رؤية جديدة للتأمين
redefining insurance

Health Perfect Application Form

Agent's signature:

Print name:

Agency Code:

Please attach a current passport photograph for each person covered by this application. Please write the individuals' name on the reverse of the photo.

ONLY FOR UNITED ARAB EMIRATES

Please complete this form using Block Capitals and by ticking the relevant boxes. It is important that you provide the following information so that we can properly assess your application. If, therefore, you do not answer the questions we shall take that failure to answer to mean that you have nothing to disclose. This application must be completed by you or your parent/legal guardian in your/their own handwriting. If you need to make a correction, please initial the change.

1 YOUR PERSONAL DETAILS (PLEASE KEEP US INFORMED OF ANY CHANGE OF YOUR ADDRESS)

Title : ☐ Mr. ☐ Mrs. ☐ Miss	First Name:
Middle Name:	Last Name:
Date of Birth: DD/MM/YYYY	P.O.Box:
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widow	
Home Location	**Work Location**
Emirate/City: Area: Address:	Emirate/City: Area:
Email:	Passport Number:
Tel: Country Code Area code Number	Mobile: Country Code Area code Number
Occupation:	Industry:
Do You: ☐ Live in Abu Dhabi ☐ Work in Abu Dhabi ☐ Have a residence Visa/work permit in Abu Dhabi ☐ N/A	
For Northern Emirates only: Salary Band: ☐ Less than or equal to AED 4,000 ☐ AED 4,000 to AED 12,000 ☐ More than AED 12,000	
Name of Company (Employer):	Nationality:
Emirates ID Number/ID application number:	Place of Visa issuance:
VISA UID Number:	The Sponsor:
Select your plan: ☐ HP1 ☐ HP2 ☐ HP3 ☐ HP4 ☐ HP5 ☐ HP6 ☐ HP7	

SPOUSE DETAILS (PLEASE KEEP US INFORMED OF ANY CHANGE IN ADDRESS)

First Name:	Middle Name:
Last Name:	Date of Birth: DD/MM/YYYY
Nationality:	Emirates ID/Application number:
Place of VISA issuance:	The Sponsor:
Passport Number:	VISA UID number:
Occupation:	Industry:
For Northern Emirates only: Salary Band: ☐ Less than or equal to AED 4,000 ☐ AED 4,000 to AED 12,000 ☐ More than AED 12,000	
Work Location	
Emirate/City:	Area:

WebMed Quote/Policy Number: To be completed by the agent

CHILDREN DETAILS (PLEASE KEEP US INFORMED OF ANY CHANGE IN ADDRESS)						
Name	**Nationality / Passport Number**	**Relationship**	**Date Of Birth**	**Emirates ID / Application Number**	**VISA Issued in**	**UID number**
	Nationality Passport #	Son/Daughter	DD/MM/YYYY		Emirate	
	Nationality Passport #	Son/Daughter	DD/MM/YYYY		Emirate	
	Nationality Passport #	Son/Daughter	DD/MM/YYYY		Emirate	
	Nationality Passport #	Son/Daughter	DD/MM/YYYY		Emirate	

2 EXISTING OR PREVIOUS MEDICAL INSURANCE

Do you currently have medical insurance? ☐ Yes ☐ No		
☐ AXA Gulf	Policy number:	Policy expiry date: DD/MM/YYYY
☐ Other insurer	Policy number:	Policy expiry date: DD/MM/YYYY

3 CONFIDENTIAL MEDICAL HISTORY

(Declarations must be made in writing on this application. Verbal declarations WILL NOT be accepted)

Here is your opportunity to tell us about any symptoms, discomfort or medical conditions occurring before your policy starts (whether or not medical advice has been sought). If you declare any symptoms, discomfort, diagnosed medical condition we can include it in your pre-existing condition benefit. If not, we will exclude it entirely.

AXA reserves the right to determine whether a condition existed before your policy began based on our global experience.

Typical examples of the things you should tell us about are varicose veins, allergies, backache, foot disorders (e.g. bunions), piles, gynaecological problems (including any irregularities of menstruation), complications of pregnancy, digestive irregularities, skin problems, trouble with heart, limbs, eyes, 'nerves' etc any ear, nose or throat problems or any pains, swellings, lumps or fever, this list is not exhaustive.

You must also tell us if you are or think you may be pregnant.

	Applicant	Family member 1	Family member 2	Family member 3	Family member 4
Name:					
Height (cm):					
Weight (kg):					
Do you smoke?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, how many cigarettes per day?					
1. In the last 2 years have you experienced (or are you now experiencing) any symptoms or discomfort that have persisted for more than 7 days such as but not limited to; fever, pain, migraine, headache, cough, vomiting, diarrhea, fatigue, dizziness, bleeding, itching, toothache?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
a. If you have answered 'yes' to the question above, have you treated yourself or been treated by anybody else?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Has any of those symptoms or discomfort come back?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c. Which physician is most familiar with your family history?					

2. In the last 2 years have you noticed any lumps or other mass, changes in moles or other skin problems or have you had any loss of function such as but not limited to; movement, hearing, vision or speech?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
a. If you have answered 'yes' to the question above, have you treated yourself or been treated by anybody else?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
3. In the last 2 years have you had or do you now have any medical condition requiring treatment lasting longer than 7 days?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
4. In the last 2 years have you or are you now taking any medication for more than 7 days, whether you have been advised to or not?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
5. In the last 12 months have you been advised by a medical practitioner or other expert to change your diet, undertake more physical exercise or change your lifestyle in other way?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
6. Have you ever been diagnosed with any form of cancer and/or undergone or been advised to undergo any screening to rule out a potential cancer diagnosis?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
7. Do you suffer from any of the below, if yes, then please provide medical reports:										
a. Diabetes	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
b. Blood vessel (Veins and arteries) diseases disorders	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
c. Chronic obstructive pulmonary disease (COPD)	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
d. Cancer of any type	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
e. Nervous system surgeries	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
f. Diseases of the brain's veins and arteries	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
8. In the last 5 years have you been hospitalized or undergone surgery of any kind?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
9. For female applicants; are you currently pregnant or undergoing any form of fertility treatment?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
10. Have you ever had any complications associated with conception, a pregnancy and/or given birth by caesarean section?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
11. Do you foresee any need to visit any medical practitioner or therapist of any kind in the coming year for a follow-up visit, planned hospitalization, health screening/ checkups or because you have any symptoms/discomfort of any kind?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
12. If there is any major condition that we should know about (in good faith you must declare it).	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

- **If there is any medical condition falling outside the 5 years period mentioned, in such case you should declare it in good faith.**
- **Please give details overleaf.**
- **Please continue on a separate sheet if necessary for further detailed information.**
- **If you answered yes to any of the questions mentioned above, please provide us with the latest medical report for the related medical condition.**

4 MEDICAL PRACTITIONER(S) MOST FREQUENTLY USED IN THE LAST 5 YEARS

Name:

Address:

Telephone No.:

5 YOUR SIGNATURE AND DECLARATION

I declare that to the best of my knowledge and belief the statements on this application form are full, true and correct, I/We have declared all material facts related to this application/quotation form. I/We understand that non – disclosure or misrepresentation of any material fact including but not limited to the medical declaration may invalidate the quoted terms/the health insurance policy and/or coverage of any undeclared medical conditions. I/We understand that this document is the basis of my/our insurance policy and upon acceptance will become a part of the contract and shall be read together with all the documents issued in connection with the policy.

I shall read the AXA Insurance Healthcare Series Membership Agreement when received and that I agree to be bound by it. In the event of any dispute, I agree to follow the AXA insurance (Gulf) B.S.C (c) arbitration process in the first instance. I agree that the acceptance of my application shall be on the basis of these statements. I agree that AXA may contact my/our medical practitioner(s) for further details of my/our medical history and authorise such practitioner(s) to release any information AXA may require.

I have read and understood the terms and conditions relating to cancellation of this policy.

I have understood that to incept my policy, I must provide a passport size photograph, passport/visa copies, the latest medical reports (if needed) for each member, Valid national ID copy for each member, copy of the last insurance certificate or the last insurance membership card for each member (if residing in Abu Dhabi) – Originals is needed for verification and the signed underwriting/acceptance letter provided by AXA (if applicable).

Print Name:	Date: DD/MM/YYYY

Signature:

Please note: You are advised to keep a record of all information supplied in connection with this application, including any letters you send to us in connection with it. If you would like a copy of this application please let us know within 3 months. **After completing this application form and signing the Declaration, please return to your nearest AXA office or broker office if you are using one.**

DECLARATION CONTINUED - IF YOU HAVE ANSWERED "YES" IN PART 3 ABOVE, PLEASE SPECIFY THE DETAILS OF THE MEDICAL CONDITION(S)

Signature:

AXA Insurance (Gulf) B.S.C. (c)

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