Proposal Form

Individual & Family Healthcare Insurance

Please complete this form using BLOCK CAPITALS and by ticking the relevant items.
Kindly enclose Passport copies and photographs of the members to be insured.

1.	Client Details			
A.	Name	First Name:		
		Last Name:		Ms. ☐ Mrs. ☐ Mr. ☐
B.	Nationality		Date of Birth (dd/mm/yyyy)	
C.	Company		Designation:	
		Building:		
D.	Address	Street:		
		PO Box:	City:	Emirates:
E.	Contact Number	Mobile:	Tel:	
F.	Email			

2.	Existing or Previous Medical Insurance			
	Do you currently have medical Insurance?		Yes ☐ No ☐	OIC ☐ Others ☐
	Policy number		Expiry Date	

3. Additional Family Members to be Covered

Title	Name	Nationality	Relationship (wife/husband/son/Daughter)	Date of Birth DD/MM/YYYY	Passport No	Living In	Visa Issued in

4. Select your Plan

UAE Only		GCC & SE ASIA	World Wide (Excl. USA & Canada)		World Wide (Incl. USA & Canada)	
Restricted ☐	Comprehensive ☐					
Plan 1 ☐	Plan 2 ☐	Plan 3 ☐	Plan 4 ☐	Plan 5 ☐	Plan 6 ☐	Plan 7 ☐

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5. Medical History

Declarations must be made in writing on this application. Verbal declarations will not be accepted.

	Applicant	Member 1	Member 2	Member 3	Member 4
Name					
Height (cm)					
Weight (kg)					
Any symptoms of Discomfort experienced during the past 2 years	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Nature of symptoms /discomfort/medical conditions					
Nature of treatment received					
When did it start?					
How long did it last?					
Need for any further treatment	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Present state of health					
Any diagnosed medical conditions during the past 5 years?					
Nature of symptoms/discomfort/medical conditions					
Nature of treatment received					
When did it start?					
How long did it last?					
Need for any further treatment	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Present state of health					

- If there is any medical condition falling outside the 5 years period mentioned, in such cases you should declare it in good faith.
- Please give details overleaf.
- Please continue on a separate sheet if necessary for further detailed information.
- If you answered yes to any of the questions mentioned above, please provide us with the latest medical report for the related medical condition

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6. Medical Practitioner(s) Most frequently used in the last 5 years

Name			
Address	Building:		
	Street		
	PO Box:	City	Emirates:
Contact Number	Tel:		

7. Declaration

I hereby declare that to the best of my knowledge and belief the above particulars are true and complete and full information has been disclosed. I understand that non-disclosure or misrepresentation of any fact may lead to the refusal of any claim or the cancellation of any policy

I hereby authorize the giving of (a) medical information from my doctor and any doctor who has at any time attended and (b) information from any life / health assurance office to which a proposal on my life has at any time been made.

I hereby agree that this proposal and declaration or any written statement made by me in reference to the proposal shall be the basis of the contract between the Company and me.

Date		Proposer's Signature	

8. Declaration Continued

Signature