WorldCare application form: Group (FMU) employees

Administered by: NOW HEALTH INTERNATIONAL

Insured by: RSA

For company use – intermediary details and stamp

Intermediary company:	Fax number:
	Email address:
Contact name:	Official stamp:
Telephone number:	

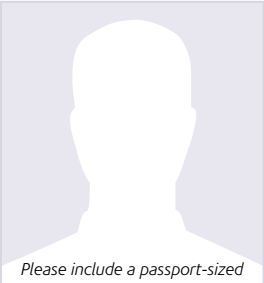
Please complete this form using BLOCK CAPITALS.

Full medical underwriting (FMU) is the process whereby the **Underwriters** assess the declared details in deciding if any special terms apply. All employees and **Eligible Dependants** must complete an application form and send it to Royal & Sun Alliance Insurance Middle East B.S.C. (c), c/o Now Health International Gulf Third Party Administrators LLC, Ground floor, Al Shaiba Building, Dubai Outsource City, PO Box 502163, Dubai, UAE. **You** can also scan and email it to MEAQuotes@worldcare.ae or fax it to +971 (0) 4450 1429.

A deliberate or reckless misrepresentation by **You** may lead to **Us** voiding **Your** membership. Where **You** make a careless misrepresentation **We** may void **Your Group Plan** or decline or reduce related claim payments. A misrepresentation is an untrue statement of fact relied on by one party, in this case **Us**, in establishing the terms of a contract (**Your Group Plan**). **You** should ensure that **You** complete **Your** application carefully, accurately and fairly. If **You** are unsure on any matter **You** should contact **Us**.

We advise **You** to keep a record of all information **You** supply to **Us** in connection with this application.

Please enclose any medical reports or test results with **Your** application. **You** may be required to complete a further medical questionnaire if **We** need more information. All information will be treated in strict confidence.



Please include a passport-sized photograph using a white background of each applicant.

We rely on the information that **You** provide in this form to decide whether or not to accept **Your** application, and whether or not **We** need to apply special terms. Special terms are conditions that **We** may apply to **Your** cover. If **You** submit a claim for the **Treatment** of any existing condition which **You** did not tell **Us** about here or did not tell **Us** everything about, **We** may refuse to pay that claim. **We** also have the right to declare **Your** membership to the **Group Plan** void, or **We** may impose special terms on **Your Group Plan** which **We** will apply retrospectively. Please take the greatest care to ensure that this application form is completed fully and accurately.

If, after completing **Your** application form and before the latest of either **Our** written acceptance, payment of premium or **Your Start Date**/**Entry Date**, anything occurs which affects the information **You** provided in this form, such as a change in **Your** state of health or the state of health of any of **Your Dependants**, **You** must tell **Us** in writing about the change.

We reserve the right to decline or accept **Your** application or to accept **Your** application form with special terms.

Please send **Your** completed application form along with a copy of **Your** government issued identity document to **Us** via **Your** intermediary, or direct to Now Health International Gulf Third Party Administrators LLC, Ground floor, Al Shaiba Building, Dubai Outsource City, PO Box 502163, Dubai, UAE. **You** can also scan and email it to MEAQuotes@worldcare.ae or fax it to +971 (0) 4450 1429.

Section 1: Name of Insured Person

First name(s):	Family name:
What do **You** like to be called?	

*(If **Your** full name is John Andrew Smith, **You** might like to be called John or Mr Smith or Andy. **We** will address all correspondence to **You** in this way.)*

Section 2: Insured Person details

Address:					
Email address:					Preferred telephone number *(including country code)*:
Is this **Your**	Mobile ☐	Home ☐	Work ☐		*If **You** would like SMS notifications, please tell us **Your** mobile number:*
Gender:	Male ☐	Female ☐			Date of birth (dd/mm/yyyy): / /
Marital status:	Married ☐	Unmarried ☐			**Country of Residence**:
Residential region: (e.g. Umm Suqeim First)					Nationality:
Passport number:		UID (Visa) number:			File number (Visa):
Emirates ID number: (000-0000-0000000-0)					Emirate of Visa issuance:
Height (cm/ft):					Weight (kg/lbs):
Occupation:					Occupation industry:

Work region: (e.g. Oud Metha)	
Monthly salary:	< 4,000 AED ☐ 4000 < 12,000 AED ☐ > 12,000 AED ☐ Unsalaried ☐
Commission based salary:	Yes ☐ No ☐
Are **You** or any intended member of this policy, or any family member or close associate a politically exposed person? (If yes please provide further details)	Yes ☐ No ☐

Section 3: Spouse and Dependant details

Spouse details		
First name(s):	Family name:	
What does he/she like to be called?		
Email address:	Phone number:	
Gender: Male ☐ Female ☐	Date of birth (dd/mm/yyyy): / /	
Marital status: Married ☐ Unmarried ☐	**Country of Residence**:	
Residential region: (e.g. Umm Suqeim First)	Nationality:	
Passport number:	UID (Visa) number:	File number (Visa):
Emirates ID number: (000-0000-0000000-0)	Emirate of Visa issuance:	
Height (cm/ft):	Weight (kg/lbs):	
Occupation:	Occupation industry:	
Work region: (e.g. Oud Metha)		
Monthly salary:	< 4,000 AED ☐ 4000 < 12,000 AED ☐ > 12,000 AED ☐ Unsalaried ☐	
Commission based salary:	Yes ☐ No ☐	

Dependant details	Dependant 1	Dependant 2	Dependant 3	Dependant 4
First name(s):				
Family name:				
What do they like to be called?				
Email address:				
Phone number:				
Gender:	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Date of birth (dd/mm/yyyy):	/ /	/ /	/ /	/ /
Marital status:	Married ☐ Unmarried ☐	Married ☐ Unmarried ☐	Married ☐ Unmarried ☐	Married ☐ Unmarried ☐
Country of Residence:				
Residential region: (e.g. Umm Suqeim First)				
Nationality:				
Passport number:				
UID (Visa) number:				
File number (Visa):				
Emirates ID number: (000-0000-0000000-0)				
Emirate of Visa issuance:				
Height (cm/ft):				
Weight (kg/lbs):				

Relationship to **Planholder**:				
Occupation (ages 16+):				
Occupation industry:				
Work region: (e.g. Oud Metha)				
Monthly salary:	< 4,000 AED ☐ 4000 < 12,000 AED ☐ > 12,000 AED ☐ Unsalaried ☐	< 4,000 AED ☐ 4000 < 12,000 AED ☐ > 12,000 AED ☐ Unsalaried ☐	< 4,000 AED ☐ 4000 < 12,000 AED ☐ > 12,000 AED ☐ Unsalaried ☐	< 4,000 AED ☐ 4000 < 12,000 AED ☐ > 12,000 AED ☐ Unsalaried ☐
Commission based:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Section 4: Doctor's contact details

Please give details of **Your** current usual doctor or the one who is most familiar with **Your** medical history.

Medical Practitioner's details

Name:	Telephone number:
Address:	
Date of last attendance and reason:	

Section 5: Insurance details

5.1 Do **You** currently have health insurance with another company? Yes ☐ No ☐

If yes, please give details:

5.2 Do **You** intend to continue with the existing insurance? Yes ☐ No ☐

5.3. Have **You** been insured previously with Now Health International? Yes ☐ No ☐

If yes, please give dates of when insured and previous policy number:

5.4 Have **You** ever had an application for **Medical Insurance** declined or had special terms imposed? Yes ☐ No ☐

If yes, please give details:

Section 6: Health declaration

If **You** have more than five **Dependants**, please use a separate sheet of paper and attach it to this application.
You do not need to disclose matters related to common colds, **Vaccinations** or hayfever.

	Insured Person	Dependant (Spouse)	Dependant 1	Dependant 2	Dependant 3	Dependant 4
6.1 Have **You** in the last five years ever undergone any **Surgical Procedure,** been a patient or been treated in a **Hospital**, clinic, sanatorium, nursing home or other medical institution where **You** were off work for more than one week, and/or received more than 10 days **Treatment**?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6.2 Are **You** currently taking any kind of medication (other than oral contraceptives), or is any **Treatment** or tests currently being performed or planned, or any day or **In-Patient** hospitalisation scheduled?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Have **You** ever received **Treatment**, tests or investigations for, been diagnosed with, or been hospitalised or had signs or symptoms of for:

6.3	Asthma, bronchitis, tuberculosis, pneumonia or any other respiratory conditions?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6.4	Anxiety, depression, psychological, psychiatric, mental condition, drug or alcohol addiction or abuse?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6.5	Blood disorders, anaemia, haemophilia, thalassemia or other abnormal blood tests? Have **You** ever been tested positive for HIV, Hepatitis B or C?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6.6	**Cancer**, cyst, polyp, or any abnormal growth whether cancerous or benign?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6.7	Digestive disorder including stomach, colon, rectum, hernia or any other bowel problems?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6.8	Disorders of the kidneys, spleen, liver, pancreas, bladder, prostate, renal or recurrent urinary conditions?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6.9	Diabetes, thyroid disorders or weight management problems?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6.10	Epilepsy, multiple sclerosis or other neurological conditions?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6.11	High blood pressure, heart or circulatory conditions, stroke or higher than normal cholesterol level?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6.12	Knee, back or skin disorders, rheumatism, gout, arthritis or disease of the bone, spine, joint, muscle?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6.13	Any type of disease, physical impairment, congenital or hereditary disorder, disability, recurrent illness, currently pregnant, major injury or **Medical Condition** not already noted above?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6.14	Females only Have **You** ever suffered from any breast or gynaecological disorders?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6.15	Are **You** currently pregnant?	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐

If yes, have there been any complications to date? Please give details:

Last menstrual period date :

6.16	Are **You** currently trying to get pregnant?	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
6.17	Are **You** undergoing any form of fertility **Treatment**?	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐

If yes, please give details:

☐ I understand and acknowledge any pregnancy not declared at the time of this application's coverage will be at the sole discretion of Royal & Sun Alliance Insurance Middle East B.S.C. (c). Royal & Sun Alliance Insurance Middle East B.S.C. (c) 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 Royal & Sun Alliance Insurance Middle East B.S.C. (c).

Additional information

If **You** answered 'Yes' to any of questions 6.1 to 6.17, please provide details in the box below.
Please provide as much detail as possible, including the date and nature of diagnosis, frequency and severity of symptoms, date of last episode as well as details of any past, current or known future **Treatment**.

Member name	Diagnosis (If none made please describe the exact nature of symptoms suffered)	Date of consultation	Treatment received	Date of last treatment/ symptoms	Any underlying cause	Specific location on body including left or right	Outcome (e.g. on-going complete recovery, likely to recur) or for smears, frequency (annually, 6-monthly)

Section 7: Important notes

Royal & Sun Alliance Insurance Middle East B.S.C. (c) and Now Health International may contact **You** with details of other products and services which may be of interest to **You**. **You** may be contacted by post, telephone or email if appropriate. If **You** do not wish this to happen please tick this box ☐.

*As per the Dubai Health Authority circular, **We** cannot back date cover for Dubai resident visa holders (only in exceptions for new born and this is limited to up to 7 days).

By signing this Application Form **You** consent to the processing and transfer of information (including sensitive information) described in this notice. Without this consent **We** will not be able to consider **Your** application.

Section 8: Declaration and authorisation

I hereby apply for cover on behalf of all the persons named in this application form for a WorldCare **Group Plan** as specified above.

I have received and read the **Benefit Schedule**, Terms and Conditions, Definitions, **Benefits** and exclusions of this **Group Plan**. I understand that the Application Form, **Certificate of Insurance**, **Benefit Schedule** and the Members' Handbook incorporating the **Group Plan** terms and conditions make up the contract between **Us** and all form part of the **Group Plan** Agreement. I am aware that cover shall be provided in accordance with the Agreement.

- I declare that the information given in this application is true and that disclosure in respect of each person included in this application is complete, even if some of the information provided is not in my own handwriting. I understand it is unlawful for me or my **Dependants** to knowingly provide false, incomplete or misleading facts or information (ie. misrepresentation) for the purpose of defrauding or attempting to defraud Royal & Sun Alliance Insurance Middle East B.S.C. (c). Penalties may include imprisonment, fines, denial of coverage, loss of premium, loss of **Benefits** and legal damages.
- I understand that I must notify 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, before the latest of either written acceptance, payment of premium or the **Start Date/Entry Date**.
- For the purpose of this application I authorise any doctor who has ever treated or advised any of the persons named in this application to provide any information which may be required in connection with **Treatment** related to any claim under this **Group Plan**. I have discussed the terms of this authorisation with my partner and competent adult **Dependants**, and I have obtained their consent to the release of their healthcare information pursuant to this authorisation.
- I declare that I have read and understood the following from the members' handbook:
  - cancellation and termination rights
  - complaints procedures and referral rights to the financial ombudsman service
  - law and jurisdiction of the **Group Plan**
  - language of the **Group Plan** and **Our** service
  - compensation arrangements
  - Now Health International Gulf Third Party Administrators LLC is acting on behalf of Royal & Sun Alliance Insurance Middle East B.S.C. (c) for the purpose of administering **Group Plans**.
- I and those to be covered under this **Group Plan** acknowledge and agree to our personal data being processed by Royal & Sun Alliance Insurance Middle East B.S.C. (c), its administrator or its group companies and those other parties, wherever located, for the purpose of administering my **Group Plan**.
- I understand that Royal & Sun Alliance Insurance Middle East B.S.C. (c) cannot be liable and therefore will not pay claims if my **Group Plan** is lapsed should Royal & Sun Alliance Insurance Middle East B.S.C. (c) be unable to collect my premium for whatever reason and I do not provide an alternate method of payment within seven days of receiving requests for alternative methods of payment.
- I agree that where **Medical Treatment** is received within the provider network by me or any of my **Dependants** and, except where previously agreed by Royal & Sun Alliance Insurance Middle East B.S.C. (c), it is determined that the **Treatment** or **Medical Condition** is not refundable within the terms and conditions of the **Group Plan**, I agree that I am liable to Royal & Sun Alliance Insurance Middle East B.S.C. (c) for all claims settled for such medical **Treatment** in connection with any non-covered claim.
- I understand and confirm that where I have not repaid funds disbursed in good faith by Royal & Sun Alliance Insurance Middle East B.S.C. (c) in respect of non-covered medical **Treatment**, valid claims may be offset against outstanding funds due to Royal & Sun Alliance Insurance Middle East B.S.C. (c) and/or my **Group Plan** may be suspended until the outstanding amounts have been settled in full.
- I acknowledge that if it is determined by Royal & Sun Alliance Insurance Middle East B.S.C. (c) that a claim was fraudulent my Membership of the **Group Plan** may be voided with immediate effect.
- I understand that if I am able to claim any costs from another insurance policy for the cost of any treatment or benefits received, Royal & Sun Alliance Insurance Middle East B.S.C. (c) will only be liable for a proportional share of the total costs.
- I have read the important notes.
- I agree to the declaration above and understand that cover is provided in accordance with the terms and conditions of the WorldCare **Group Plan**.

Signature (Insured Person):

Date (dd/mm/yyyy):

/ /

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