

Application Form

This form is interactive in PDF format

To be completed by the Policy Holder

ALL boxes must be completed and ALL questions answered or the form and your application will be rejected.

1. POLICY HOLDER DETAILS:

First Name: Surname:

Sex: Male Female Married: Yes No Date of Birth: Height: Weight:

Residency: Occupation: Nationality:

2. DEPENDANTS TO BE COVERED:

DEPENDANT 1:

First Name: Surname:

Sex: Male Female Relation: Spouse Child Date of Birth: Height: Weight:

Residency: Occupation: Nationality:

DEPENDANT 2:

First Name: Surname:

Sex: Male Female Relation: Spouse Child Date of Birth: Height: Weight:

Residency: Occupation: Nationality:

DEPENDANT 3:

First Name: Surname:

Sex: Male Female Relation: Spouse Child Date of Birth: Height: Weight:

Residency: Occupation: Nationality:

DEPENDANT 4:

First Name: Surname:

Sex: Male Female Relation: Spouse Child Date of Birth: Height: Weight:

Residency: Occupation: Nationality:

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3. REQUESTED PRODUCT:

Insert the quote number provided:

or choose a Set Plan below:

For information about the following pre-set plans please refer to our Precious Metals TOB Summary

1. CHOOSE A PLAN:	2. CHOOSE THE LEVEL OF BENEFITS:					3. CHOOSE THE DEDUCTIBLE:	
Select <input type="checkbox"/>	Bronze <input type="checkbox"/>	Silver <input type="checkbox"/>	Silver Plus <input type="checkbox"/>	Gold <input type="checkbox"/>	Platinum <input type="checkbox"/>	AED 50 <input type="checkbox"/>	AED 75 <input type="checkbox"/>
Prestige <input type="checkbox"/>	Bronze <input type="checkbox"/>	Silver <input type="checkbox"/>	Silver Plus <input type="checkbox"/>	Gold <input type="checkbox"/>	Platinum <input type="checkbox"/>	Nil <input type="checkbox"/>	AED 50 <input type="checkbox"/>

Plans with an enhanced Maternity Package, including Silver Plus, Gold and Platinum plans, are not available to solo female applicants i.e. those wishing to be insured without a husband and any eligible children also covered on the Policy.

4. HEALTH DECLARATION:

Important Note: i) No liability will be accepted for any medical condition which is present or was foreseeable at the time of enrolment unless such medical condition has been accepted by us in writing. ii) Failure to declare a medical condition may result in claims being refused or cover withdrawn. If in doubt about medical condition please disclose it. Declarations must be made in writing on this enrolment form. Verbal declarations will not be accepted.

Please answer ALL the following questions by selecting the relevant box.

DETAILS ABOUT INSURED PERSON(S):

	Policy Holder		Dependant 1		Dependant 2		Dependant 3		Dependant 4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. In the last five years have you suffered from or with any:										
a) Nervous, mental or psychiatric illnesses / conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Slipped discs or other spinal disorders (fainting episodes, blackouts, seizures (fits))?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Low / high blood pressure, heart diseases, including ischemic heart diseases, or other circulatory disorders, etc?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Diabetes or sugar in urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Fistula, piles, hernia, varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Conditions or injuries of the bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Conditions of the uterus, ovaries, or any specific / non-specific gynaecological disorders or obstetrics disorders including missed abortions / ectopic pregnancy / any other pregnancy complications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Disorders of primary or secondary sexual organs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Conditions of the breast or urinary tract?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Respiratory disorders or allergic conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Disorders of the stomach, kidney, liver or any abdominal organ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Lumps, growths (benign / malignant), boils, cysts, fibroids or wounds?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Problems with eyes (including if you require visual aids, eye glasses or contact lenses)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Diseases of the ears or hearing aids or difficulty in hearing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	Policy Holder		Dependant 1		Dependant 2		Dependant 3		Dependant 4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
2) Do you take any regular medications (e.g. pain killers, chronic condition medications, hormone administration)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Are you aware of any condition that may require/is requiring a physicians or specialist consultation or treatment in the future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Have you undergone any inpatient stay in a hospital or nursing home in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Are you currently under any medical observation or receiving medical treatment or intending to seek medical advice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Are you undergoing regular medical reviews or check-ups?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Have you suffered any other conditions, illnesses, diseases, medical complaints in the last 5 years, or are there any other facts relevant to your general state of health that should be disclosed? (If in doubt tick "Yes").	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) If female, are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) If female, are you trying to get pregnant (including undergoing any form of fertility treatment)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10) If female, when was your last menstrual period?	<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	

* Please provide full details for any questions answered "Yes" in the table on the next page:

Only complete questions 11 - 16 if Dental Cover is to be provided

	Policy Holder		Dependant 1		Dependant 2		Dependant 3		Dependant 4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
11) When did you last receive dental treatment (eg: 08/2015)? Please provide details in the table below.	<input type="text" value="MM / YYYY"/>		<input type="text" value="MM / YYYY"/>		<input type="text" value="MM / YYYY"/>		<input type="text" value="MM / YYYY"/>		<input type="text" value="MM / YYYY"/>	
12) Do you currently have any pain or discomfort in the oral cavity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13) Do you have any aesthetic problems regarding tooth alignment or gums forwardly placed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14) Do you experience pain when:										
a) Having hot food or drink?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Having cold food or drink?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Clenching?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Bending forward?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) During flights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15) Any wisdom teeth not erupted yet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16) Are there any other facts relevant to your dental health that should be disclosed? (If in doubt please tick "Yes").	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Please provide full details for any questions answered "Yes" in the table on the next page:

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5. ADDITIONAL QUESTIONS:

- i) Has any female applicant ever given birth? Yes No If "Yes", how? Vaginal Delivery Elective C-Section Unplanned C-Section
Select multiple answers if applicable for multiple births
- ii) How many sick days has each working applicant taken off work in the last 12 months? Applicant 1 Applicant 2
- iii) Name of current insurer: _____
- iv) Reason(s) for applying for a GlobalCare insurance plan? Better Price Service Issues Upgrading Insurance New to Dubai Other Reason
- If you answered "Other" Reason please provide details: _____
- _____

6. POLICY HOLDER'S CORRESPONDENCE DETAILS:

Full Name: _____

Telephone: _____ Mobile: _____

Complete Address: _____

PO Box: _____ Email: _____

IMPORTANT NOTES

The Insurer has the right to cancel any policy if it is found that application documents have been completed incorrectly/untruthfully. Application Rejection/Policy Termination will be immediate and no refund will be given.

I hereby apply for insurance cover for the above listed Quotation and acknowledge the Terms and Conditions of the GlobalCare health insurance products. I accept that all my dependents who are eligible must be enrolled in the same plan.

I also accept that the Insurer may require personal information about any of the applicants to assess their state of health, and that failure to supply such personal information will result in the Insurer being unable to process/provide insurance products/services and other related services.

I understand and acknowledge any pregnancy not declared at the time of this application's coverage will be at the sole discretion of the Insurer. The Insurer has the right to not cover any maternity claims to any undeclared pregnancy. I also acknowledge and understand any pregnancy, which arises within forty calendar days from the date of this application; coverage will also be at the discretion of the Insurer.

I hereby declare and warrant that the above statements are true and complete. I hereby authorise the Insurer to seek medical information from any Hospital / Medical Practitioner who has at any point in time attended or may attend any disease or illness that affects my physical or mental health. I agree that this document shall form the basis of the contract should the insurance be effected. The Insurer shall incur no liability under the Insurance Policy, in case that after the insurance cover is effected it is found that the statements, answers or particulars stated in this form and its questionnaires are incorrect or untrue in any respect. I have read the Terms & Conditions and accept the coverage subject to the Terms & Conditions with its exclusions.

Date:

DD / MM / YYYY

Signature:

(Applicant, or Legal Guardian of person to be insured)

**Once completed this form is valid for 30 days. If insurance has not been accepted by the applicant after 30 days a new form must be completed and submitted.*