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DUBAI INSURANCE

William Russell

Global Health Plans

Application Form for Individuals & Families (Full Medical Underwriting)

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

Broker/intermediary details

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

.....

Your personal details

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

Address: .....

.....

Mobile number: ..... Home 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 your visa): ..... Is your monthly salary above AED4,000? ☐ Yes ☐ No

Dependants to be included

Please enter details for all dependants to be covered. You may include your spouse and children, provided your children are aged less than 18 years old, or less than 25 years old if in continuous, full-time education. Children aged 18 and over, 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/full-time education				
Passport number				
Emirates ID number				
UID number (found on visa)				

Start date required

When would you like your 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.

Previous/current insurance

1. Has anyone named on this form ever applied for a plan or been insured with Dubai Insurance Company or William Russell?

   ☐ Yes ☐ No

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

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Previous/current insurance (continued)

2. Has anyone named on this form 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: .....

.....

3. Does anyone named on this form currently have any other health insurance? ☐ Yes ☐ No

If YES, please state the name of insurer: .....

Policy number: ..... Policy expiry date: .....

Please select the cover you require

Please choose a health plan, then select the optional benefits you require.

If you have one, please state the quote illustration reference for the quote you wish to accept: .....

Plan:	Excess required:			
Gold	☐ Nil	☐ $15 or AED55 per visit	☐ $30 or AED110 per visit	☐ $50 or AED185 per visit
Silver	☐ Nil	☐ $15 or AED55 per visit	☐ $30 or AED110 per visit	☐ $50 or AED185 per visit

Medical networks available

☐ **General Network Plus** ☐ **General Network excluding Mediclinic City hospital**

☐ **General Network** ☐ **General Network excluding all hospitals/clinics in the Mediclinic Group**

Options available with the health plans

☐ **Medevac Plus**
☐ **Dental Basic** – only available with the Silver plan
☐ **Dental Plus** – only available with the Gold plan, and with the Silver plan **if** Dental Basic is also selected

Your Elite plan area of cover

The standard area of cover for the Elite plans is worldwide excluding the USA. If you require cover in the USA, please select **one** of the options below. Otherwise, we will assume that you require the standard area of cover.

USA cover options

☐ Add cover in the USA, limited to US$100,000 during temporary trips of not more than 45 days (this limit is increased to $250,000 for unforeseen emergency treatment for conditions you have never suffered from before).

Add-ons available with your health plan

Travel plan	☐ You	☐ Spouse	☐ Children
Personal accident plan	☐ You	☐ Spouse	

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

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Add-ons available with your health plan (continued)

You only need to complete the next two questions if you have selected a personal accident plan.

1. 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 activities and how often they are undertaken:

.....

.....

2. 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 undertaken:

.....

.....

.....

The personal accident plan does not cover accidents as a result of hazardous activities/occupations. Cover for hazardous activities and 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. Your plan benefits and excess will be denominated in this currency.

☐ US Dollars ☐ UAE Dirhams

Health declaration

Your 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.

	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/cider • Pints of strong beer or cider • 175ml glasses of wine • 250ml glasses of wine • 35ml measures of spirits			

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Health declaration (continued)

Medical questions for EACH person to be insured

① Has any person named on this form ever experienced 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 upper and lower respiratory conditions (including allergies)?** ☐ Yes ☐ No
For example: asthma, chronic obstructive pulmonary disease (COPD), shortness of breath, chest infections, pneumonia, bronchitis, upper respiratory tract infections, tuberculosis (TB), 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

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Health declaration (continued)

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

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

③ 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

④ Is any person named on this form currently taking any medication, prescribed or otherwise? ☐ 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 YES, have there been any complications to date: .....

.....

⑦ Please state the last menstrual period date for applicable individuals named on this form: .....

.....

⑧ Is anyone name on this form currently trying to get pregnant? ☐ Yes ☐ No

⑨ Is anyone name on this form currently undergoing any form of fertility treatment? ☐ Yes ☐ No

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

Question no: ..... Name of person affected: .....

Date(s) on which the injury or condition first occurred: .....

Date symptoms were last experienced: .....

Please state what diagnosis was made: .....

.....

What treatment was received: .....

.....

.....

Is any future treatment required, including consultations with a physician or periodic tests or reviews?

☐ Yes ☐ No If YES, please give details: .....

.....

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Question no: ..... Name of person affected: .....

Date(s) on which the injury or condition first occurred: .....

Date symptoms were last experienced: .....

Please state what diagnosis was made: .....

.....

What treatment was received: .....

.....

.....

Is any future treatment required, including consultations with a physician or periodic tests or reviews?

☐ Yes ☐ No If YES, please give details: .....

.....

.....

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 only accept them in English.

Your 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 of your dependants regularly see a different physician, please provide this information on a separate piece of paper.

Name of physician: ..... Title: .....

Address: .....

.....

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

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

Marketing communication preferences

We would like to stay in touch with you in ways we think you might find helpful. Every now and then we would like to share information about the expat lifestyle plus other useful content we think could be of interest to you, like promotions for products and services. These could include being contacted by email or by phone. We won't spam you or share your details with anyone else and you can unsubscribe at any time.

Please tick the box to opt into our marketing communications:

☐ Email
☐ Newsletter
☐ Phone
☐ Text/SMS
☐ No thank you (no direct marketing allowed)

We value your privacy and will never sell your data on to third parties. You can read our full privacy policy here.

How we use your information

Please read this section carefully.

- We will use the information that you have given us on this application form for the purposes of administering your plan, processing your claims, identifying and preventing fraud, complying with our legal and regulatory obligations, and carrying out research and statistical analysis to help us improve our services. We will not retain your information for longer than is necessary.
- We may share your information with other organisations in relation to the above purposes, e.g. the insurer of your

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How we use your information (continued)

plan, payment service providers, and our emergency medical assistance service providers.

- Telephone calls to and from Dubai Insurance Company may be recorded for training and monitoring purposes.
- We will process the personal information of each person named on this form, including sensitive information such as details about your/their health, in accordance with our privacy policy.
- Our privacy policy also contains information about who to contact if you have any questions about how we use your information, or if you would like to request a copy of the information we hold about you. For full details of our privacy policy, please visit globalplans.ae/privacy or consult your plan agreement

Declaration for your plan

Please read this section carefully and sign below.

- I understand that my application for a health plan is subject to written acceptance by Dubai Insurance psc.
- I declare that I have taken reasonable care to answer every question for all persons named on this form fully, accurately, and to the best of my knowledge and belief. I also 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 my plan being cancelled.
- I understand that I must inform Dubai Insurance psc., in writing, of any changes in the facts provided in my application, including any change in health of any persons named on this form, occurring before the start date of my plan.
- In order to process my claims, I understand that Dubai Insurance psc. may need to obtain details of my medical history and the medical histories of all persons named on this form.
- I authorise Dubai Insurance plc. 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 understand that these documents may be sent via email to that broker or intermediary.
- 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 psc. within 30 days of the plan start date, and provided no claim has been made.
- I understand and acknowledge any pregnancy not declared at the time of this application's coverage will be at the sole discretion of the insurer. The insurer has the right to not cover any maternity claims to any undeclared pregnancy. I also acknowledge and understand any pregnancy, which arises within forty calendar days from the date of this application; coverage will also be at the discretion of the insurer

Some important notes

Please make sure that this form and all supplementary documents are legible. Your completed application form is valid for 28 days from the date you signed the form. If cover has not commenced within 28 days, you may have to complete a new form. If the health of any person named on this forms 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.

Name of applicant: .....

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

Global Plans Team
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