SUMMIT FOR THE UAE
International healthcare plans for the Northern Emirates

Application Form

For policies with moratorium

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.
3) On page 5, for 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 9. In line with our legal obligations, we won't be able to process your application without these signatures. A parent or guardian should complete this section for any applicants under the age of 18.
   - All adult applicants wishing to appoint the policyholder and/or a broker as the main point of contact for this policy must provide consent as detailed in Sections 6 and 7.

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.

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

Group name

Group number

If you are already included in your company policy and you want to add a new dependant, please state your policy 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 continues reaching you.

We will consider applicants for cover up to the day before their 76th birthday.

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

Surname

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

Height cm Weight kg

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 it)

Details of any current domestic or international health insurance:

Name of insurer

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

orient
orient insurance pjsc

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. **We will consider adult dependants for cover up to the day before their 76th birthday**.

If there is insufficient space for all dependants, please use another Application Form and ensure that all relevant Declaration(s) and Consent(s) 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 at birth	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Occupation (mandatory, please state if student)			
Height	cm	cm	cm
Weight	kg	kg	kg
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 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 Medical Underwriting terms available

Moratorium underwriting

Under a Moratorium policy you will not immediately be covered for pre-existing medical conditions.

Moratorium underwriting means there will be a 24-month waiting period before claims for any pre-existing medical conditions may become eligible.

Your claim will not be paid if it's relating to a pre-existing medical condition, if one or more of the following have applied within the 24-month period before your start date (or the date shown in your Insurance Certificate):

- It could be reasonably foreseen that the medical condition would occur after your start date.
- The condition clearly showed itself to be present by having signs or symptoms, required treatment, investigations or medication.
- To the best of your knowledge, you were aware you had the condition.

Once you have completed a continuous 24-month period after your joining date, we may cover your pre-existing medical condition provided you have not had symptoms, needed or received treatment, medication, a special diet or advice, or had any other indications of the condition.

If you have had symptoms, needed or received treatment, medication, a special diet or advice or other indications of any condition during the 24-month waiting period, the waiting period will restart for that condition (rolling moratorium).

5 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 understand that this application will be the basis of the contract between 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, in accordance with the applicable legislation**.
- 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:
  - I have read and understood the full definitions, benefits, exclusions and conditions of this policy, including the details relating to pre-existing conditions and moratorium terms.
  - I have received, read and understood the Benefit Guide and Table of Benefits and I accept the terms and conditions as summarised there.
  - 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 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.
  - 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.

6 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 so, simply consent to this in the '**Approvals**' section below.

The policyholder will be authorised to act on behalf of all named 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, ask the insurer in writing to revoke it.

7 Broker appointment (if applicable)

By consenting below in the '**Approvals**' section, I authorise the named broker 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 the insurer in writing to revoke it.

8 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 4 270 8800 to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, please email us at: **AZChelpline@nextcarehealth.com**

9 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

- **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.
- **Permission to obtain my data from third parties.** To rovide 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.
- **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 service providers outside of the 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

10 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 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	☐	☐	☐	☐

11 Approvals

Please indicate the section you're providing consent for.

5. Declaration**	☐	
6. Policyholder appointment**	☐	
7. Broker appointment (if applicable)	☐	Broker name:
8. Your personal data**	☐	
9. Data consent**	☐	
10. Marketing preferences	☐	

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.

Please return your fully completed form by:

Email: AZChelpline@nextcarehealth.com

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 Application Form or the application process, please contact our Helpline on: 800 6334 (toll-free from inside the UAE) or +971 (0)56 681 977 (from outside the UAE)

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