Summit – International Healthcare Plans for Oman

Group Member Declaration Form

If you choose to complete a paper version of this form, **PLEASE COMPLETE IT IN BLOCK CAPITALS.**

If you are adding a new dependant 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 form

1. You must complete this form in full and tell us all relevant information.
2. Section 4 must be signed by the policyholder. Section 7 must be signed by all adult applicants. In line with our legal obligations for processing data, 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.

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 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 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 Y Y Gender: Male☐ Female☐

Home country

Nationality

Principal country of residence

Full address in principal country of residence (mandatory)

Primary phone number 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)

Details of any current domestic or international health insurance:

Name of insurer

Policy number Start date D D / M M / Y Y Y Y

2 Dependants to be covered under the contract

Dependants 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 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 Declaration Form and ensure that all relevant declaration(s) and consent(s) sections are signed and dated.

	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 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			

Details of any current domestic or international health insurance

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

3 Medical questionnaire

1. Have you or any of your dependants ever had a past history of cancer (including benign brain tumours), a heart condition or stroke, joint replacement, psychiatric or mental illness? Yes ☐ No ☐
2. In the last 12 months, have you or any of your dependants had any signs or symptoms that may require a visit to a medical professional or are you or any of your dependants awaiting any reviews, treatment or investigation for any current or past medical problems? Yes ☐ No ☐
3. Do you or any of your dependants have any long-term, ongoing or chronic condition for which you have regular appointments or need a review or treatment for? Yes ☐ No ☐
4. If the plan includes maternity cover, are you or any of your dependants currently pregnant? Yes ☐ No ☐
5. In the last two years, have you or any of your dependants on this application had any other problems or concerns about their health which are not dealt with in questions 1 to 4 above? Yes ☐ No ☐

Additional information for 'Yes' answers

If you answered Yes to any of the questions within the medical questionnaire 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 number	Name of the person	Symptom and/or medical condition, including the date it started.	What treatment, medication or special diet have you been given? Please include dates and specify names of drugs and dosage.	What follow-up consultation, medical investigations, diagnostic tests or procedures are needed or have been recommended?	Do you still have this medical condition or symptom?	What date did you last see any health care professional for this medical condition or symptom?
		D D / M M / Y Y Y Y			Yes ☐ No ☐	D D / M M / Y Y Y Y

Question number	Name of the person	Symptom and/or medical condition, including the date it started (dd/mm/yyyy)	What treatment, medication or special diet have you been given? Please include dates and specify names of drugs and dosage.	What follow-up consultation, medical investigations, diagnostic tests or procedures are needed or have been recommended?	Do you still have this medical condition or symptom?	What date did you last see any health care professional for this medical condition or symptom? (dd/mm/yyyy)
		D D / M M / Y Y Y Y			Yes ☐ No ☐	D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y			Yes ☐ No ☐	D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y			Yes ☐ No ☐	D D / M M / Y Y Y Y

If there is insufficient space in the table above, please use another Group Member Declaration Form.

4 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 understand that this application will be the basis of the contract between Muscat Insurance Company S.A.O.G. (the insurer) and myself, and that any false, incorrect or misleading statement or non-disclosure of material information may make this insurance null and void.
- 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 allow the insurer, 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, the insurer (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, 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 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 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 the insurer may not be suitable if my dependants 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 Y Y

5 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 sign below.

I authorise 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 authorisation will remain in place until I ask the insurer in writing to revoke it.

Dependant 1's signature
D D / M M / Y Y Y Y

Dependant 2's signature
D D / M M / Y Y Y Y

Dependant 3's signature
D D / M M / Y Y Y Y

6 We care about your personal data protection

The data protection notice explains how Allianz acting as the policy administrator protects your privacy. This is an important notice which outlines how Allianz will process your personal data. You should read it before submitting any personal data. To read the Data Protection Notice, visit: **www.allianzcare.com/en/privacy.html**

Alternatively, you can contact Allianz on **+ 353 1 630 1301** to request a paper copy of the full Data Protection Notice. If you have any queries about how Allianz use your personal data, contact Allianz by email at: **AP.EU1DataPrivacyOfficer@allianz.com**

7 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

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.** 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 third party service providers who 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 AP.EU1DataPrivacyOfficer@allianz.com

Applicant's signature
D D / M M / Y Y Y Y

Dependant 1's signature
D D / M M / Y Y Y Y

Dependant 2's signature
D D / M M / Y Y Y Y

Dependant 3's signature
D D / M M / Y Y Y Y

8 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 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 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	☐	☐	☐	☐
In-app notifications	☐	☐	☐	☐
Phone	☐	☐	☐	☐
Post	☐	☐	☐	☐

Please return your fully completed form by:

Email: AZCunderwriting@nextcarehealth.com

Fax: +971 (0) 4 251 5071

Post: Orient Insurance PJSC, 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 Group Member Declaration Form or the application process, please contact our Helpline on: **800 77757** (toll-free from inside Oman) or **+353 1 630 1301** (from outside Oman)