International Healthcare Plans for Dubai (Direct Settlement)

Application Form

Please complete this form in **BLOCK CAPITALS**

If you are adding a new dependent to an existing policy, please state your policy number:

If you are applying to join an existing group scheme, please state:

Group name

Group number

Guidelines on How to complete this Application Form

1. You must complete the Application form in full and tell us all relevant information. Once you have sent us your application, our Medical Underwriting Team will review the details. If you have told us about any medical conditions we may ask you for more information. We will then assess the information and get back to you with our decision as quickly as possible.
2. If you already have one of our healthcare plans, please tell us about any medical conditions you have claimed for since joining us.
3. Section 7 must be signed by the policyholder. Sections 8 and 11 must be signed by all adult applicants. In line with the European General Data Protection Regulation (GDPR), we won't be able to process your application without these signatures. A parent or guardian should complete these sections for any applicants under the age of 18. Section 9 needs to be signed by all adult applicants wishing to appoint a broker as the main point of contact for this policy.
4. If any person applying for cover is undergoing dental treatment, please ensure a dental questionnaire is completed. This can be requested by emailing to **underwriting@international-healthcare.com**

Wherever the following words and phrases appear in this form, they will have the meanings as defined below.
Home country: A country for which you (or your dependents, if applicable) hold a current passport or which is your principal country of residence.
Principal country of residence: The country where you and your dependents (if applicable) live for more than six months of the year.

1 APPLICANT DETAILS (Please note that the applicant will be the policyholder)

You must tell us if your contact details change so we can ensure that correspondence reaches you.

Mr.☐ Mrs.☐ Ms.☐ Miss☐ Other First name

Surname

Date of birth D D / M M / Y Y Gender: Male☐ Female☐

Home country

Nationality

Principal country of residence

Full address in principal country of residence (mandatory)

Primary phone number (mandatory) COUNTRY CODE AREA CODE

Secondary phone number COUNTRY CODE AREA CODE

Email address (mandatory), please print

Occupation (mandatory) (If you are a student, please state this here)

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 D D / M M / Y Y

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 D D / M M / Y Y

2 DEPENDENTS TO BE COVERED UNDER THE CONTRACT

Dependents can include 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 24th birthday if they are in full-time education. If they are aged 18 to 23 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 dependents, please use another Application Form.

	Dependant 1	Dependant 2	Dependant 3
Relationship to applicant	Spouse/Partner ☐ Child ☐	Spouse/Partner ☐ Child ☐	Spouse/Partner ☐ Child ☐
First name			
Surname			
Date of birth	D D / M M / Y Y	D D / M M / Y Y	D D / M M / Y Y
Gender	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Occupation (mandatory, please state if student)			
Email address (mandatory for dependents over 18)			
Home country			
Principal country of residence			
Nationality			
Emirates ID number			
Passport Number			
Passport Expiry Date	D D / M M / Y Y	D D / M M / Y Y	D D / M M / Y Y
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 ☐	Single ☐ Married ☐	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 ☐	Resident ☐ Citizen (i.e. UAE locals, GCC locals) ☐ Establishment ☐ Property owner ☐	Resident ☐ Citizen (i.e. UAE locals, GCC locals) ☐ Establishment ☐ Property owner ☐

	Dependant 1	Dependant 2	Dependant 3
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 ☐	Less than 4,000 AED per month ☐ Between 4,001 - 12,000 AED per month ☐ Greater than 12,000 AED per month ☐ No salary ☐	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 ☐	Includes commission ☐ Does not include commission ☐	Includes commission ☐ Does not include commission ☐

Details of any current domestic or international health insurance

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

3 START DATE OF COVER

Please indicate the date you require cover from: D D / M M / Y Y

Our acceptance of your application for cover is confirmed when we issue your Insurance Certificate and your cover is 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)	☐ Worldwide	☐ Worldwide excluding USA		
Select your Core Plan (Please refer to the Benefit Guide and Table of Benefits for details of the various plans listed)	☐ Dubai Premier Individual	☐ Dubai Classic Individual	☐ 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	☐ Dubai Gold Individual	☐ Dubai Silver Individual	☐ 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)	☐ No co-payment	☐ 10% co-payment	☐ 20% co-payment
Select your Optional Plans (Optional plans can only be purchased in conjunction with a Core and an Out-patient Plan)	Dental Plan	☐ Dubai Individual Dental 1	☐ Dubai Individual Dental 2	
	Repatriation Plan	☐ Dubai Individual Repatriation Plan		
Select your Hospital Network	☐ Comprehensive Network (access to all medical providers in the network including the Dubai based American Hospital)	☐ Comprehensive Network (Excl. AHD, CCAD & SEHA) (provides access to all medical facilities in the "Comprehensive Network" except for the Dubai based American Hospital, Cleveland Hospital and SEHA.	☐ Standard Network (access to all medical providers in the "Comprehensive Network (Excl. AHD, CCAD & SEHA)", except for the Dubai based Welcare Hospital and the City Hospital)	

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

5 PRE-EXISTING CONDITIONS

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

We would deem any such condition to be pre-existing if we could reasonably assume you or your dependents 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 dependents' 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.

6 HEALTH DECLARATION

Please answer the following questions based on your own and your dependents' full medical history. **All material facts (facts likely to influence our assessment and acceptance of this application) must be disclosed. 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	Dependent 1	Dependent 2	Dependent 3
Height	☐☐☐ cm	☐☐☐ cm	☐☐☐ cm	☐☐☐ cm
Weight	☐☐☐ kg	☐☐☐ kg	☐☐☐ kg	☐☐☐ kg
Have you used any form of tobacco in the past year?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
If yes, how much per day on average?	☐☐☐ /day	☐☐☐ /day	☐☐☐ /day	☐☐☐ /day
Do you drink alcohol?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
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 "zero")	☐☐☐ /week	☐☐☐ /week	☐☐☐ /week	☐☐☐ /week
Do you wear glasses or contact lenses? If Yes, please state:	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
• Condition				
• Number of dioptres for each eye (this appears on the prescription from the optician)	☐☐☐ Right eye ☐☐☐ Left eye	☐☐☐ Right eye ☐☐☐ Left eye	☐☐☐ Right eye ☐☐☐ Left eye	☐☐☐ Right eye ☐☐☐ Left eye

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, irregular heartbeat, murmur, chest pain, clots, blood disorder, abnormal blood pressure, high cholesterol, etc. Yes☐ No☐

(b) **Any dermatological disease or disorder**, such as, but not limited to psoriasis, dermatitis, eczema, allergy, acne, etc. Yes☐ No☐

(c) **Any endocrine disease or disorder**, such as, but not limited to diabetes, weight problems, gout or thyroid problems or other hormonal imbalances, etc. Yes☐ No☐

(d) **Any eye, ear, nose and throat disease or disorder**, such as, but not limited to cataract, glaucoma, hearing loss, sinus problems, tonsils, adenoids, etc. 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, liver problems, etc. Yes☐ No☐

(f) **Any infectious or viral disease or disorder**, such as, but not limited to: hepatitis A/B/C, herpes, HIV, malaria, meningitis, blood infection, sexually transmitted disease, etc. Yes☐ No☐

(g) **Any muscular or skeletal disease or disorder**, such as, but not limited to back, neck or joint pain, arthritis, paralysis, joint replacement, any cartilage and ligament problem, etc. Yes☐ No☐

(h) **Any neurological disease or disorder**, such as, but not limited to stroke, multiple sclerosis, epilepsy, neurodegenerative disorder, seizures, migraine, Alzheimer's or other form of dementia, etc. 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, naevus, etc. Yes☐ No☐

(j) **Any psychiatric or psychological disorder**, such as, but not limited to ADHD, Autism spectrum disorders, depression, anxiety, chronic fatigue syndrome, eating disorder, obsessive-compulsive disorders, phobic disorders, alcohol/drug problem, etc. Yes☐ No☐

(k) **Any respiratory disease or disorder**, such as, but not limited to chronic obstructive pulmonary disorder, asthma, bronchitis, sinusitis, shortness of breath, etc. Yes☐ No☐

(l) **Any urological or reproductive organs disease or disorder**, such as, but not limited to kidney or urinary tract problem, menstrual impairment, fertility problem, fibroids, endometriosis, testicular or prostate problem, etc. Yes☐ No☐

(m) **Any other accident, injury, disease or disorder** not already disclosed. Yes☐ No☐

2. Please tell us whether you or your dependents:

(a) Are currently taking any prescribed or over-the-counter drugs, medication, tablets or other treatment. Yes☐ No☐

(b) 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☐

(c) 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), etc. Yes☐ No☐

Please do NOT disclose results of any genetic (DNA or RNA) tests, as these are not required for medical underwriting.

(d) Within the past 2 years have experienced any symptoms or medical complaints such as, but not limited to: Yes☐ No☐

- Fever and continuous cough (within the last 2 weeks)
- Shortness of breath
- 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, etc.

(e) Have been recommended or decided to self-isolate? Yes☐ No☐

Please complete questions 3 and 4 only if you are purchasing dental cover.

3. Is any person included in this application currently undergoing or have they been advised to undergo any dental treatment? Yes☐ No☐

If yes, please complete a Dental Questionnaire, which can be requested by emailing underwriting@international-healthcare.com

4. Does any person included in this application:

(a) Suffer from periodontitis (extensive disorder of the gum and the tooth-supporting structures)? Yes☐ No☐

(b) Have any crowns, inlays, implants, fillings, bridges or missing teeth? Yes☐ No☐

If yes, please state in the table below the person's name and the type and quantity of each of the above, including how many teeth are affected by a bridge.

5. 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 D D / M M / Y Y
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 D / M M / Y Y

(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.

Additional information for Yes answers

If you answered Yes to any part of the questions 1, 2, 3 or 4 within the previous Health Declaration section, please provide details in the table below. **Please tell us if a full recovery has been made or if you or your dependents have any medical condition or disease related to or arising from the original diagnosis. Please enclose supporting up-to-date medical reports/test results if possible.**

Question number	Name of the person affected by the medical condition	Diagnosis - where applicable state the area of the body affected (e.g. left arm, right foot)	Exact date of onset of the condition	Frequency and severity of symptoms and date of last symptoms	Investigations, blood tests or readings	Past and current treatment	Current status (e.g. ongoing, any complications, complete recovery, recurrent)

If there is insufficient space in the table above, please use another Application Form

Please provide the name, address and telephone number of the regular/family doctor for everyone included in this application.
Please use a separate sheet if the space provided is not sufficient.

7 DECLARATION

Please read the following declarations carefully and only sign below if 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.
- **I undertake to inform Orient Insurance PJSC immediately in writing of any changes in my or my dependents' 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 authorize 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 dependents under the age of 18 and for dependents 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 Insurance Product Information Document and I accept the terms and conditions as summarized there and further explained in my Benefit Guide.
  - 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, email or fax 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. If the content is not in accordance with the Application Form but I enter no protest within 30 days following the issue date of the Insurance Certificate, I will be considered to have accepted the offer of cover.
  - 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 dependents and I are or become resident in countries where local compulsory health insurance restrictions are in place (e.g. Switzerland).
  - 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.

As the applicant, I sign and date this form for and on behalf of everyone included in this application.

Applicant's signature

Applicant's printed name

Date D D / M M / Y Y

8 POLICYHOLDER APPOINTMENT

This section must be completed by all dependents wishing to appoint the policyholders 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 sign below.

I authorize INSERT NAME OF POLICYHOLDER

to act on my behalf in the administration of this policy. This may include the disclosure of sensitive medical information. This authorization will remain in place until I ask Orient Insurance PJSC in writing to revoke it.

Dependent 1's signature

D D / M M / Y Y

Dependent 2's signature

D D / M M / Y Y

Dependent 3's signature

D D / M M / Y Y

9 BROKER APPOINTMENT (IF APPLICABLE)

For office use only —
Agent details and stamp

I authorize _____ INSERT NAME OF BROKER

to act on my behalf in relation to the administration of this policy. This may include the disclosure of sensitive medical information. This authorization will remain in place until I ask Orient Insurance PJSC in writing to revoke it.

Applicant's signature	Dependent 1's signature	Dependent 2's signature	Dependent 3's signature
D D / M M / Y Y	D D / M M / Y Y	D D / M M / Y Y	D D / M M / Y Y

10 WE CARE ABOUT YOUR PERSONAL DATA PROTECTION

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 and should be read by you before the submission of any personal data to us. To read our Data Protection Notice visit: **www.nextcarehealth.com/PrivacyStatement**

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, you can always contact us by e-mail at: **MEHelpline@international-healthcare.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 dependents named below agree with the following:			
Name of applicant	Name of dependent 1	Name of dependent 2	Name of dependent 3

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 MEHelpline@international-healthcare.com

Applicant's signature	Dependent 1's signature	Dependent 2's signature	Dependent 3's signature
D D / M M / Y Y	D D / M M / Y Y	D D / M M / Y Y	D D / M M / Y Y

12 MARKETING PREFERENCES

I (the applicant) and my dependents 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 indicating ☐ below.

Name of applicant	Name of dependant 1	Name of dependant 2	Name of dependant 3

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

☐	☐	☐	☐

- 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.

☐	☐	☐	☐

- 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.

☐	☐	☐	☐

- Such communications should be sent to me by the following methods:

☐ Email	☐ Email	☐ Email	☐ Email
☐ In-app notifications	☐ In-app notifications	☐ In-app notifications	☐ In-app notifications
☐ Phone	☐ Phone	☐ Phone	☐ Phone
☐ Post	☐ Post	☐ Post	☐ Post

13 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, by bank transfer.

Payment frequency

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:

	Annual	Half-yearly	Quarterly
Bank transfer	☐	☐	☐

PLEASE RETURN YOUR FULLY COMPLETED FORM BY:

Email to: underwriting@international-healthcare.com
Fax to: + 971 (0)4 251 5071
Post to: Orient Insurance PJSC , Allianz Care 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)