MEDIGLOBAL HEALTH INSURANCE

Application for Individual and Family Insurance

Developed by IMG

RAK INSURANCE

This plan is underwritten by Rak Insurance Company. It is distributed, managed and administered, as agent for and on behalf of the Company, by International Medical Group® ("IMG®").

Please complete this form in block capitals using black ink. For all sections, please ensure you answer every question and sign and date this form. An incomplete form will delay the processing of your application. Please send the completed application to UAE.contact@imglobal.com.

Policy Number:
Requested effective date:

SECTION 1 YOUR PERSONAL AND COVER DETAILS

1.1 DETAILS ABOUT YOU

Title:	First Name(s):	Family Name:
Date of Birth: (DD/MM/YYYY)	☐ Male ☐ Female	Marital Status:
Height:	Weight:	Nationality:
Passport No:	Emirates ID No:	UID No:
Emirate from which visa/residency is issued:		Occupation:
Salary: ☐ less than 4,000 AED/month	☐ 4,001-12,000 AED/month	☐ more than 12,000 AED/month
Is salary commission based? ☐ yes ☐ no		Active at Work Since:
Participating organisation (Non-UAE National):		

1.2 DETAILS ABOUT YOUR SPOUSE

Title:	First Name(s):	Family Name:
Date of Birth: (DD/MM/YYYY)	☐ Male ☐ Female	Marital Status:
Height:	Weight:	Nationality:
Passport No:	Emirates ID No:	UID No:
Emirate from which visa/residency is issued:		Occupation:
Salary: ☐ less than 4000 AED/month	☐ 4001-12000 AED/month	☐ more than 12000 AED/month ☐ no salary
Is salary commission based? ☐ yes ☐ no		Active at Work Since:
Participating organisation (Non-UAE National):		

1.3 DETAILS ABOUT YOUR DEPENDENTS (Under 18 years or under 25 years if unmarried or in full time education)

First Name(s):	Family Name:	Date of Birth: (DD/MM/YYYY)
☐ Male ☐ Female	Height:	Weight:
Nationality:	Passport No:	Relation to You:
First Name(s):	Family Name:	Date of Birth: (DD/MM/YYYY)
☐ Male ☐ Female	Height:	Weight:
Nationality:	Passport No:	Relation to You:
First Name(s):	Family Name:	Date of Birth: (DD/MM/YYYY)
☐ Male ☐ Female	Height:	Weight:
Nationality:	Passport No:	Relation to You:
First Name(s):	Family Name:	Date of Birth: (DD/MM/YYYY)
☐ Male ☐ Female	Height:	Weight:
Nationality:	Passport No:	Relation to You:

Is there a member of your family that is not proposed for insurance: ☐ yes ☐ no
If "yes", please comment in Section 3.

1.4 CONTACT DETAILS (Telephone Numbers: +Country(Area)Number)		
Phone (Mobile):	Phone (Home):	Phone (Work):
Personal Email Address:		Fax:
Residential Street Address:		
City:	Country:	P.O Box:
Postal Address (if different to residential):		
City:	Country:	P.O Box:
Workplace Street Address:		
City:	Country:	P.O Box:

1.5 PLAN OPTION AND DEDUCTIBLE (This must be the same for all family members.)	
PLAN OPTION: ☐ MediEssential ☐ MediSelect ☐ MediElite	DEDUCTIBLE: ☐ Nil ☐ Dhs 50

1.6 GEOGRAPHICAL AREA OF COVER (This must be the same for all family members.)		
☐ AREA 1 Algeria, Bahrain, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Qatar, Saudi Arabia, Syria, Tunisia, United Arab Emirates, Yemen	☐ AREA 2 Worldwide excluding USA, Canada, China, Hong Kong, Macau, Japan, Singapore, Taiwan	☐ AREA 3 Worldwide
NETWORK REQUIRED: ☐ Comprehensive ☐ General Plus ☐ General		

1.7 OPTIONAL BENEFITS (These additional benefits are optional. Please check the appropriate box should you opt for this cover)

DENTAL & VISION ☐ Yes	**WORLDWIDE PERSONAL ACCIDENT COVER**
Dental Maximum sum insured • Dhs 2,500	Maximum benefit payable for 1 unit Dhs 250,000
Vision maximum benefit (payable every 24 months) • Dhs 375 examinations • Dhs 500 materials	Number of units required: (Please tick) ☐ 1 ☐ 2

MATERNITY Increased maximum limit per pregnancy including overseas (for non-residents of Abu Dhabi only)
Dhs 30,000 ☐ Yes

SECTION 2.1

Please answer the following questions for you and every Family Member included on this application. For any questions answered "Yes," please identify the Family Member to whom the answer applies. Provide complete details of all "Yes" answers in Section 3 of this application.	Yes	No	Name of Family Member
1. Are you or any other applicant currently disabled, pregnant, or unable to perform normal activities?			
2. Are you or any other applicant presently hospitalized, or scheduled for or in need of hospitalization or surgery?			
3. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder?			
4. Have you or any other applicant ever had, been recommended to have, or are you currently on a waiting list for any organ transplant (other than corneal)?			
5. Do you or any other applicant participate in professional sports or are a professional pilot?			

	Yes	No	Name of Family Member
6. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past five (5) years? If yes, please explain in Section 3.			
Have you or any family member applying for coverage EVER experienced manifestation or symptoms of, suffered from, sought consultation, examination, testing or been treated for, or been diagnosed with, any disease, condition, illness, medical problem, disorder, sickness or other problem arising from, involving, or relating to any of the following:			
7. Heart, cardiac, cardiovascular and/or circulatory, including, but not limited to: congestive heart failure, heart attack, angina, chest pain, arteriosclerosis, atherosclerosis, elevated blood pressure, hypertension, swelling of feet/ankles, thrombosis, phlebitis, rheumatic fever, or heart murmur? If yes, in addition to Section 3, please complete the following: a) Date of most recent blood pressure reading: _____ b) Most recent blood pressure reading: _____AS/_____DS c) Medications taken (Types and Dosage): _____ c) How often advised to follow up with Physiwcian: _____			
8. Blood, blood vessels, spleen, arteries, veins or disorders of the blood, including, but not limited to: anemia, hemophilia, leukemia, hepatitis, lymph glands, or high cholesterol?			
9. Diabetes, hyperglycemia or hypoglycemia? If yes to diabetes, in addition to Section 3, please complete the following: a) Diabetic Type: ☐ Type I ☐ Type II b) Date diagnosed: _____ c) Controlled by diet only: ☐ Yes ☐ No c) Medications taken (Types and Dosage): _____ _____ e) Date of most recent HbA1c Test: _____ f) Results of HbA1c Test (1 - 10): _____			
10. Asthma or allergies? If yes, in addition to Section 3, please specify which one and complete the following: a) Date diagnosed: _____ b) Has hospitalisation or emergency room treatment been required? If yes, list date(s): _____ and description: _____ c) Please list known triggers:_____ d) Medications taken (Types and Dosage): _____ _____ e) Frequency of attacks: _____			
11. Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump, calcification, or growth of any kind?			
12. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid or metabolic disorders, or obesity?			

	Yes	No	Name of Family Member
13. Kidney, urinary tract functions, kidney or bladder stones or infections?			
14. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy pneumonia?			
15. Mental and nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, ADD or ADHD, chemical or drug abuse or dependency, alcoholism, psychiatric counseling and/or support groups, depression, anxiety, chronic fatigue, or eating or sleeping disorders?			
16. Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebral ischemic attacks?			
17. Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease or disorder, vertebrae degeneration or any other back or neck condition, rheumatism, arthritis, gout, tendonitis, osteoporosis or inflammation?			
18. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice, diagnosis or treatment, and disorders of the reproductive system, including but not limited to: vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus, and hormone replacement therapy?			
19. For male applicants, disorders of the reproductive systems, including, but not limited to: prostate or elevated PSA level, erectile dysfunction or infertlity consultation, advice, diagnosis or treatment?			
20. Congenital, genetic, hereditary or other birth condition or defect including, but not limited to: mental retardation, Down Syndrome, or other chromosome disorder, physical disorder, deformity or defect?			
21. Digestive system, stomach, or intestines, including, but not limited to: esophageal regurgitation, gastritis, ulcers, colon, or rectum disorders?			
22. Eyes, ears, nose, mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation, chronic sinusitis, or TMJ?			
23. Any other disease, medical problem, illness, injury or condition of any kind not listed?			
24. Do you or any family member applying for coverage currently use or during the past five years have you used tobacco in any form?			
25. Have you or any family member applying for cover ever applied for or purchased medical insurance through IMG, RAK Insurance or received services from Neuron? (If yes, please provide policy number, if any, and details.)			
26. During the last twelve (12) months, have you or any family member applying for coverage experienced manifestation or symptoms of, been diagnosed with, or received any consultation, examination, testing or treatment (including medications) for, any medical, health, mental, physical or nervous condition? If yes, please explain in Section 3.			
27. Have you or any family member applying for coverage ever been rejected, cancelled, rated or declined for coverage under any health, life or disability insurance policy? If yes, please explain in Section 3.			
28. During the last twelve (12) months, have you or any family member applying for coverage been covered under any health or medical insurance plan, including a government sponsored health care plan? If yes, please state the name and location of the insurance company, the policy number, and the applicable dates of coverage.			

SECTION 2.2

Please list all prescribed and over the counter medications and any surgeries for you and for each Family Member for whom it applies (use the corresponding letter(s) from Section 1). Please attach additional pages as necessary.

Family Member *(use letters from Section 1)*	Medications and Dosages	Conditions	Date(s) of Treatment
Family Member *(use letters from Section 1)*	Surgeries		Date(s) of Treatment

Family Practitioner's Details - The following information must be completed.
(If not the same for all applicants please provide further details on additional pages)

Doctor's Name:	Telephone:
Address:	
Country:	Postal/Zip Code:
Date Last Seen:	Reason:

SECTION 3

For any question answered "YES" in Section 2, please identify each Family Member for whom the answer applies (using the corresponding letter(s) from Section 1), and provide complete details of the medical condition at issue, including the name, address and telephone number of the attending physician(s), hospital(s), clinic(s) and all other health care providers involved, diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. Please attach additional pages as necessary. RAK Insurance and the Company reserve the right to request additional medical information prior to acceptance of Application.

Name of Family Member	Condition(s)/Diagnosis, Prognosis, Past & Present Course of Treatment(s), Medications and Surgeries	Physician/Hospital/ Clinic/Health Care Provider Name(s), Address & Telephone	Date of Onset	Date of last symptoms	Date(s) of last Treatment	Current state (ongoing/ resolution)

If any Family Member applying for coverage has ever been rejected, cancelled, rated or declined for coverage under any health, life or disability insurance policy (see Question 27), please explain below:

_____

_____

_____

_____

Additional Comments: _____

_____

_____

_____

AGREEMENT I (we) understand and hereby agree that:
(i) I (we) choose to enroll for insurance under the Group Healthcare Insurance as offered by RAK Insurance on the date of its receipt hereof. (ii) this policy will be provided in accordance with the policy Wording; and I (we) will read it upon receipt and be bound by it. (iii) This application will be the basis for and form a part of any insurance issued and IMG and RAK Insurance can and will rely upon the accuracy and completeness of the information provided herein. (iv) I (we) understand and agree that no coverage will be effective until this application has been duly accepted in writing by RAK Insurance, (v) no modification or waiver relating to this application or the coverage applied for will be binding upon RAK Insurance or IMG unless approved in writing by an officer of RAK Insurance or IMG, (vi) any misrepresentation or omission contained herein will void the insurance policy, and any and all claims and benefits thereunder will be forfeited and waived, (vii) My (our) responses to the statements and questions contained in this application are true, accurate complete and correctly recorded in all respects, and I (we) will supplement such responses prior to the requested effective date in the event of any change or addition thereto. (viii) I (we) understand and agree that: (a) marketing brochures and policy wordings are available prior to application upon request, (b) the insurance agent, broker, website, or other producer, if any, involved with respect to the solicitation of this application is acting solely as my legal agent and representative and is representing my personal interests, and that such person has no authority to bind or speak for, and is not acting as the legal agent or representative of, RAK Insurance or IMG, (ix) The subjects, risks, and benefits of insurance for which I (we) enroll for insurance under the policy are not intended or considered by me (us) to be resident, located or performed in particular country. The law specified in this policy shall be the law of the United Arab Emirates. RAK Insurance as carrier and underwriter of the policy is solely liable for the insurance coverage and benefits to be provided thereunder, and IMG acts solely as agent for RAK Insurance and IMG has no direct or independent liability under the any policy Period. (x) RAK Insurance and IMG, their employees, representatives, agents and any other persons or organisations performing services for them or on their behalf may use, disclose or transfer to any organisation any information, including personal information, about me (us) obtained or collected in connection with this application, (whether contained in this application or otherwise) for the purpose of: (1) assessing this application and providing on-going insurance and customer service; (2) processing and giving effect to credit/debit card payments; (3) providing marketing material in respect of insurance related services of IMG or is associated companies; and (4) processing claims or analysing insurance.

CERTIFICATION I am (we are) currently in good health and, except for the conditions and other information disclosed herein, I (we) have not been diagnosed with, sought consultation or been treated for, and have not experienced manifestation or symptoms of and do not suffer from any pre-existing condition which I (we) foresee may require treatment in the future or for which I (we) intend to claim under this insurance, and if this application is signed as guardian or proxy of the applicant, the signer warrants their authority and capacity to so act and bind the applicant. By acceptance of coverage and/or submission of any claim for benefits, the applicant ratifies the authority of the signer to so act and bind the applicant.

MEDICAL RELEASE I (we) authorise any doctor, practitioner, medical specialist, hospital, clinic, health care related facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, employee or benefit plan administrator having information as to my (our) care, advice, treatment, diagnosis or prognosis of any physical or mental condition, and/or employment status, to provide such information to IMG and/or RAK Insurance and my producer/broker involved in procurement of this application and/or policy coverage.

THIS FORM MUST BE SIGNED AND DATED

X_____ _____

Signature of Applicant, Guardian, or Proxy | Date (DD/MM/YYYY)

X_____ _____

Signature of Spouse | Date (DD/MM/YYYY)