

GLOBAL HEALTH EMPLOYEE APPLICATION FORM (MORATORIUM)

Please complete this form in block capitals using black ink



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 ELITE PLAN REQUIRED

Platinum Gold Silver Bronze

Optional benefits required:

Out-patient direct billing in UAE, Bahrain, Kuwait, Oman and Qatar on the Platinum, Gold and Silver plans Available to residents of UAE, Bahrain, Kuwait, Oman and Qatar with a nil or \$15/AED55 excess. Access provided to the Neuron Comprehensive Network.

Available with Silver and Bronze 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

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 in this Area of Cover for any treatment received in the USA, Canada, the Caribbean, or within the London area.**

OR, GLOBAL HEALTH ESSENTIAL PLAN REQUIRED

Essential Care Plus **Essential Care**

NB. Out-Patient direct billing in UAE, Bahrain, Kuwait, Oman and Qatar automatically included on the Essential Care Plus plan for employees resident in these countries on a nil or \$15/AED55 excess. Access provided to the Neuron General Network

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 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.

EXCESS REQUIRED

- Nil** Standard excess for Bronze and Essential Care. Available for Platinum, Gold, Silver and Essential Care Plus with a 5% premium loading.
- \$15/AED55** Standard excess for Platinum, Gold, Silver and Essential Care Plus. Not available for Bronze and Essential Care.
- \$30/AED100** Available for Platinum, Gold and Silver with a 5% discount. Not available for Bronze and Essential plans.
- Other, please state:** _____ To view higher excess options, please visit our web site or contact Dubai Insurance Company psc.

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: _____

Is your occupation, and/or your partner's occupation 100% office based? YES NO

If NO, please provide a job description, and/or provide full details of any activities that are not office based and indicate how often you participate in them:

Do you and/or your partner participate in hazardous activities? YES NO

If YES, please provide a job description, and/or provide full details of any hazardous activities that you participate in, and indicate how often you participate in them:

NB: The Global Personal Accident plan does not cover accidents arising out of hazardous occupations and hazardous activities. Cover for your hazardous occupations/activities may be subject to a premium loading, and/or special terms.

Hazardous Activities include (but are not limited to) off-piste skiing, scuba diving to a depth of more than 30 metres and unsupervised scuba diving, rock-climbing or mountaineering normally involving the use of ropes or guides, pot-holing, hang-gliding, parachuting, bungee-jumping, hunting on horseback, or driving or riding in any kind of race or competition, flying other than as a passenger in a commercial aircraft, riding or pillion on motorcycles, motor scooters or mopeds, or any other activity that places you in a similar degree of danger as any of those mentioned here.

PREVIOUS/CURRENT INSURANCE

Have you previously held a policy, or do you currently hold a policy, with Dubai Insurance Company psc or William Russell Limited? 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

For additional children included on the plan, please supply the information requested above on a separate sheet.

REQUIREMENT FOR PHOTOGRAPHIC IDENTIFICATION

In order to administer claims through the Neuron network, we are required to obtain a photograph of each insured person and to display it on their individual insurance membership card. Please ensure that you submit a photograph of yourself in jpeg format along with this application. We are unable to issue your membership cards until we have received all photographs therefore you will not be able to use the direct billing network until this is done. If you are also applying for cover on behalf of your dependants, please also ensure that you submit a photograph of each of them. In submitting a photograph, you give us permission to reproduce the image on the individual membership card.

PRE-EXISTING MEDICAL CONDITIONS AND RELATED CONDITIONS**IMPORTANT:**

The Global Health plans do not cover the treatment of pre-existing medical conditions and related conditions. A pre-existing medical condition means any disease, illness or injury for which you have received medication, advice or treatment, or for which you have experienced symptoms, whether the condition has been diagnosed or not, any time in the 2 year period before the date on which your Global Health plan starts.

After two years of continuous cover, some pre-existing medical conditions will become eligible for benefit, subject to the terms and conditions of your plan, provided you have not consulted any doctor or medical practitioner for medical treatment or advice (including check-ups), or taken medication, (including injections), or been advised to follow a special diet, or suffered symptoms for that medical condition, or for any related condition, for a continuous period of two years.

Examples of pre-existing conditions that will never be covered include diabetes, hypertension (raised blood pressure), hyperlipidaemia (raised cholesterol levels), ischemic heart disease, cancer, thyroid disease, and auto-immune disorders. If you have suffered from any of these conditions, or any other condition for which it is generally accepted medical advice that it be monitored in any way, then that condition – and any related conditions – will never be covered. Examples of related conditions are raised cholesterol levels and heart disease and stroke. If you have suffered from high cholesterol before your date of entry to the plan you will never be covered for cardiac problems or strokes.

GENERAL DECLARATION OF GOOD HEALTH

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. Been admitted to hospital or undergone an operation in the last 12 months..... **Yes** **No**
- B. Suffered from, been diagnosed with, treated or prescribed drugs for any form of cancer, or heart disease, or any other serious or chronic illness that requires regular medication and/or monitoring? Examples of serious or chronic illness include diabetes, high blood pressure and/or cholesterol, ischemic heart disease, cancer, spinal disc disease, thyroid disease, and auto-immune disorders (if you have a medical condition and are uncertain about whether it is chronic, you should disclose it) **Yes** **No**
- C. Been tested HIV and/or Hepatitis C positive?..... **Yes** **No**
- D. Had an application for insurance turned down or accepted at special terms?..... **Yes** **No**

If you answered YES to any question, please state the name(s) of the person(s) and details:

CONTINUING DUTY OF DISCLOSURE

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, 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.

DOCTOR'S CONTACT DETAILS

1. **Please give details of the doctor who is most familiar with the medical history of each person named in this application (if the details of the doctor is the same for each person named in the application you only need enter the information once).**

	Practice name and address (and doctor's name if available)	
Applicant		Practice tel no:..... Practice email:..... Length of time you have known this doctor:..... If less than 2 years, please complete question 2
Partner		Practice tel no:..... Practice email:..... Length of time you have known this doctor:..... If less than 2 years, please complete question 2
Child 1		Practice tel no:..... Practice email:..... Length of time you have known this doctor:..... If less than 2 years, please complete question 2
Child 2		Practice tel no:..... Practice email:..... Length of time you have known this doctor:..... If less than 2 years, please complete question 2
Child 3		Practice tel no:..... Practice email:..... Length of time you have known this doctor:..... If less than 2 years, please complete question 2

2. 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).

	Practice name and address (and doctor's name if available)	
Applicant		Practice tel no:..... Practice email:..... Length of time you have known this doctor:..... Date of last consultation:.....
Partner		Practice tel no:..... Practice email:..... Length of time you have known this doctor:..... Date of last consultation:.....
Child 1		Practice tel no:..... Practice email:..... Length of time you have known this doctor:..... Date of last consultation:.....
Child 2		Practice tel no:..... Practice email:..... Length of time you have known this doctor:..... Date of last consultation:.....
Child 3		Practice tel no:..... Practice email:..... Length of time you have known this doctor:..... Date of last consultation:.....

For additional children included on the plan, please supply the information requested above on a separate sheet.

THE INSURER

The Insurer of your plan will be Dubai Insurance Company psc.

DECLARATION AND AUTHORISATION

I hereby apply for cover on behalf of all the persons named in this application form for a 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 and/or William Russell Limited 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 and/or William Russell Limited 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.

I, and all those named in this application, understand that in order to assess my claim, Dubai Insurance Company psc and/or William Russell Limited may need to obtain details of my medical history. I, and all those named in this application, hereby authorise any physician, healthcare professional, hospital, clinic and other healthcare institution to disclose to Dubai Insurance Company psc and/or William Russell Limited, to the extent allowed by applicable law, any information concerning the medical history, services, supplies, or treatment provided to anyone listed on this application, including those services involving dental, substance abuse and HIV/AIDS.

I understand that Dubai Insurance Company psc and/or William Russell Limited may rely on this information to administer my policy and claims and to determine policy coverage according to applicable laws and regulations.

If I have 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.

I understand that if I leave my current employment my eligibility to this group scheme 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 policy with Dubai Insurance Company psc and/or William Russell Limited, I may need to reapply, and new terms may be issued.

I hereby give Dubai Insurance Company psc and/or William Russell Limited authorisation to send my insurance documents in pdf format by email to the email address I have stated in this application. If I have applied through an intermediary, I hereby give Dubai Insurance Company psc and/or William Russell Limited authorisation to send my insurance documents in pdf format by email to my intermediary.

I understand that my personal data will be processed in accordance with the Data Protection Act (1988) and the EU Data Protection Directive 95/46/EC.

I understand that Dubai Insurance Company psc and/or William Russell Limited will hold and process my personal data for the purposes of processing my Global Health plan, processing any claims submitted under my Global Health plan and providing other related services, which may include sharing my personal data with the insurers of my plan, doctors and other medical professionals involved in my treatment or care (or the treatment or care of other persons insured under my Global Health plan), Dubai Insurance Company psc and/or William Russell Limited's emergency assistance providers and other agents. I understand that this may include the transfer of personal data to countries outside the European Union and in signing this form I consent to such transfer and use.

I also understand that my personal data may be disclosed to any regulatory body that may require Dubai Insurance Company psc and/or William Russell Limited to disclose it and that, in the event of fraud or suspected fraud, my personal data may be disclosed to other parties, including but not limited to, the appropriate law enforcement agencies.

I consent to Dubai Insurance Company psc and/or William Russell Limited processing personal and sensitive data about me and other persons included on this application form. I understand that all personal data I supply must be accurate and confirm that I have the specific consent of all other persons included on this application to disclose their personal data.

I understand that telephone calls to Dubai Insurance Company psc and/or William Russell Limited may be recorded and monitored.

I understand that I may ask to review my personal or healthcare information and request amendments, to the extent allowed by law, and that I may revoke this authorisation at any time.

This authorisation shall remain valid for the term of my Global Health plan, including any periods of cover following subsequent renewals, or for so long as allowed by law.

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.
- If you are applying for a plan with access to the Neuron Networks please ensure you have included a photograph in jpeg format of yourself and all others named on this application form for use on your membership cards.
- 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.