Sphera

International healthcare for you and your family
Plans for Dubai and Northern Emirates

Application Form for policies with full medical underwriting

Before you start, please consider that:

1) If you choose to complete a printed version of this form, PLEASE COMPLETE IT IN BLOCK CAPITALS.
2) 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.
3) If you already have one of our healthcare plans and you are applying for a cover upgrade or for a new plan, please tell us about any medical conditions you have claimed for since joining us.
4) On page 10, on the '**Approvals**' section;
   - The applicant and each named dependant above 18 need to sign this section.
   - All adult applicants must provide consent as detailed in Section 11. In line with our legal obligations, 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.
   - All adult applicants wishing to appoint the policyholder and/or the broker as the main point of contact for this policy must provide consent as detailed in Sections 8 and 9.

Just for clarity...

You will see that we often refer to the following phrases in this form. This is what we mean:
Home country: A country for which you (or your dependants, if applicable) hold a current passport or which is your principal country of residence.
Principal country of residence: The country where you and your dependants (if applicable) live for more than six months of the Insurance year.

If you are already included in your company policy and you want to add a new dependant, please state your policy number:

Are you completing this form to join an existing company policy? Please state:

Group name

Group number

1 Applicant's details (The applicant will be the policyholder)

Your contact details will also be used to communicate with you on important things regarding your policy. You must tell us if your contact details change over time, 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 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)

orient
orient insurance pjsc
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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 D D / M M / Y Y Y Y

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 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 ☐ Child ☐	Spouse ☐ Child ☐	Spouse ☐ Child ☐
First name			
Surname			
Date of birth	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
Gender	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Occupation (mandatory, please state if student)			
Email address (mandatory for dependants over 18)			
Home country			
Principal country of residence			
Nationality			
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)			

	Dependant 1	Dependant 2	Dependant 3
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 ☐
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 your cover

From what date do you require cover? D D / M M / Y Y Y Y

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.

☐ Worldwide ☐ Worldwide excluding USA

Select your Core and Out-patient Plan

Core and Out-patient Plans

Please refer to the Benefit Guide and Table of Benefits for details of the various plans listed below.

☐ Sphera Essence ☐ Sphera Base ☐ Sphera Enhanced ☐ Sphera Signature

Select your Out-patient Plan co-payment

To reduce your Out-patient Plan premium, please note that it is mandatory to select a co-payment from the options below, based on your selected plan. Two co-payment options are available with the Essence and Base Plans and four co-payment options are available with the Enhanced and Signature Plans. Once you've selected a co-payment option, please read across to find the relevant premium discount. The co-payment selected is payable per insured person, per visit on Out-patient services and applies to all benefits with the exception of 'Video consultation services', 'Cancer screening', 'Preventive services' and 'Vaccinations'. Also, our premiums are expressed in whole numbers (i.e. without any cents), therefore, percentages may be slightly higher or lower than those stated below.

Out-patient Plan co-payment	Sphera Essence	Sphera Base	Sphera Enhanced	Sphera Signature	Premium discount
10%, up to max. US$ 14 per visit on out-patient services	N/A	N/A	☐	☐	15%
20%, up to max. US$ 28 per visit on out-patient services	N/A	N/A	☐	☐	25%
10% per visit on out-patient services	☐	☐	☐	☐	20%
20% per visit on out-patient services	☐	☐	☐	☐	30%

Select your Dental Plan

Please note that it is mandatory to select one of the following Dental Plans. They can't be bought separately. The Sphera Dental 1 Plan can be selected with any of the four Sphera Plans. The Sphera Dental 2 and Sphera Dental 3 Plans can only be selected with either the Sphera Enhanced or Sphera Signature Plans. You can't buy them separately or in conjunction with the Sphera Essence or Sphera Base Plans.

Dental plans

☐ Sphera Dental 1 ☐ Sphera Dental 2 ☐ Sphera Dental 3

Select your Optional Plan

The optional plan can only be purchased in conjunction with a Core and Out-patient Plan.

Maternity Plan

Please note that the Maternity plan can only be purchased with either the Sphera Enhanced Plan or the Sphera Signature Plan. It cannot be purchased with the Sphera Essence or Sphera Base Plans. It cannot be bought separately.

☐ Sphera Enhanced Maternity

Select your Hospital Network

☐ **Comprehensive Network:** includes all medical facilities within our UAE provider network.

☐ **General Plus Network:** excludes premium healthcare providers (American Hospital Group, Mediclinic Group, Cleveland Clinic Abu Dhabi, King's College Hospital, and Dr. Sulaiman Al Habib).

☐ **General Network:** features additional exclusions of high-cost providers beyond those excluded from Comprehensive and General Plus networks.

☐ **Restricted Enhanced Network:** includes selected cost-effective providers delivering a complete range of medical services throughout the UAE.

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	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? 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	/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 NO	/week	/week	/week	/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. the due date D D / M M / Y Y 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 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 from a) to t) above, please provide details in the table below. **Please tell us if a full recovery has been made or if you or your dependants 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	Diagnosis - where applicable state the area of the body (e.g. left arm, right foot or tooth affected)	Exact date of onset of the condition	Date and frequency of symptoms (Daily, Weekly, Monthly, Irregular)	Past and current treatment, investigations, blood tests or readings (please include name, dosage and frequency of usage of medication and provide dates of when treatment started, how often it was required and when it ended)	Current status (e.g. ongoing, any complications, complete recovery, recurrent or ongoing) Please also indicate if you continue to see a dentist for an ongoing issue, or have stopped attending recommended routine dental checkups
Policyholder						
Dependant 1						
Dependant 2						
Dependant 3						

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 (and dentist, where applicable) 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. You will need to sign below in the '**Approvals**' section to confirm you understand and accept them.

- I declare that all information provided in this application is true, complete, and accurate to the best of my knowledge, including any answers not in my own handwriting. I understand that this application forms the basis of the insurance contract with Orient Insurance PJSC and its authorised agents, and that any false, misleading, or omitted information may render the policy void under applicable law.
- I acknowledge my responsibility to inform Orient Insurance PJSC in writing of any changes to my or my dependants' health status or other material facts occurring between the date of this application and the start date of the policy.
- I confirm that I have read and understood the definitions, benefits, exclusions, and conditions of the policy, including those relating to pre-existing conditions, as outlined in the Benefit Guide and Table of Benefits. Based on this information, I believe the selected product meets my insurance needs.
- I understand that:
  - This application is valid for two months from the date of signing.
  - I may withdraw my application within 30 days of receiving the full policy terms, provided no claims have been submitted, and receive a full refund of the premium.
  - It is my responsibility to verify the accuracy of the Insurance Certificate once issued.
  - Cover is subject to the terms and conditions in effect at the start or renewal date of the policy.
  - My healthcare cover may not be suitable in jurisdictions with compulsory health insurance requirements, and I am responsible for ensuring compliance with local regulations.

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 and 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 Medical consent and data disclosure declaration

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.

Purpose of Consent

This declaration serves as formal consent for the collection, processing, and disclosure of my personal and health-related data by Orient Insurance PJSC and its authorised agents (including but not limited to Nextcare), for the purposes of underwriting, administering insurance cover, and processing claims under my health insurance policy.

Scope of Data Access

I hereby authorise Orient Insurance PJSC and its agents to obtain, access, and process my health and personal data from third parties, including but not limited to:

- Licensed doctors and medical practitioners
- Hospital and nursing staff
- Medical institutions and diagnostic centers
- Care homes and rehabilitation facilities
- Statutory health insurance funds
- My plan sponsor or employer
- Professional medical associations
- Public authorities and regulatory bodies
- The NABIDH Health Information Exchange System (Dubai Health Authority)

This authorisation includes access to historical medical records, including those predating the inception of the current insurance policy, where such data is deemed relevant to the assessment or processing of a medical claim.

Waiver of Confidentiality

I expressly waive any rights I may have under applicable medical confidentiality or secrecy laws, solely for the purposes outlined above. I release all individuals and institutions listed above, as well as Orient Insurance PJSC and its agents, from any legal obligation to maintain confidentiality in respect of the data disclosed under this consent.

Verification and Disclosure Rights

I consent to Orient Insurance PJSC and its agents verifying any statements made in relation to my health condition and to contacting other insurers to confirm details of any previous or existing insurance contracts I may have applied for.

Consent Requirement and Consequences

I understand that providing this consent is a prerequisite for the issuance of my insurance policy and the processing of any claims. Failure to provide consent may result in the inability to offer cover or process claims.

Consent for Minors

Where applicable, consent must be provided by a parent or legal guardian for any insured person under the age of 18.

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

- 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 Approvals

Please indicate the section you're providing consent for.

7. Declaration**	☐
8. Policyholder appointment	☐
9. Broker appointment (if applicable)	☐
10. Your personal data**	☐
11. Medical consent and data disclosure declaration**	☐
12. Marketing preferences	☐

Broker name:

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
D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	D D / M M / Y Y Y 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	☐	☐	☐
Card	☐	☐	☐

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 M M / Y Y Y Y

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 D D / M M / Y Y Y Y

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).

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