

GLOBAL HEALTH INDIVIDUAL APPLICATION FORM (MORATORIUM)



WILLIAM RUSSELL
Peace of mind wherever you are

Please complete this form in block capitals using black ink

YOUR BROKER DETAILS

If you were introduced to Dubai Insurance Company psc through a broker, please state their name and company:

Name of broker:

Company name:

YOUR 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:

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:

GLOBAL HEALTH ELITE PLAN REQUIRED

Platinum Gold Silver Bronze

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

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 20% premium loading.
- \$50/AED185 per claim** Standard excess for Platinum, Gold, Silver and Essential Care Plus. Not available for Bronze and Essential Care.
- \$100/AED367 per claim** Available for Platinum, Gold and Silver with a 5% discount. Not available for Bronze and Essential plans.
- \$250/AED919 per annum** Available for Platinum, Gold, Silver, Bronze, Essential Care Plus and Essential Care plans. This is the only per annum excess available, all other excesses are on a per claim basis.
- Other, please state: _____ To view higher excess options, please visit our web site or contact William Russell Limited. NB Higher excess options are only available on a per claim basis.

OPTIONAL PLANS REQUIRED**Global Travel** Who do you require cover for: Self Partner Whole family**Global Personal Accident** Who do you require cover for: Self 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**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.

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.

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 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.****If you have suffered from any type of serious or chronic medical condition you can apply for an underwritten Global Health plan. You can do this by completing an underwritten application form available from our web-site or from Dubai Insurance Company psc. Our underwritten application form will ask you specific questions about your medical history and your answers will enable us to advise you before you join of any exclusions that will apply permanently to your cover.****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.

CURRENCY, METHOD AND FREQUENCY OF PREMIUM PAYMENT

Please state the currency in which you wish to pay premiums:*

*NB: The currency in which you pay your premium will be the currency in which your plan benefits and excess are denominated.

US Dollars UAE Dirhams

Method and frequency of payment options available

Please note that semi-annual health, travel and personal accident premiums include a 3% surcharge, and quarterly and monthly health, travel and personal accident premiums include a 5% surcharge.

1. **Cheque or bank draft:** **Annually** Payable to Dubai Insurance Company psc and drawn on a UAE bank account.

2. **Bank transfer:** **Annually**

3. **Credit/debit card:** **Annually** **Semi-annually** **Quarterly** **Monthly**

A credit/debit card authorisation form is attached.

NB: You can only pay your premium on a semi-annual, quarterly or monthly basis if you have selected the US dollar currency. AED dirham premiums must be paid annually by cheque, bank draft or transfer (the first premium before the start of your cover and, thereafter, before your renewal date).

START DATE

Date on which you wish your Global Health plan to commence:

On acceptance **Other (Please state):**

Please note that application forms are only valid for 28 days and that we cannot commence your plan until we have accepted your application form and have received payment of your first annual, semi-annual, quarterly or monthly premium in accordance with the terms of the Global Health plan agreement. Cover cannot be backdated.

SAVE PAPER AND MAKE A DONATION TO CHARITY - IMPORTANT INFORMATION ABOUT YOUR INSURANCE DOCUMENTS

Insurance documents take up a lot of paper, so unless you specifically request paper documents and a plastic card, we will e-mail your insurance documents to you as a pdf document so that you can save and view them when required.

As well as being a fast, reliable way for you to receive your insurance documents, this results in a saving to William Russell Limited. When you agree to this, we will donate US\$5 to one of the charities we support. Woking Sam Beare Hospice and CHASE, are local organisations here in the UK providing invaluable hospice care, and Medecins Sans Frontieres, is an international humanitarian medical aid charity.

Please make your choice here:-

Please donate US\$5 to charity. I would like to receive my insurance documents by e-mail in pdf format

I would like to receive paper documents and a plastic card.

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 understand that upon receipt of my Global Health plan documents, if I am not entirely satisfied, I can cancel my application from inception and receive a full refund of the premium I have paid, provided I return the documents to Dubai Insurance Company psc and/or William Russell Limited within 30 days of the start of the policy, and provided I make no claim.

I agree that Dubai Insurance Company psc and/or William Russell Limited or the insurer may rescind the policy and release themselves from any liability whatsoever if it is proved that I have omitted to declare any relevant information, or have given any incorrect, incomplete or misleading information.

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.

If I have indicated that I wish to pay by credit or debit card, I agree that Dubai Insurance Company psc and/or William Russell Limited may debit my account with the appropriate premiums on or before their due dates, and all subsequent renewal premiums due as invoiced by Dubai Insurance Company psc and/or William Russell Limited until I give written notice that I wish to terminate this agreement. I understand that my cover will terminate in accordance with the terms of the Global Health plan agreement if Dubai Insurance Company psc and/or William Russell Limited are unable to collect my premium – for whatever reason – and I do not provide Dubai Insurance Company psc and/or William Russell Limited with an alternate method of payment immediately.

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 applicant:

Date:

Signature of partner:

Date:

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.



Global Plans Team
Dubai Insurance Company psc
PO Box 3027, Dubai, UAE.
T + 971 4 2697706
F + 971 4 2691304
sales@globalplans.ae
www.globalplans.ae



GLOBAL PLANS CREDIT/DEBIT CARD AUTHORISATION FORM

Please complete this form in block capitals using black ink



PLEASE NOTE: UAE dirham payments are NOT accepted by credit/debit card. If you wish to pay by UAE Dirhams, you must contact us to pay annually by cheque, bank draft or bank transfer.

APPLICANT/POLICY-HOLDER DETAILS

Full name of applicant/policyholder: _____

Policy number: _____

CREDIT/DEBIT CARD DETAILS

I would like to pay my plan premium by the following credit/debit card:

Mastercard VISA American Express

Credit/debit card number: _____

Start date: _____

Expiry date: _____

Name as on card: _____

Address to which card is registered: _____

AUTHORISATION - TO BE SIGNED BY THE APPLICANT/POLICY HOLDER

I hereby authorise that the card account specified above may be debited with the appropriate annual/monthly premium(s) due, and all subsequent renewal premiums due as notified by Dubai Insurance Company psc, until I give notice in writing that I wish to terminate my plan agreement.

I understand that my premiums may increase at each plan renewal date. I understand that premiums due under the plan must be received by Dubai Insurance Company psc on or before their due date and, should any attempt by Dubai Insurance Company psc to debit the above card be declined, I understand that my plan cover will cease from the day before the unpaid premium due date, and that Dubai Insurance Company psc will not be liable for any lapse in cover.

Signature of applicant/policyholder: _____

Date: _____

AUTHORISATION - TO BE SIGNED BY THE CARD HOLDER WHEN THE HOLDER OF THE ABOVE CARD IS NOT THE APPLICANT/POLICY HOLDER

I hereby authorise that the card account specified above may be debited with the appropriate annual/monthly premium(s) due, and all subsequent renewal premiums due as notified by Dubai Insurance Company psc to the applicant/policy holder named above, until I give notice in writing that I wish to terminate this arrangement.

Signature of card holder: _____

Date: _____



Global Plans Team
Dubai Insurance Company psc
PO Box 3027, Dubai, UAE.
T + 971 4 2697706
F + 971 4 2691304
sales@globalplans.ae
www.globalplans.ae

