

## INDIVIDUAL / FAMILY APPLICATION FORM

### INDIVIDUAL / FAMILY MEMBERS PROPOSED FOR HEALTH INSURANCE

**PLEASE READ AND ANSWER THE PROPOSAL FORM CAREFULLY.**

Please complete this form answering each question giving full details of each member you wish to be insured under this policy.

General Information of Principal Applicant			
Full name			
Communication Address			<input type="checkbox"/> Dubai <input type="checkbox"/> Northern Emirates (NE) <input type="checkbox"/> Abu Dhabi / Al Ain
Mobile No.		E-mail address	
Principal Applicant	<input type="checkbox"/> Individual Investor and/or their Dependents <input type="checkbox"/> Employee and/or their Dependents.	<input type="checkbox"/> Domestic Maid / Worker <input type="checkbox"/> Others .....	
Plan Details			
Occupation:		Nature of Business / Industry:	
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Student		

Member Details (Please list each member who you wish us to cover under this policy i.e. Principal, Spouse, Daughter, Son)								
Member No.	Name	Date of Birth	Nationality	Relation	Gender	Height (cm)	Weight (kg)	Occupation
Member 1		DD/MM/YYYY						
Member 2		DD/MM/YYYY						
Member 3		DD/MM/YYYY						
Member 4		DD/MM/YYYY						
Member 5		DD/MM/YYYY						
Member 6		DD/MM/YYYY						
Member 7		DD/MM/YYYY						
Member 8		DD/MM/YYYY						

Is there any family member (Spouse and Child) who is not included here?  Yes     No

If yes, please specify the reason .....

All Members hold a Valid Residence VISA of UAE?  Yes     No

If No, Applicable to which member number .....

Section A - Insurance History	
Whether the member is currently covered under any Medical Insurance Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please specify the following:	
• Policy Start Date    DD/MM/YYYY	
• Whether the Current Medical Insurance Plan got Lapsed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you or any of the family members for whom the cover is being sought ever been declined or accepted for life and/or health insurance on sub-standard terms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please specify the reason .....	
Applicable for Member No -	

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Section B - Individual Medical History – Please answer for all members of the family included on this proposal form	
<p>Have you, or any member to be covered under this policy, ever suffered from, visited a doctor or taken any medication for any of the following medical conditions? <b>If Yes (1) please specify member number, CURRENT MEDICATIONS, medical report and/or diagnostic details, treatment received and recovery status on attached supplemental information sheet (2) attach all the latest medical reports related to the condition.</b> All information provided will be treated in strict confidence.</p>	
<p><b>1. Musculoskeletal and / or Connective Tissue disorders?</b>            (Example- Osteoarthritis, rheumatoid arthritis, Vit D Deficiency; myasthenia gravis, muscle weakness, gout, osteoporosis, loss of limb, bunions, cartilage damage, arthralgia, back problems like slipped disc, backache, sciatica, pinched nerve)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -
<p><b>2. Cancer, Neoplasms, Tumors?</b>            (Specify type, location, stage; treatment, whether malignant or benign)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -
<p><b>3. Blood and Blood Forming Organ Systems?</b>            (Example - Anemia, leukemia, thalassemia, bleeding disorders, blood cell disease, spleen or lymph node disorders)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -
<p><b>4. Digestive disorders?</b>            (Example - Peptic ulcer, hiatus hernia, heartburn, changed bowel habits, rectal bleeding, Crohn's disease, ulcerative colitis, irritable bowel syndrome, gall bladder problems etc.)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -
<p><b>5. Endocrine, Nutritional, Metabolic and/or Immunity disorders?</b>            (Example - Diabetes, thyroid or pituitary gland disorders, adrenal gland disorders, auto-immune disorders etc)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -
<p><b>6. Nervous System or Sense Organs disorders?</b>            (Example - Ear injury/infection, vertigo, hearing, eye injury/disease, retina, glaucoma, vision, muscular dystrophy, brain/nerve degeneration, meningitis, paralysis, seizures, epilepsy, neuralgia, stroke, , quadriplegia, paraplegia)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -
<p><b>7. Genitourinary disorders?</b>            (Example - Kidney/bladder infections, renal failure, kidney stones, endometriosis, menstrual disorders, salpingitis, ovarian cysts, uterine fibroids, prostate problems, testicle infections, hemorrhoids, fissures)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -
<p><b>8. Cardiovascular disorders?</b>            (Example - Hypertension, Myocardial infarction (Heart Attack) / Coronary artery disease, Stroke, cerebral ischemia, rheumatic fever, atherosclerosis, aneurysm, embolism, peripheral vascular disease, heart valve disease, irregular heartbeat, pulmonary embolism, phlebitis, deep vein thrombosis, varicosities)             In case you are suffering from hypertension please specify your Systolic    Diastolic readings:            Systolic: _____    Diastolic: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -
<p><b>9. Respiratory disorders?</b>            (Example: Sinusitis, allergies, tonsillitis/laryngitis, bronchitis, emphysema, pneumonia, asthma, shortness of breath, persistent cough, coughing up blood, cystic fibrosis, allergic rhinitis, sleep apnea, chronic obstructive airway disease, any lung surgery)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -
<p><b>10. Skin-Subcutaneous disorders?</b>            (Example - Dermatitis, seborrhea, pruritus, etc.)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -
<p><b>11. Psychological or mental disorders</b>            (Example – Sleep Disorder, Depression, bipolar disorder, anxiety disorder, schizophrenia).</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -
<p><b>12. Have you experienced any symptoms of any medical problem (like unintentional weight loss, abnormal bleeding, persistent headaches) in the last 12 months, regardless of whether a healthcare professional has been consulted or are you awaiting results for any tests performed (example - ECG, blood or urine tests, CT or MRI scan) other than for routine purpose?</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No.-
<p><b>13. Any Other Medical Conditions</b></p> <p style="margin-left: 20px;">a. Any Congenital disease or malformations</p> <p style="margin-left: 20px;">b. Are you HIV positive or have any medical condition or symptom indicative of HIV infection or AIDS?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No.-

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<b>14.</b> In the last 5 years, have you been hospitalized or undergone a surgical procedure including endoscopy or biopsy at a clinic or an out-patient facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -
<b>15.</b> Any other pre-existing disease(s), symptoms, and/or complaints within the last 5 years not mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -

#### Section C - Family Medical History (Father, Mother, Siblings)

1. Have any members of your immediate family (parents or siblings) ever been diagnosed with Cancer, Heart Disease, Stroke, Diabetes, Kidney Disease, Paralysis, Multiple Sclerosis, Huntington's disease, Alzheimer's, or any other inherited conditions at or before the age of 65 years?     Yes     No
- If yes, please provide details in the below table:

Medical Condition	Relationship	Age of Onset (in Years)

#### Section D – Lifestyle & Habits

<b>1.</b> Do your occupation/hobbies associated with any specific accident/health hazard like corrosive chemicals, explosives, radiation, working underwater/underground or at height, working in mines, non-commercial flying activities, diving, mountaineering, any form of motorbike/car racing etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -
<b>2.</b> Do you smoke? If yes, what do you smoke and how many times per day? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -
<b>3.</b> Do you drink alcohol? If yes, what type and how many units per week? _____ <small style="color: red;">where *1 unit is equivalent to half a pint of beer, one standard glass of wine, or a single measure of spirits.</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -

#### Section E – Maternity Related (Applicable for Female Member Only)

<b>1.</b> Are you currently pregnant? If yes, have there been any complications to date, expected delivery date? DD/MM/YYYY	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -
<b>2.</b> Last Menstrual period Date	DD/MM/YYYY
<b>3.</b> Are you currently trying to get pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -
<b>4.</b> Are you undergoing any form of fertility treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -
<b>5.</b> Have you had any history of maternity complications as on date or childbirth and the puerperium including abortions currently or in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No Applicable to Member No. -

#### FALSE INFORMATION

All material facts must be disclosed. Failure to do so may invalidate any insurance policy from inception. A material fact is one which is likely to influence an insurer in the assessment and/or acceptance of the proposal. If you are unsure as to whether a fact is material or not, it should be disclosed to the Insurance Company.

Any person who, knowingly and with intent to defraud any insurance company or other person, files a proposal for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

#### ADDITIONAL INFORMATION

- Please note that each page of this Proposal Form should be signed by the Applicant or his/her legal representative.
- This proposal and any information provided by the applicant does not constitute a contract or effect insurance cover for the applicant and any members identified.

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- In case of acceptance of the applicant by Insurance Company, any conditions or exclusions and acceptable premium payment methods will be communicated to the applicant.
- Signing of this proposal form is not the commencement of insurance coverage. The commencement of insurance Coverage will be confirmed upon the written acceptance of this Proposal Form by Insurance Company and issuance of the Insurance Policy.
- Only upon Insurance Company acceptance of the conditions, exclusions and provision of an acceptable premium payment methods will the cover be instigated and the relevant Insurance Policy and membership cards, if included, be provided.

SUPPLEMENTAL INFORMATION SHEET			
Please specify <b>CURRENT MEDICATIONS</b> with <b>Brand Name, Daily Dosage, Medical Report &amp; Diagnostic Details</b> , treatment received and recovery status or any information deemed necessary			
Section	Question	Member Number	Supplemental Information
Applicant Signature			Date DD/MM/YYYY

DECLARATION AND SIGNATURE	
<p style="color: red;">I / We understand and acknowledge any pregnancy not declared at the time of this application for 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 40 calendar days from the date of this application; coverage will also be at the discretion of the insurer.</p> <p style="color: red;">I/ We, the undersigned, hereby declare that to the best of my knowledge, all the above answers are full, complete, and true. Non-disclosure or misrepresentation of material facts shall cause cancellation of the policy from the effective date without premium refund or re-underwrite the policy based on the updated information.</p> <p style="color: red;">I /We, the undersigned, hereby declare that I have no objection in receiving Emails, SMS, WhatsApp messages or telephone calls from Alliance Insurance &amp; its representatives (Brokers / Alliance Authorized Agents &amp; Providers) with regards to my Insurance Application &amp; Services</p> <p style="color: red;">It is agreed and understood that the final premium shall be defined by ALLIANCE INSURANCE (P.S.C.), as a result of the underwriting process. In case of additional premium and/or specific exclusion(s), the Applicant shall be advised prior to the issuance of the Policy applied for. In case of Applicant acceptance, the relevant policy shall be issued together with instructions and authorizations scheduling the subsequent payment(s) due</p> <p style="color: red;">On behalf of my legal dependents listed above and myself, I hereby give authorization to my hospital, physician or other person who provides medical services to myself or any of my family members to release all medical information to ALLIANCE INSURANCE (P.S.C.) or its representative and hereby waive our right of medical confidentiality to the benefit of ALLIANCE INSURANCE (P.S.C.) and its representative.</p>	
Name of the Applicant	
Applicant Signature	Date DD/MM/YYYY

**NOTE: KINDLY ATTACH COPY OF VALID PASSPORT WITH VALID VISA PAGE, EMIRATES ID & PHOTOGRAPH FOR EACH MEMBER.**