

EMPLOYEE APPLICATION FORM (UNDERWRITTEN)

Please complete this form in block capitals using black ink



GLOBAL HEALTH®
Health Insurance for Expatriates



دبي للتأمين
DUBAI INSURANCE

SECTION 1: TO BE COMPLETED BY THE EMPLOYER

EMPLOYER/EMPLOYEE DETAILS

Employer:	Group no:
Employee name:	Mr/Dr/Mrs/Ms/Miss
Date of employment:	

GLOBAL HEALTH ESSENTIAL PLAN REQUIRED

- Essential Care Essential Care Plus

Optional benefits required:

- Dental care cover: \$500/AED1,835 with 25% co-insurance, or \$250/AED917.50 with 25% co-insurance
Maternity care cover: \$5,000/AED18,350 with 20% co-insurance, or \$2,500/AED9,175 with 20% co-insurance

Area of cover:

The Global Health Essential plans are available to expatriates everywhere outside Australia, Canada, the Caribbean, Europe, New Zealand, Orchid countries, and the United States of America. Emergency cover only is provided for unforeseen emergency treatment, covered by your plan, and received during temporary trips of up to 90 days duration to any EU country, Andorra, Australia, Bali, Channel Islands, China, Cyprus, Gibraltar, Greenland, Hong Kong, Iceland, Japan, Liechtenstein, Macau, Monaco, New Zealand, Norway, San Marino, Singapore, Switzerland and Taiwan (up to US\$50,000). No cover is provided for any treatment received in the USA, Canada, the Caribbean, and within the London area.

OR, GLOBAL HEALTH ELITE PLAN REQUIRED

- Bronze Silver Gold Platinum

Optional benefits required:

Available with Bronze and Silver plans:

- Dental care cover: \$500/AED1,835 with 25% co-insurance, or \$250/AED917.50 with 25% co-insurance
Maternity care cover: \$5,000/AED18,350 with 20% co-insurance, or \$2,500/AED9,175 with 20% co-insurance

Available with Gold plan:

- Maternity Plan: Routine maternity care, out-patient complications of pregnancy, childbirth & caesarean delivery \$6,400/AED23,488 with 20% co-insurance. Cover for newborns (first 28 days of life) \$40,000/AED146,800.

Available with Platinum plan:

- Maternity Plan: Routine maternity care, out-patient complications of pregnancy, childbirth & caesarean delivery \$12,000/AED44,040. Cover for newborns (first 28 days of life) \$48,000/AED176,160.

Area of cover required:

- Area One** provides world-wide cover excluding the United States of America.
 Area Two provides world-wide cover, subject to cover in the USA being limited to US\$100,000 during temporary trips of not more than 45 days duration.
 Area Three provides world-wide cover, subject to cover in the USA being limited to US\$250,000 during temporary trips of not more than 90 days duration.
 Area Four provides cover in Africa & the Indian Sub-continent, plus cover for unforeseen emergency treatment, covered by your plan, and received during temporary trips of up to 90 days duration outside Africa & the Indian Sub-continent (up to US\$100,000). No cover is provided for any treatment received in the USA, Canada, the Caribbean, or within the London area.

EXCESS REQUIRED

To view higher excess options, please visit our web site or contact the Global Plans Team at Dubai Insurance Company

- Nil** Standard excess for Essential Care and Bronze. Available for Essential Care Plus, Silver, Gold and Platinum with a 20% loading.
 \$15/AED55 Standard excess for Essential Care Plus, Silver, Gold and Platinum. Not available for Essential Care or Bronze.
 \$30/AED110 Available for Silver, Gold and Platinum with a 5% discount. Not available for Essential plans or Bronze.
 Other (Please state):

OPTIONAL PLANS REQUIRED

Global Travel Who do you require cover for: Employee Partner Whole family

Global Personal Accident Who do you require cover for: Employee Partner

Please select the benefit limit:

\$75,000 / AED275,250

\$150,000 / AED550,500

\$225,000 / AED825,750

\$300,000 / AED1,101,000

\$375,000 / AED1,376,250

NB: The Global Personal Accident plan does not cover accidents arising out of hazardous occupations and hazardous activities. When personal accident benefit cover is required for an employee whose occupation is not 100% office based and/or who participates in hazardous activities of any kind, a detailed job description and/or details of their hazardous activities must be submitted to us. Cover for hazardous occupations/activities may be subject to a premium loading, and/or special terms.

SECTION 2: TO BE COMPLETED BY THE EMPLOYEE

PERSONAL DETAILS

First name: _____ Surname: _____ Mr/Dr/Mrs/Ms/Miss _____

Address: _____

Telephone No (for correspondence): _____ Telephone No (other): _____ Fax No: _____

Email (home): _____ Email (other): _____

Date of birth: _____ Nationality: _____ Male Female

Country of residence: _____ How long have you lived here: _____

Occupation: _____

Do you and/or your partner participate in any hazardous activities? Yes No If Yes, please give full details: _____

PREVIOUS/CURRENT INSURANCE

Have you previously held a policy, or do you currently hold a policy, with William Russell or Dubai Insurance Company? Yes No

Previous/current policy number: _____ Date of expiry of policy: _____

Have you previously been insured, or are you currently insured, with another health insurer? Yes No

Name of Insurer: _____

FAMILY MEMBERS TO BE INCLUDED IN THE PLAN

Please enter the names and details of all dependants for whom cover is required. You may include your partner and children, up to age 18 or up to age 25 if in full-time education - proof will be required. Children aged 18 or over who are not in full-time education must make their own application for cover.

First name(s)	Surname	Date of birth dd/mm/yy	Relationship to applicant	Country of residence	Occupation/ Full-time education
Partner					
Child 1					<input type="checkbox"/> Yes <input type="checkbox"/> No
Child 2					<input type="checkbox"/> Yes <input type="checkbox"/> No
Child 3					<input type="checkbox"/> Yes <input type="checkbox"/> No
Child 4					<input type="checkbox"/> Yes <input type="checkbox"/> No

HEALTH DECLARATION

IMPORTANT

The Global Health plans do not cover the treatment of pre-existing conditions and related conditions. A pre-existing condition means any disease, illness or injury for which you have received medication, advice or treatment, or you have experienced symptoms, whether the condition has been diagnosed or not, at any time before the start of your cover. A related condition is any disease, illness or injury that is caused by a pre-existing condition or results from the same underlying cause as a pre-existing condition.

We rely on the information that you give us in this form when we decide whether or not to accept your application, and whether or not we need to apply special terms. Special terms are exclusions or conditions that we may apply to your cover. If you submit a claim for the treatment of any pre-existing condition or related condition which you omitted to tell us about here or you omit to tell us everything about, we will refuse to pay that claim. We also have the right to declare your Global Health plan void, or we may impose special terms on your plan which will apply retrospectively. Please therefore take the greatest care to ensure that this application form is completed fully and accurately.

If, after completing your application form, any changes occur in the facts contained in the form, such as a change in your state of health or the state of health of any of your dependants, you must tell us in writing about the change, and we reserve the right to decline or accept your application with special terms.

Please give full details about each condition by answering the questions in the following health declaration accurately and in as much detail as possible. Please continue on a separate sheet if necessary. We cannot accept your application if this health declaration is incomplete.

1. **Your height (cms):** _____ **Your weight (kgs):** _____ **Your partner's height (cms):** _____ **Your partner's weight (kgs):** _____

2. Have any persons named in this application ever:

- A. Undergone a surgical operation (including any cosmetic surgery or any refractive laser eye surgery)?..... Yes No
- B. Been a patient in a hospital clinic or sanatorium?..... Yes No
- C. Been advised to have any medical tests or investigations?..... Yes No
- D. Had any abnormal medical test results?..... Yes No
- E. Been tested HIV and /or Hepatitis C positive?..... Yes No
- F. Had an application for insurance turned down or accepted at special terms?..... Yes No

3. Are any of the persons named in this application aware of any symptoms or abnormal signs which may give rise to a claim?..... Yes No

4. Are any persons named in this application currently taking any drugs or medication?..... Yes No

5. Have any persons named in this application ever suffered from, been diagnosed with, treated or prescribed drugs for:

- A. Conditions of the eyes, ears, nose or throat?..... Yes No
- B. Fainting, blackouts or fits?..... Yes No
- C. Any high blood pressure, heart or circulatory conditions?..... Yes No
- D. Diabetes or any other endocrine disorder?..... Yes No
- E. Any rheumatic or arthritic conditions (including gout)?..... Yes No
- F. Any spine, bone, muscle or joint conditions?..... Yes No
- G. Asthma, respiratory, pulmonary or allergic conditions?..... Yes No
- H. Genito-urinary or renal conditions?..... Yes No
- I. Stomach, liver or bowel conditions?..... Yes No
- J. Cysts, tumour or cancer?..... Yes No
- K. Any skin conditions?..... Yes No
- L. Any gynaecological or breast conditions?..... Yes No
- M. Any physical defect, infirmity or congenital illness?..... Yes No
- N. Any nervous, mental or psychiatric condition?..... Yes No
- O. Any alcohol and/or drug dependency problem?..... Yes No
- P. A higher than normal cholesterol level?..... Yes No
- Q. Any neurological conditions, including migraine and/or headaches?..... Yes No
- R. Any other type of disease, injury or medical condition?..... Yes No

6. Has any person named in this application ever suffered from any pre or post natal complications, complications of childbirth or suffered any miscarriage?..... Yes No

If you have answered YES to any question, please give full details below. Please continue on a separate sheet if necessary.

Question No:	Name of person who suffered the illness/injury:
Date(s) on which the illness/injury occurred:	
Diagnosis:	
Treatment/tests performed and results:	
Date you last suffered symptoms or received treatment relating to this condition:	
Name and address of treating physician:	
Give details of any foreseeable need for further consultation or treatment for this condition:	

Question No:	Name of person who suffered the illness/injury:
Date(s) on which the illness/injury occurred:	
Diagnosis:	
Treatment/tests performed and results:	
Date you last suffered symptoms or received treatment relating to this condition:	
Name and address of treating physician:	
Give details of any foreseeable need for further consultation or treatment for this condition:	

Question No:	Name of person who suffered the illness/injury:
Date(s) on which the illness/injury occurred:	
Diagnosis:	
Treatment/tests performed and results:	
Date you last suffered symptoms or received treatment relating to this condition:	
Name and address of treating physician:	
Give details of any foreseeable need for further consultation or treatment for this condition:	

DOCTOR'S CONTACT DETAILS

1. When did the persons named in this application last consult a general practitioner, consultant or medical specialist?

	Applicant	Partner	Child 1	Child 2	Child 3	Child 4
Date						

2. Please give details of the doctor who is most familiar with your medical history and the medical history of your family members.

Name: _____ Practice name: _____

Address: _____

Telephone No: _____ Fax No: _____ Email: _____

Length of time you have known this doctor: _____ If less than two years, please complete question 4.

3. If this doctor does not treat all persons named in this application, please supply additional information.

Name: _____ Practice name: _____

Address: _____

Telephone No: _____ Fax No: _____ Email: _____

Who does this doctor treat? _____

Length of time the patient has known this doctor: _____

4. If you or your family member(s) have known the doctor(s) above for less than two years, please provide details of the previous doctor(s).

Name: _____ Practice name: _____

Address: _____

Telephone No: _____ Fax No: _____ Email: _____

Who did this doctor treat? _____

Length of time the patient has known this doctor: _____

Date of last consultation _____

THE INSURER

The insurer of your Global Health plan will be Dubai Insurance Company psc. The administrator of your plan will be William Russell Limited.

DECLARATION AND AUTHORISATION

I hereby apply for cover on behalf of all the persons named in this application form under my employer's Global Health plan as specified above. I have made a full and complete disclosure about the medical history of each person included in this application and I fully understand that pre-existing conditions as defined in the Global Health plan agreement shall not be covered by the insurance plan. I also understand that I must notify Dubai Insurance Company psc of any changes in the facts contained in this application form, such as a change in the state of health of any person named in it. I authorise any doctor who has ever treated or advised any of the persons named in this application to provide Dubai Insurance Company psc with any information they may require in connection with treatment related to any claim under this plan. I declare that the information given in this application is true and complete.

If my employer has applied for a travel insurance plan, I declare that at the time of purchasing this insurance or at the time of booking any future trip(s), I am aware of no reason why any journey or trip should be cancelled or curtailed or expense be incurred.

Signature of employee:

Date:

Signature of employee's partner:

Date:

Signed on behalf of the employer:

Date:

Position in company:

IMPORTANT:

Please ensure you have given an answer to every question. An incomplete form will delay your application. If after completing, signing and dating your application form any changes occur in the facts you have given us, such as a change in your state of health or in the state of health of any of your dependants, you must tell us in writing about the change, and we reserve the right to decline to accept your application or to accept your application with special terms.

This application form will be valid for 28 days from the date on which it is signed. If cover is not commenced within 28 days, we reserve the right to request that a new application form is completed.



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