Global Plans
Plans created by William Russell

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DUBAI INSURANCE

Global Health Plans

Individual Application Form

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.

Broker/intermediary details

If you were introduced to us by an intermediary or broker, please state their name, company and PHIR number.

Name of broker: ..... Name of company: ..... PHIR no.: .....

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 your 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)				

Start date required

When would you like your Global Health plan to start?

☐ On acceptance of your application ☐ Specific date: .....

Please note that your application is only valid for 28 days from the date we receive it. Cover cannot be backdated.

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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: .....

Choose your health insurance plan

Please choose a **health plan**, then select the **optional benefits** you require. If you have one, please state the quote illustration ID for the quote you wish to accept: .....

Choose your plan

☐ **Elite Silver** ($15 or AED55 excess per visit) ☐ **Elite Gold** ($15 or AED55 excess per visit)

Neuron medical network required

☐ **Comprehensive** (widest network of medical facilities) ☐ **General Plus** (excludes some of the more expensive facilities)

Optional benefits available with the Elite plans

☐ **Medevac plus**

☐ **Dental plus** – available with Silver only if Dental basic is also selected, and on Gold.

☐ **Dental basic** – only available with Silver.

Choose your Elite Area of Cover

☐ **Area One** Worldwide cover, excluding the USA.

☐ **Area Two** Worldwide cover, with cover in the USA limited to $100,000 during temporary trips of not more than 45 days. This limit is increased to $250,000 for unforeseen emergency treatment.

☐ **Area Three** Worldwide cover, with cover in the USA limited to $250,000 during temporary trips of not more than 90 days.

Add-ons available with your health insurance plan

GLOBAL TRAVEL PLAN ☐ You ☐ Spouse ☐ Family

GLOBAL PERSONAL ACCIDENT PLAN ☐ You ☐ Spouse

Please answer the following questions ONLY if you have opted for Personal Accident cover. If you have opted for cover for your spouse, we also require details of their occupation and any hazardous activities they undertake.

Please select the level of Personal Accident benefit you require:

☐ $75,000 or AED275,250 ☐ $150,000 or AED550,500 ☐ $225,000 or AED825,750

☐ $300,000 or AED1,101,000 ☐ $375,000 or AED1,376,250

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:

.....

The Global Personal Accident plan 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.

Paying for your plan

Please select the currency in which you would like to pay your premiums:

☐ US Dollars ☐ UAE Dirhams

Your plan benefits and excess will be denominated in the currency in which you pay your premiums.

Please select your payment method and frequency:

Bank transfer ☐ Annually

Cheque ☐ Annually (payable to Dubai Insurance Company psc., drawn on a UAE bank account)

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 ever 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 five 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 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 declare that I have provided full details of medical conditions existing before the start date of my plan for all persons named on this form. I understand that misrepresentation could result in claims being rejected or not fully paid, and/or 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 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 I have applied through 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.

I understand that, upon receipt of my insurance documents, if I am not entirely satisfied, I can cancel my application from inception and receive a full refund of the premium paid, provided I notify Dubai Insurance Company psc. within 30 days of the plan start date, and provided no claim has been made.

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:** .....

Global Plans Team
Dubai Insurance Company,
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DUBAI INSURANCE

Global Health Plans

Application for Neuron Services

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.

Important information about the Neuron claims service

Neuron LLC administers the claims service for the Global Health plans. All insured persons receive a network membership card from Neuron, which allows them to receive eligible treatment from the medical facilities in Neuron's extensive network. By eligible treatment, we mean treatment covered under the Global Health plans, subject to any applicable benefit limits.

When an insured person presents their network card to a medical facility within their chosen Neuron network, the medical facility will request a form of identification in order to verify that the person is indeed insured. Once verified, the medical facility will only ask the insured person to pay the excess amount displayed on the network card. Treatment will be provided without the insured person having to make any other form of payment. The bill for the medical treatment will be sent straight to Neuron, who will settle directly with the medical facility.

Neuron is obliged to settle all bills received from medical facilities within their network. This means that insured persons have an obligation only to use their network card for eligible treatment covered under their Global Health plan. If an insured person is in any doubt about what is eligible, they should contact Neuron or our Claims Team before they receive treatment. It is very important that you and all insured persons understand the obligations of using the Neuron claims service.

Lost network cards

If an insured person's network card is lost or stolen, we will apply a charge of AED 25 for providing a replacement.

If you wish to cancel your Global Health plan

If you wish to cancel your Global Health plan, you must return to us the network cards belonging to you and your dependants. We will only cancel your cover from the date on which you return your network card(s) to us. We can accept torn copies of the Neuron cards. The cards need to be sent to us by mail in order for us to proceed with your cancellation of cover. Our address can be found at the end of this form.

Upon receipt of the network cards, we will confirm whether any claims have been made against your plan. No refund will be made in respect of unused premium if any insured person has made a claim against the policy. A *pro rata* refund will be paid in respect of unused premium only if no insured persons have made a claim against the policy. The refund will be paid only when all network cards have been returned.

When an insured person claims for treatment not covered by your plan

When an insured person presents their Neuron network card for a treatment or service that is not covered by your Global Health plan, you will be liable for any costs incurred. For example, this situation could arise if an insured person uses their network card to pay for the treatment of a medical condition that is not eligible for benefit under your Global Health plan, or if the treatment costs incurred exceed any applicable benefit limits.

As soon as we are made aware of an ineligible claim, we will write to you and ask you to repay to us the ineligible costs.

If you fail to repay those ineligible costs, or if one of your dependants makes more than one ineligible claim, we will require immediately your network card and those of your dependants. Future claims must be submitted to our Claims Team for consideration.

Requirement for photographic identification

To produce network cards, we require a photograph of each insured person to be displayed on their card. Please submit a photograph for each insured person in JPEG format. We are unable to issue any network cards until we have received all photographs. Insured persons will not have access to the Neuron direct billing networks until this is done. In submitting these photographs, you give us permission to reproduce the images on the respective network cards.

Declaration

I hereby apply for membership of my chosen Neuron network. I understand that I must submit a photograph of each insured person in JPEG format, and this photograph will be displayed on each insured person's network card. I understand that my Global Health plan cannot commence until Dubai Insurance Company psc. has received photographs for all insured persons.

We fully understand the important information provided above about the Neuron claims service, and in particular that I will be liable for any ineligible claims submitted to a medical facility in the Neuron network. I agree to indemnify Dubai Insurance Company psc. in respect of such ineligible claims.

I understand that any credit issued by Dubai Insurance Company psc. in respect of any premium refund should I wish to cancel my plan will be calculated from the date that all network cards are received by Dubai Insurance Company psc.

I will ensure that all insured persons are fully aware of the benefits covered under the Global Health plan, as well as all treatments and conditions that are not covered, or which are subject to certain limits, to avoid incorrect claiming on their network cards.

Name of applicant: ..... **Plan number:** .....

Signature: ..... **Date:** .....

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