

Under Dubai Health Authority rules, we are required to hold the following additional identification information on file. Please ensure you complete the following fields, as without this, we cannot progress your application.

Emirates ID number

Passport Number

Passport Expiry Date

Visa/Work Permit UID number

File number

City, i.e. actual city of residence based on Dubai Statistics Center (DSC)

Location, i.e. actual location in city of residence based on Dubai Statistics Center (DSC)

Marital status: Single Married

Emirate where visa was issued

Work location or location of Sponsor Head Office (e.g. Umm Suqaim – 1, Umm Suqaim – 2)

Sponsoring entity status: Resident Citizen (i.e. UAE locals, GCC locals) Establishment Property owner

Sponsoring entity ID (i.e. residence or citizen file number, establishment code or property owner UID)

Salary band: less than 4,000 AED per month between 4,001 - 12,000 AED per month greater than 12,000 AED per month No salary

Income: Includes commission Does not include commission

Details of any current domestic or international health insurance:

Name of insurer

Policy number Start date

Please note that your policy documentation will be provided in English.

2 Your dependants' details

You can add dependants to your policy. Dependants are your spouse/partner and any children financially dependent on you up to the day before their 18th birthday, or up to the day before their 26th birthday if they are in full-time education. If they are aged 18 to 25 and in full-time education, please attach either a letter from the college/university confirming their student status or a copy of their student ID.

If there is insufficient space for all dependants, please use another Application Form and ensure all relevant declarations and consents are signed and dated.

	Dependant 1	Dependant 2	Dependant 3
Relationship to applicant	Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/>	Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/>	Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/>
First name	<input type="text"/>	<input type="text"/>	<input type="text"/>
Surname	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of birth	<input type="text" value="DD / MM / YYYY"/>	<input type="text" value="DD / MM / YYYY"/>	<input type="text" value="DD / MM / YYYY"/>
Gender at birth	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Occupation (mandatory, please state if student)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address (mandatory for dependants over 18)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Home country	<input type="text"/>	<input type="text"/>	<input type="text"/>
Principal country of residence	<input type="text"/>	<input type="text"/>	<input type="text"/>
Nationality	<input type="text"/>	<input type="text"/>	<input type="text"/>
Emirates ID number	<input type="text"/>	<input type="text"/>	<input type="text"/>
Passport Number	<input type="text"/>	<input type="text"/>	<input type="text"/>
Passport Expiry Date	<input type="text" value="DD / MM / YYYY"/>	<input type="text" value="DD / MM / YYYY"/>	<input type="text" value="DD / MM / YYYY"/>
Visa/Work Permit UID number	<input type="text"/>	<input type="text"/>	<input type="text"/>
File number	<input type="text"/>	<input type="text"/>	<input type="text"/>
City, i.e. actual city of residence based on Dubai Statistics Center (DSC)	<input type="text"/>	<input type="text"/>	<input type="text"/>

	Dependant 1	Dependant 2	Dependant 3
Location, i.e. actual location in city of residence based on Dubai Statistics Center (DSC)			
Marital status	Single <input type="checkbox"/> Married <input type="checkbox"/>	Single <input type="checkbox"/> Married <input type="checkbox"/>	Single <input type="checkbox"/> Married <input type="checkbox"/>
Emirate where visa was issued			
Work location or location of Sponsor Head Office (e.g. Umm Suqaim - 1, Umm Suqaim - 2)			
Sponsoring entity status	Resident <input type="checkbox"/> Citizen (i.e. UAE locals, GCC locals) <input type="checkbox"/> Establishment <input type="checkbox"/> Property owner <input type="checkbox"/>	Resident <input type="checkbox"/> Citizen (i.e. UAE locals, GCC locals) <input type="checkbox"/> Establishment <input type="checkbox"/> Property owner <input type="checkbox"/>	Resident <input type="checkbox"/> Citizen (i.e. UAE locals, GCC locals) <input type="checkbox"/> Establishment <input type="checkbox"/> Property owner <input type="checkbox"/>
Sponsoring entity ID (i.e. residence or citizen file number, establishment code or property owner UID)			
Salary band	Less than 4,000 AED per month <input type="checkbox"/> Between 4,001 - 12,000 AED per month <input type="checkbox"/> Greater than 12,000 AED per month <input type="checkbox"/> No salary <input type="checkbox"/>	Less than 4,000 AED per month <input type="checkbox"/> Between 4,001 - 12,000 AED per month <input type="checkbox"/> Greater than 12,000 AED per month <input type="checkbox"/> No salary <input type="checkbox"/>	Less than 4,000 AED per month <input type="checkbox"/> Between 4,001 - 12,000 AED per month <input type="checkbox"/> Greater than 12,000 AED per month <input type="checkbox"/> No salary <input type="checkbox"/>
Income	Includes commission <input type="checkbox"/> Does not include commission <input type="checkbox"/>	Includes commission <input type="checkbox"/> Does not include commission <input type="checkbox"/>	Includes commission <input type="checkbox"/> Does not include commission <input type="checkbox"/>

Details of any current domestic or international health insurance

Name of current insurer (if applicable)			
Current policy number (if applicable)			

3 Start date of your cover

From what date do you require:

/ /

You will have confirmation that your application for cover has been accepted when we issue you the Insurance Certificate. Your cover will be valid from the start date shown on the Certificate.

4 Plan details (This section does not need to be completed if you are applying as part of a group scheme)

Please note that each plan chosen will apply to all policy members.

Select your area of cover (The area of cover is subject to full terms and conditions as stated in the Benefit Guide)	<input type="checkbox"/> Worldwide	<input type="checkbox"/> Worldwide excluding USA			
Select your Core Plan (Please refer to the Benefit Guide and Table of Benefits for details of the various plans listed)	<input type="checkbox"/> Dubai Elite Individual	<input type="checkbox"/> Dubai Prime Individual	<input type="checkbox"/> Dubai Select Individual		
Select your Out-patient Plan (Please note that an Out-patient Plan must be selected as dictated by Dubai Health Authority requirements)	Out-patient Plan	<input type="checkbox"/> Dubai Gold Individual	<input type="checkbox"/> Dubai Silver Individual	<input type="checkbox"/> Dubai Pearl Individual	
	Select your Out-patient Plan co-payment (Please note that the co-payment option selected will apply per person, per out-patient visit)	<input type="checkbox"/> No co-payment	<input type="checkbox"/> 10% co-payment, up to max. US\$ 14 per visit	<input type="checkbox"/> 20% co-payment, up to max. US\$ 28 per visit	
Select your Optional Plans (Optional plans can only be purchased in conjunction with a Core and an Out-patient Plan)	Dental Plan (Please note that, as mandated by the Dubai Health Authority, you are required to select the Dubai Individual Dental Plan 4 at a minimum. Alternatively, you may choose any of the other three Dental Plans if you prefer more comprehensive coverage.)	<input type="checkbox"/> Dubai Individual Dental 1	<input type="checkbox"/> Dubai Individual Dental 2	<input type="checkbox"/> Dubai Individual Dental 3	<input type="checkbox"/> Dubai Individual Dental 4
	Enhanced Maternity Plan	<input type="checkbox"/> Dubai Elite Enhanced Maternity	<input type="checkbox"/> Dubai Prime Enhanced Maternity		
	Repatriation Plan	<input type="checkbox"/> Dubai Individual Repatriation Plan			
Select your Hospital Network	<input type="checkbox"/> Comprehensive Network (access to all medical providers in the network including the Dubai based American Hospital)	<input type="checkbox"/> Comprehensive Network Excl. CCAD (excludes Cleveland Clinic Abu Dhabi)	<input type="checkbox"/> Standard Network (excludes Cleveland Clinic Abu Dhabi, OP at American Hospital, Hospitals under Mediclinic Group)	<input type="checkbox"/> RN Enhanced Network (please refer to the RN Enhanced network list for the full details on included providers)	

5 Medical Underwriting terms available

Full medical underwriting

This means we assess your health history when considering your insurance application and likely terms of cover. If you have a pre-existing condition (as defined below), you must declare this accurately, honestly and completely ensuring you answer all questions asked in the 'Your Health' section below for all applicants.

Pre-existing conditions

Pre-existing conditions are medical conditions for which one or more symptoms have appeared at some point during your or your dependants' lifetime. This applies regardless of whether you or your dependants sought any medical advice or treatment.

We would deem any such condition to be pre-existing if we could reasonably determine that you or your dependants have known about it. Your policy will cover pre-existing conditions unless we tell you otherwise in writing.

We will also treat as pre-existing any medical conditions that arise between the date you complete the Application Form and the later of the following:

- The date we issue your Insurance Certificate, or
- The start date of your policy

Pre-existing conditions will be subject to full medical underwriting and if they are not disclosed, they will not be covered or other underwriting measures may apply, as outlined by the Dubai Health Authority. Therefore, it is important that in the periods outlined above, you inform us if there is any change to your and your dependants' health status or to any material facts (facts likely to influence our assessment and acceptance of this application). In addition, you will need to provide further information, if requested.

If you already have one of our healthcare plans and are applying for a cover upgrade or for a new policy, please tell us about any medical conditions you have claimed for since joining us.

6 Your Health

Please answer the following questions based on your own and your dependants' full medical history. You must disclose all material facts (i.e. facts likely to influence our assessment and acceptance of this application). If you are in any doubt about whether a fact is material, then you should disclose it to us. Failure to disclose all material facts may invalidate the policy.

This health declaration is valid for two months from the date you complete and sign the form.

	Applicant	Dependant 1	Dependant 2	Dependant 3
Height	<input type="text"/> <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> cm
Weight	<input type="text"/> <input type="text"/> <input type="text"/> kg	<input type="text"/> <input type="text"/> <input type="text"/> kg	<input type="text"/> <input type="text"/> <input type="text"/> kg	<input type="text"/> <input type="text"/> <input type="text"/> kg
Have you used any form of tobacco in the past year?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, how much per day on average? 1 cigarette = 1 unit, 1 medium cigar = 2 units, 1 gram roll-your-own tobacco = 2 units, 1 pipe bowl tobacco = 2.5 units, 10mg e-cigarette nicotine = 1 unit, if none state NO	<input type="text"/> <input type="text"/> <input type="text"/> /day	<input type="text"/> <input type="text"/> <input type="text"/> /day	<input type="text"/> <input type="text"/> <input type="text"/> /day	<input type="text"/> <input type="text"/> <input type="text"/> /day
Do you drink alcohol?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, how many units of alcohol do you drink per week? 1 short = 1 unit, 250ml beer = 1 unit, 1 glass wine = 1 unit. If none state NO	<input type="text"/> <input type="text"/> <input type="text"/> /week	<input type="text"/> <input type="text"/> <input type="text"/> /week	<input type="text"/> <input type="text"/> <input type="text"/> /week	<input type="text"/> <input type="text"/> <input type="text"/> /week

1. Has any person included in this application ever suffered from, been in hospital with, or had tests, investigations or treatment of any kind, for the following conditions?

- (a) Any heart or circulatory disease or disorders, such as, but not limited to, heart attack, coronary artery disease, vascular disease, irregular heartbeat, murmur, chest pain, clots, blood disorder, abnormal blood pressure or high cholesterol. Yes No
- (b) Any dermatological disease or disorder, such as, but not limited to psoriasis, dermatitis, eczema, allergy or acne. Yes No
- (c) Any endocrine disease or disorder, such as, but not limited to, diabetes, pancreatitis, weight problems, gout or thyroid problems or other hormonal imbalances. Yes No
- (d) Any eye, ear, nose and throat disease or disorder, such as, but not limited to, cataract, glaucoma, detached retina, hearing loss, ear infections, sinus problems, tonsillitis, adenoiditis or myopia with levels greater than -6. Yes No
- (e) Any gastrointestinal disease or disorder, such as, but not limited to stomach problems, hernia, haemorrhoids, gall stones, colon polyps, Crohn's disease, colitis or liver problems. Yes No
- (f) Any infectious or viral disease or disorder, such as, but not limited to, hepatitis A/B/C, herpes, HIV, SARS-CoV-2 / COVID-19, malaria, meningitis, blood infection or sexually transmitted disease. Yes No
- (g) Any muscular or skeletal disease or disorder, such as, but not limited to back, neck or joint pain, arthritis, fibromyalgia, joint replacement, any cartilage and ligament problem or carpal tunnel syndrome. Yes No
- (h) Any neurological disease or disorder, such as, but not limited to stroke, multiple sclerosis, epilepsy, neurodegenerative disorder, paralysis, seizures, migraine, Alzheimer's or other form of dementia. Yes No
- (i) Any oncological disease or disorder, such as, but not limited to any cancer, leukaemia, lymphoma, tumour, skin lesion, growth, lump, cyst, mole, polyp or naevus. Yes No

- (j) **Any psychiatric or psychological disorder**, such as, but not limited to attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, depression, anxiety, chronic fatigue syndrome, eating disorder, obsessive-compulsive disorders, phobic disorders or alcohol/drug problem. Yes No
- (k) **Any respiratory or lung disease or disorder**, such as, but not limited to chronic obstructive pulmonary disorder, sarcoidosis, asthma, bronchitis, sinusitis, shortness of breath or allergy. Yes No
- (l) **Any urological or reproductive organs disease or disorder**, such as, but not limited to kidney or urinary tract problems, menstrual impairment, fertility problems, fibroids, endometriosis, testicular or prostate problems. Yes No
- (m) **Any congenital disease or disorder** present at or before birth, such as but not limited to, adrenal hyperplasia, cystic fibrosis, Down syndrome, haemophilia, heart defects, Huntington's disease, Klinefelter's syndrome, Marfan syndrome, malformations and spina bifida. Yes No
Please do NOT disclose results of any genetic (DNA or RNA) tests as these are not required for the underwriting process.
- (n) **Any other accident, injury, disease or disorder** not already disclosed. Yes No

2. Please tell us whether you or your dependants:

- (o) Are currently taking any prescribed or over-the-counter drugs, medication, tablets or other treatment. Yes No
- (p) Are expecting to have a medical review, has been referred for further tests/investigations, or is awaiting results or any treatment due to accident, injury, disease or disorder. Yes No
- (q) Have undergone any tests or investigations within the last 10 years which resulted in referral for further medical advice or treatment, such as, but not limited to biopsy, colonoscopy, colposcopy, computed tomography (CT), mammogram, magnetic resonance imaging (MRI), Papanicolaou test (PAP), or prostate-specific antigen test (PSA), echocardiogram (Echo) or ultrasound (US). Yes No
Please do NOT disclose results of any genetic (DNA or RNA) tests, as these are not required for medical underwriting.
- (r) Have experienced within the past two years, any recurrent or ongoing symptoms or medical complaints NOT related to a condition already disclosed such as, but not limited to: Yes No
 - Fever (103°F/39.4°C or above) and/or continuous cough
 - Shortness of breath
 - Hoarseness
 - Severe/ongoing headache
 - Mole or skin marking that has bled, changed or become painful
 - Tingling
 - Blurred or double vision
 - Unexpected weight loss
 - Bleeding per rectum, change in bowel habit or urine frequency,
 - Loss of sensation, seizures, loss of consciousness
 - Abnormal bleeding
 - Joint pain/stiffness etc.
- (s) Have been recommended or decided to self-isolate within the past 30 days? Yes No

Please complete the following question only if you are purchasing dental cover.

- (t) Is any person included in this application currently undergoing or have they been advised to undergo any dental treatment, dental surgery, dental prosthesis, orthodontics or periodontics? Yes No

3. Pregnancy declarations

- (a) Is any person on this application **currently pregnant**? Yes No
 If yes please state the following:
 1. the name of the pregnant person
 2. due date / /
 3. have there been any complications to date? Yes No
- (b) Is any person on the application form **trying to get pregnant**? Yes No
 If Yes, please state the name of the person trying to get pregnant
- (c) Date of the last Menstrual Period / /
- (d) Is any person on the form **undergoing any form of fertility treatment**? Yes No
 If Yes, please state the name of the person undergoing fertility treatment

I understand and acknowledge that cover will be at the sole discretion of the insurer, if any pregnancy is not declared at the time of this application. The insurer has the right to decline the maternity cover and payment of any related claims. I also acknowledge and understand that the insurer may not provide maternity cover should any pregnancy arise within forty calendar days from the date of this application.

7 Declaration

Please read the following declarations carefully. You will need to sign below in the 'Approvals' section to confirm you understand and accept them.

- I declare that all information supplied above is true and complete, including those answers that are not in my own handwriting. I also declare that I have not suppressed, misrepresented or misstated any material fact. I understand that this application will be the basis of the contract between Orient Insurance PJSC and myself, and that any false, incorrect or misleading statement or non-disclosure of material medical information may make this insurance null and void, in accordance with the applicable legislation.
- I undertake to inform Orient Insurance PJSC immediately in writing of any changes in my or my dependants' state of health occurring between completing the Application Form and the start date of the policy.
- I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information in the context of this application for insurance. I consent to the fact that Orient Insurance PJSC or its agents, if it considers it appropriate, to check statements concerning my health condition and to check with other healthcare insurers all statements concerning previous or existing contracts I may have applied for.
- Subject to legal restrictions, Orient Insurance PJSC (or its medical advisers, appointed representatives or third-party experts in case of disputes) may request medical information about me from medical professionals. In these circumstances I authorise all such practitioners, physicians, dentists, members of medical professions, and employees of hospitals, health authorities and medical facilities to provide relevant medical information as requested. I also make this statement for my dependants under the age of 18 and for dependants who cannot assess the meaning of this statement.
- I confirm that:
 - I have read and understood the full definitions, benefits, exclusions and conditions of this policy, including the details relating to pre-existing conditions.
 - I have received, read and understood the Benefit Guide and Table of Benefits. I accept the terms and conditions as explained in these documents.
 - Based on the information provided within these documents and the plan selections that I have made, I believe the product I selected is most suited to my specific insurance needs.
- I understand that:
 - This Application Form is valid for two months from the date of completing and signing it.
 - I can withdraw my application in writing by letter or email within 30 days from the date I receive the full terms and conditions of my policy. Provided that I have not submitted a claim, I am then entitled to a full refund of the premium.
- I accept that:
 - It is my responsibility to check the accuracy of the information contained within the Insurance Certificate, once issued.
 - Cover will be subject to the standard terms and conditions that apply at the start or renewal date of the policy and are set out in the Benefit Guide.
 - The cover provided by Orient Insurance PJSC may not be suitable if my dependants and I are or become resident in countries where local compulsory health insurance restrictions are in place.
 - It is my responsibility to check if I am subject to any local compulsory health insurance requirements in my country of residence and I can confirm that my healthcare cover is legally appropriate.

8 Policyholder appointment

This section must be completed by all dependants wishing to appoint the policyholder as the main point of contact.

To help us administer the policy, you can nominate the policyholder as the main contact for the insurance. To do this, simply consent to this in the 'Approvals' section below.

The policyholder will be authorised to act on behalf of all dependants in the administration of this policy. This may include the disclosure of sensitive medical information. This authorisation will remain in place until I or any dependant on cover request from Orient Insurance PJSC in writing to revoke it.

9 Broker appointment (if applicable)

By consenting below in the 'Approvals' section, I authorise the named to act on my behalf in relation to the administration of this policy. This may include the disclosure of sensitive medical information. This authorisation will remain in place until I ask Orient Insurance PJSC in writing to revoke it.

10 Your personal data

Our Data Protection Notice explains how we, NEXtCARE, the administrators (data processors) acting on behalf of your insurer, protect your privacy. This is an important notice which outlines how we will process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice visit: www.nextcarehealth.com/privacy-notice

Alternatively, you can contact us on +971 4 2708800 to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, please e-mail us at: AZChelpline@nextcarehealth.com

11 Data Consent

We need your consent to collect and process your health and other personal data. If you do not give explicit consent, we may not be able to provide you with your policy or process any claims you may be entitled to make. If you agree, we will process your data for the following reasons and activities.

A parent or guardian should complete the consent for any member under the age of 18.

I (the applicant), and the dependants named below agree with the following:

Name of applicant	Name of dependant 1	Name of dependant 2	Name of dependant 3
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

- 1. Permission to collect, store and use my health data:** The insurer may collect, store and use my health data to administer the policy, for example to provide me with a quote for insurance cover, underwrite the risks to be insured or process any claims. The insurer may store my health data in accordance with the Consumer Code of the law applying to this insurance policy or with any other applicable law requiring the retention of the data.
- 2. Permission to obtain my data from third parties:** To provide me with insurance cover, underwrite the risks to be insured or process any claims, the insurer may obtain my health and other data from physicians, nursing and hospital staff, other medical institutions, care homes, statutory health insurance funds, my plan sponsor, professional associations and public authorities. I agree to release all individuals at these institutions and the insurer from their respective confidentiality obligations relating to my health data or other data that they have to share and use for the purposes stated above.
- 3. Sharing my data outside of the insurer:** The insurer may share my health and other data with the experts or institutions set out below. They will only use the data to the same extent and for the same purposes as the insurer. I understand that the insurer has put in place arrangements with these institutions to protect my data. I agree to release all individuals at these institutions and the insurer from their respective confidentiality obligations relating to my health data and other data that they have to share and use for the purposes set out below:
 - With independent medical experts to enable them to assess insurance risks and any benefits to be paid to me or to the third party providing treatment or service to me under my insurance policy.
 - With service providers outside of the insurer companies that perform certain services on behalf of the insurer, such as risk assessments and claims handling, where:
 - these services involve the collection and use of my health and other data, and
 - the insurer would not be able to administer my policy or pay any claims due to me without such data.
 - With co-insurers to distribute the coverage of the insurance risk jointly with other companies to which the insurer issues the policy, and to handle claims jointly.
 - With other insurers/reinsurers that may be covering the same insurance risk at the same time (multiple insurance) to:
 - distribute the payment of any compensation that may be owed to me, or
 - collaborate in the detection or prevention of fraud and financial crime.

If I change my mind about my preferences above, including withdrawing my consent to any of these items, I can let the insurer know by emailing AZChelpline@nextcarehealth.com

12 Marketing preferences

I (the applicant) and my dependants agree that the insurer may collect, use and disclose my personal data to provide me with marketing information. I understand that my personal data will only be used for the following reasons and activities, which I have expressly agreed to by ticking the boxes below.

Name of applicant	Name of dependant 1	Name of dependant 2	Name of dependant 3
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

- Information that the insurer sends about their products and services, including updates on their latest promotions and new products and services.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------
- Information sent directly by Orient Insurance PJSC on their products and services. I understand that you will disclose my relevant contact information to them for that purpose.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------
- Information sent directly by the business partners of the insurer on their products and services. I understand that you will disclose my relevant contact information to them for that purpose.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------
- Such communications should be sent to me by the following methods:

<input type="checkbox"/> Email	<input type="checkbox"/> Email	<input type="checkbox"/> Email	<input type="checkbox"/> Email
<input type="checkbox"/> In-app notifications	<input type="checkbox"/> In-app notifications	<input type="checkbox"/> In-app notifications	<input type="checkbox"/> In-app notifications
<input type="checkbox"/> Phone	<input type="checkbox"/> Phone	<input type="checkbox"/> Phone	<input type="checkbox"/> Phone
<input type="checkbox"/> Post	<input type="checkbox"/> Post	<input type="checkbox"/> Post	<input type="checkbox"/> Post

13 Approvals

Please indicate the section you're providing consent for.

- | | | |
|---------------------------------------|--------------------------|--------------|
| 7. Declaration** | <input type="checkbox"/> | |
| 8. Policyholder appointment** | <input type="checkbox"/> | |
| 9. Broker appointment (if applicable) | <input type="checkbox"/> | Broker name: |
| 10. Your personal data** | <input type="checkbox"/> | |
| 11. Data consent** | <input type="checkbox"/> | |
| 12. Marketing preferences | <input type="checkbox"/> | |

Signatures

The applicant and each named dependant above 18 need to sign this Application here. By signing, you are consenting to the relevant sections ticked above.

 Applicant's signature	 Dependant 1's signature	 Dependant 2's signature	 Dependant 3's signature
<input type="text" value="D"/> <input type="text" value="D"/> / <input type="text" value="M"/> <input type="text" value="M"/> / <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> / <input type="text" value="M"/> <input type="text" value="M"/> / <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> / <input type="text" value="M"/> <input type="text" value="M"/> / <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> / <input type="text" value="M"/> <input type="text" value="M"/> / <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>

** Please note that we won't be able to process your application if you have not provided consent for the marked sections in the Approvals' box above.

14 Payment details

You don't need to complete this section if you are applying as part of a group scheme and your employer is paying the premium.

Please don't make any payments until you receive your policy number.

Premium must be paid in US Dollars only.

Payment frequency and method

Payments are subject to the following administration surcharges: 0% for annual payment, 3% for half-yearly payments and 4% for quarterly payments

Please tick to indicate your preferred payment frequency and method:

	Annual	Half-yearly	Quarterly
Bank transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Card payment

If you choose to pay by card, please provide the following information:

Card type MasterCard VISA


Cardholder's name

Card number Expiry date / /

For security reasons, once we have transferred this information to our system, we will detach the card details from the application form and destroy them.

Card authorisation

I authorise Orient Insurance PJSC to charge my card for my health insurance. I understand I will be notified of the premium when my cover/renewal is accepted, or, if I request a change that affects my premium, such as adding a dependant. This payment will continue until I cancel the instruction by giving written notice to Orient Insurance PJSC. I understand I will be given one month's notice of any annual premium rate increase.

 Cardholder's signature _____ Date / /

Please return your fully completed form by:

Email to: AZCunderwriting@nextcarehealth.com
Post to: Orient Insurance PJSC, Allianz Designed Products, 02a Orient Building,
 Al Badia Business Park, Dubai Festival City, P.O. Box 27966, Dubai, United Arab Emirates

If you have any questions regarding this Application Form or the application process, please contact our Helpline on:
800 6334 (toll-free from inside the UAE) or + 971 (0)56 681 9977 (from outside the UAE).