or any persons named on this form, ever:

1. **Applied for a plan or been insured with either Dubai Insurance Company or William Russell?** ☐ Yes ☐ No

If YES, please state the plan number: ..... Date of expiry of plan: .....

2. **Had an application for insurance declined or accepted with special terms, or had an insurance policy cancelled by any insurance provider?** ☐ Yes ☐ No

If YES, please provide details: .....

3. **Are you currently insured with another health insurer?** ☐ Yes ☐ No

If YES, please provide details: ..... Date of expiry of plan: .....

Health declaration

Your Global Health plan will be underwritten on a full medical underwriting basis. Please complete the following health declaration and provide us with full details of any medical conditions existing before the start date of your plan. This includes conditions arising between the time you submit this application and the start date of your plan, so please contact us immediately if the information provided changes.

Please answer the following questions for each person named on this form fully, accurately, and to the best of your knowledge and belief. If you answer YES to any question, please supply full details in the spaces provided.

If you do not answer the questions fully and accurately, your plan may be cancelled, claims may be rejected, or special terms may be applied retroactively. If you are in any doubt as to whether you should tell us anything, please tell us anyway.

Please complete the following table for yourself, your spouse, and any dependants over age 18 only:

	You	Spouse	Dependants over age 18
Height (cm)			
Weight (kg)			
If you smoke, how many cigarettes/cigars do you smoke daily?			
If you consume alcohol, how many of the following do you consume each week? • *Pints of regular-strength beer or cider* • *Pints of strong beer or cider* • *175ml glasses of wine* • *250ml glasses of wine* • *35ml measures of spirits*			

Medical questions for EACH person to be insured

① Has any person named on this form <u>ever</u> suffered from any of the following conditions?

a) **Brain or nervous system conditions?** ☐ Yes ☐ No
For example: stroke/transient ischemic attack (TIA), epilepsy, migraines or repeated headaches, multiple sclerosis, meningitis, shingles, nerve pain.

b) **Cancer, tumours or growths?** ☐ Yes ☐ No
For example: polyps, benign growths or cysts, lymphomas, any cancers or pre-cancerous conditions.

c) **Heart or circulatory conditions?** ☐ Yes ☐ No
For example: high blood pressure, angina/chest pains, heart attacks or failure, abnormal heartbeat, varicose veins, raised cholesterol, stroke, deep vein thrombosis.

d) **Psychiatric or psychological conditions, drug & alcohol issues or sleep disorders?** ☐ Yes ☐ No
For example: depression, anxiety, stress, anorexia nervosa, autism, bipolar disorder, insomnia, narcolepsy, sleep apnoea, alcohol or drug dependency.

e) **Joint replacements?** ☐ Yes ☐ No

② **In the last <u>five</u> years, has any person named on this form seen a physician, or experienced any symptoms, or been admitted to a hospital or medical facility for an operation or procedure, or undergone any tests or investigations, for any of the following conditions:**

a) **Auto-immune disorders?** ☐ Yes ☐ No
For example: HIV/AIDS, rheumatoid arthritis, systemic lupus erythematosus, scleroderma.

b) **Back, joint, muscular or skeletal problems?** ☐ Yes ☐ No
For example: back or joint pain, whiplash, sciatica, degenerative changes, osteoarthritis, osteoporosis, gout, bunions, fractures, cartilage or ligament problems.

c) **Breathing or respiratory conditions (including allergies)?** ☐ Yes ☐ No
For example: asthma, chronic obstructive pulmonary disease (COPD), shortness of breath, chest infections, pneumonia, bronchitis, tuberculosis (TB), hay fever, allergies to food substances and animals.

d) **Diabetes, thyroid or any other endocrine disorder?** ☐ Yes ☐ No
For example: diabetes type 1 or 2, overactive or underactive thyroid, pituitary or adrenal problems, obesity.

e) **Eyes, ear, nose and throat or oral/dental conditions?** ☐ Yes ☐ No
For example: glaucoma, cataracts, retinal detachment, macular degeneration, hearing difficulties, repeated ear infections, tonsillitis, sinusitis, dental problems, wisdom teeth problems, gingivitis.

f) **Gynaecological or breast conditions?** ☐ Yes ☐ No
For example: complications of pregnancy, heavy or irregular periods, fibroids, endometriosis, ovarian cysts, abnormal smear tests, miscarriage, pre- and post-natal complications, breast lumps/cysts.

g) **Skin conditions (including allergies)?** ☐ Yes ☐ No
For example: eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed or allergic reactions.

h) **Stomach, liver/gall bladder, or digestive system conditions?** ☐ Yes ☐ No
For example: ulcers, irritable bowels, Crohn's disease, colitis, reflux/heartburn abdominal pain, anaemia, hepatitis, cirrhosis, gallstones, hernias, haemorrhoids/piles.

i) **Urinary, kidney or prostate conditions?** ☐ Yes ☐ No
For example: kidney infections, kidney stones, incontinence, prolapse, prostate problems, recurrent bladder or urine infections.

j) **Any alcohol and/or drug dependency problems?** ☐ Yes ☐ No

k) **Any physical defect, infirmity or congenital condition?** ☐ Yes ☐ No

l) **Any other medical condition not mentioned above?** ☐ Yes ☐ No

③ **Is any person named on this form currently taking any medication, prescribed or otherwise?** ☐ Yes ☐ No

④ **Has any person named on this form experienced any signs or symptoms of any medical condition in the last six months, whether or not a physician has been consulted?** ☐ Yes ☐ No

⑤ **Is any person named on this form currently undergoing any treatment or periodic reviews for a medical condition, physical impairment, disability or recurrent illness not already mentioned?** ☐ Yes ☐ No

⑥ **Is anyone named on this form currently pregnant?** ☐ Yes ☐ No

If you have answered YES to any of the above questions, please give full details

Question #: ..... Name of person affected by the illness/injury/condition: .....

Date(s) on which the illness/injury/condition occurred: ..... Date symptoms were last suffered: .....

What diagnosis was made and what treatment was received: .....

.....

.....

Is any future treatment required, including consultations with a physician and/or periodic tests or reviews? ☐ Yes ☐ No

If YES, please give details: .....

Please provide the name and address of the treating physician: .....

Question #: ..... Name of person affected by the illness/injury/condition: .....

Date(s) on which the illness/injury/condition occurred: ..... Date symptoms were last suffered: .....

What diagnosis was made and what treatment was received: .....

.....

.....

Is any future treatment required, including consultations with a physician and/or periodic tests or reviews? ☐ Yes ☐ No

If YES, please give details: .....

Please provide the name and address of the treating physician: .....

If you require more space, please continue on a separate sheet of paper. If you are attaching any supporting medical documents, please note that we can only accept them in English.

Physician's details

Please provide details of the physician who is most familiar with the medical history of all those named on this form. If any dependants regularly see a different physician, please provide this information on a separate piece of paper.

Name of physician: .....

Address: .....

Telephone number: ..... Email: .....

How long have you been known to this physician? .....

How we use your information

By submitting this application, you consent to Dubai Insurance Company psc. processing the personal data of each person named in this application, including sensitive medical information. We will use this data for the purposes of administrating your plan and processing your claims.

In certain cases, it may be necessary to pass your data to the insurers and reinsurers of your plan, cost control agents, banks, third party administrators, your employer's appointed intermediary (if any), and our emergency assistance service providers. If required, we will pass your data to legal or regulatory bodies, and to relevant parties in the interests of fraud prevention.

We may share your data (but not sensitive personal data) with external feedback service providers, to enable you to provide feedback about our services to an independent organisation.

Declaration for your Global Health plan

Please read this section carefully and sign below.

I understand that this application is subject to written acceptance by Dubai Insurance Company psc. I declare that I have taken reasonable care to answer all questions for each person named on this form fully, accurately, and to the best of my knowledge and belief. I confirm that I have checked with each person that the information I have provided is a true representation of the facts.

I understand that misrepresentation could result in claims being rejected or not fully paid, and/or membership to my plan being cancelled. I also understand that my Certificate of Insurance will advise me of any special terms based on the information provided on this form.

I understand that if I leave my current employment my eligibility to this group plan will no longer be valid, therefore my cover on the plan will cease with immediate effect. I understand that if I wish to take out an individual plan with Dubai Insurance Company psc., I may need to reapply, and new terms may be issued.

I understand that I must inform Dubai Insurance Company psc., in writing, of any changes in the facts provided in this application, including any change in health of any persons named on this form occurring before the start date of my plan.

I give consent on behalf of myself and each person named on this form for Dubai Insurance Company psc. to process our personal data within the provisions of the Data Protection Law 2007. I confirm that I have brought the data protection notice above to the attention of each person named on this form.

I understand that, to process my claims, Dubai Insurance Company psc. may need to obtain details of my medical history or of persons named on this form.

I authorise Dubai Insurance Company psc. to send all insurance documents as PDF files to the email address I have provided on this form. If my employer has appointed a broker or intermediary, I give consent for these documents to be sent via email to that broker or intermediary.

I understand that telephone calls to and from Dubai Insurance Company psc. may be recorded and monitored.

Important notes

Your completed application form is valid for 28 days from the date you signed the form. If cover has not commenced within 28 days, we reserve the right to request that you complete a new application form. If the health of any person named on this form changes after you submit this form, but before your plan starts, you must let us know immediately. We are unable to accept electronic signatures below.

Please provide the following documentation with your application:

- A separate Application for Neuron Services Form (appended to this form)
- Completed DHA Excel spreadsheet for all insured persons
- Photographs in JPEG format of each person named in this application

Name of applicant: .....

Signature of applicant: ..... **Date:** .....

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