

Global Protection Plans

Employee 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.

Employment details

Employer:

Employer's address:

.....

Date you started working for your employer:

Employee's details

First name: Surname: Title:

Address:

.....

Telephone number: Mobile number:

Email:

Date of birth: Nationality: Male Female

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

Previous/current insurance

1. Have you ever applied for a plan or been insured with either Dubai Insurance Company or William Russell?

Yes No If YES, please state the plan name and/or number: Date of expiry of plan:

2. Have you ever 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:

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3. Do you currently have any other life, accident or income protection insurance? Yes No

If YES, please provide details (name of insurer, amount of cover, type of insurance, etc.):

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Your occupation & any hazardous activities

Occupation: Industry:

Please state your current annual earnings, including currency:

Is your occupation 100% office-based? Yes No

If NO, please provide a breakdown of your ordinary work duties, including the percentage of work time ordinarily spent on each duty:

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Do you ever work offshore? (e.g. in the air, on water, underwater, on oilrigs) Yes No

If YES, please give full details:

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Does your work require a license which depends on your state of health? Yes No

If YES, please give full details:

Do you ever participate in hazardous activities? Yes No

If YES, please give full details of any activities and how often you participate in them:

The cover afforded by your Global Protection plan may be affected if your occupation is not 100% office-based or if you participate in hazardous activities. Cover for higher risk occupations or hazardous activities may be subject to a premium loading and/or special terms. We reserve the right to decline cover depending on your occupation and activities.

Hazardous activities include (but are not limited to) off-piste skiing, scuba diving to a depth of more than 30 metres, unsupervised scuba diving of any kind, rock-climbing or mountaineering, potholing, hang gliding, parachuting, bungee-jumping, hunting on horseback, driving or riding in any kind of race or competition, flying (other than as a passenger on a commercial aircraft), riding on motorcycles, mopeds or moto scooters (even as pillion), or any other activity which has a similar degree of danger as any of those mentioned here. If you are uncertain about whether an occupation is higher risk or whether an activity would be classed as hazardous, please provide the information as requested and we will confirm if we require anything further.

Beneficiary nomination

Your Protection plans are subject to the law of Dubai. You are strongly advised to consider completing the below table if you wish to avoid the possibility that any Death benefit payable might be distributed in accordance with the inheritance laws of Dubai, applicable if no beneficiary has been nominated and based on the Sharia law of inheritance.

I hereby nominate the following person(s) as beneficiary of the Global Life and Global Accident plans in the event of my death:

Full name	Address	Relationship to insured person	% of benefit to be paid

If one or more of the above beneficiaries is no longer living at the time of your death, we will divide the proceeds of your benefit among the surviving beneficiaries accordingly. If this is not your wish, or if you would like to appoint an alternative beneficiary in the event of the death of an above beneficiary, please state your wishes here:

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Health Declaration

IMPORTANT NOTE:

We rely on the information you give us in the form to decide whether or not we can accept your application, and if so, whether or not we need to apply any special terms to your cover, such as personal medical exclusions or loadings.

Please complete the following Health Declaration and provide us with full details of any medical conditions. **Medical conditions and related conditions will not be covered by your plan**, unless you have told us about them and we have agreed to cover them.

Please answer the following questions 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 there is insufficient space please continue on an additional sheet of paper.

If, after you have submitted the application, we find that you have not answered 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 as it better to provide information that turns out not to be relevant to the risk than to miss out something that causes problems later.

If something changes after you have sent us the form but before we have confirmed your cover has started, you must write in and update us.

Please complete the following table:

What is your height? (cm)			
What is your weight today? (kg)			
Has your weight changed by more than 10 kg in the last 2 years? If YES, please provide details	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you smoked cigarettes/cigars in the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If YES, please give the average number a day
What is your typical weekly alcohol consumption?	Beer, lager or cider up to alcohol 4.5% volume pints	
	Beer, lager or cider alcohol 4.6% volume or more pints	
	Wine 175ml glasses	
	Fortified wine 50ml glasses	
	Spirits 35ml measures	

① **Have you consulted a healthcare practitioner in the last 3 years?** Yes No

If YES, please give full details (please continue on an additional sheet of paper if required):

② **Please answer the following:**

a) **Have you ever tested positive for hepatitis B or hepatitis C, or are you awaiting the results of such a test?**

Yes No

b) **Within the last five years have you been exposed to the risk of HIV infection? (This can be contracted through unsafe sex, intravenous drug abuse, or blood transfusions or surgery undertaken outside Europe)** Yes No

If 2a and/or 2b is answered as YES, please provide full details:

③ **Have you ever suffered from, been diagnosed with, treated or been prescribed drugs for:**

- a) **Auto-immune disorders?** Yes No
For example: HIV/AIDS, rheumatoid arthritis, systemic lupus erythematosus, scleroderma.
- b) **Cancer, growths or tumours?** Yes No
For example: any type of cancer, pre-cancerous conditions, benign growths.
- c) **Back, joint, muscular or skeletal problems?** Yes No
For example: back or joint pain, whiplash, sciatica, degenerative changes, osteoarthritis, osteoporosis, gout, bunions, joint replacements, fractures, cartilage or ligament problems.
- 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) **High blood pressure, cardiac or circulatory conditions?** Yes No
For example: angina/chest pains, heart attacks, abnormal heartbeat, palpitations, varicose veins, strokes, deep vein thrombosis, high cholesterol.
- f) **Breathing or respiratory conditions?** Yes No
For example: asthma, chronic obstructive pulmonary disease (COPD), emphysema.

- g) **Stomach, liver/gall bladder, or digestive system conditions?** Yes No
For example: ulcers, irritable bowels, Crohn’s disease, colitis, reflux/heartburn abdominal pain, liver inflammation, cirrhosis, gallstones, hernias, haemorrhoids/piles.
- h) **Any depression, anxiety of other psychiatric or psychological conditions?** Yes No
For example: anxiety, bipolar disorder, schizophrenia, stress, low mood, depression, eating disorders.
- i) **Any kidney or prostate conditions?** Yes No
For example: chronic kidney disease, raised PSA level.
- j) **Any alcohol and/or drug dependency problems?** Yes No
- k) **Any other medical condition not mentioned above.** Yes No

If you have answered YES to any of the sub-questions in question 3, please give full details

Please continue on a separate sheet if necessary.

Question number	Month/year of onset	Condition and cause if known	Frequency of symptoms	Treatment and medication (please state if ongoing)	Month/year of last symptoms or “ongoing”
				Treating Physician name and address:	
				Treating Physician name and address:	
				Treating Physician name and address:	
				Treating Physician name and address:	

④ **Are you currently pregnant?** Yes No

If YES, please confirm the due date, and details of any non-standard treatment and/or medication you have received, or are continuing to receive:

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⑤ In the last 3 years, have you been told the result of any medical test you have had was abnormal? Yes No

Month/year	What was the test?	What was the reason for it?	Have you had a subsequent test that you have been told was normal?

⑥ Do you have any other signs, symptoms, conditions, disabilities or impairment for which the following apply:

- You are waiting to see a GP or specialist
- You are due to have surgery
- You are waiting to have tests or investigations or to receive the results
- You are still under follow-up by a GP or specialist
- You are on medication prescribed or otherwise
- You routinely use any type of aid except spectacles and lenses

Yes No

Month/year of onset	Condition and cause if known	Duration of symptoms	Treatment and medication (please state if ongoing)	Number of days off work	Month/year of last symptoms

⑦ Additional question for Income Protection applications please answer the following question (not required for life insurance application):

Have you been absent from work for more than 5 consecutive days in the last 5 years, for reasons other than annual leave?

Yes No

If YES, when was each absence period?

From: To: Reason:

From: To: Reason:

Are you fully recovered from the illness/injury that caused each absence? Yes No

If NO, please provide full details:

If you require more space, please continue on a separate sheet of paper.

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 administering 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, and your employer's appointed intermediary (if any). 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 Protection 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 on this form fully, accurately, and to the best of my knowledge and belief.

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 this plan does not cover medical conditions existing before the start date of the plan, or related conditions, unless I have provided full details to Dubai Insurance Company psc and they have agreed to cover it. I also understand that my Certificate of Insurance will advise me of any medical conditions excluded from cover based on information provided.

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 will need to reapply, and new terms will 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 occurring before the start date of my plan.

I give consent for Dubai Insurance Company psc to process my personal data within the provisions of the Data Protection Law 2007.

I understand that, to process my claims, Dubai Insurance Company psc may need to obtain details of my medical history.

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.

I declare that I am actively at work (that is, am consistently working my contracted number of hours, am undertaking my normal duties, and am not working contrary to medical advice).

Important notes

- Any copies of documents, including this form, must be clearly legible when received by us.
- We are unable to accept electronic signatures below.

Name of employee:

Signature of employee: **Date:**