DMed

DEPENDENTS INDIVIDUAL MEDICAL INSURANCE (DMed)

Application Form

Please complete this form using Capitals and by ticking the relevant boxes. This is an application for Insurance. Every information this application seeks is important. Please read all questions and answer them carefully. You must provide complete and correct information. Incomplete/incorrect/partially correct information may lead to cancellation of proposal and policy even if it is issued. Coverage can incept only after we have received the full amount of premium and have explicitly accepted the risk.

PERSONAL DETAILS

Title: ☐ Mr. ☐ Mrs. ☐ Miss	**First Name**	**Second Name**:
Date of Birth: DD/MM/YYYY	**Family Name:**	**Maiden name**
Nationality	**Marital Status** : ☐ Married ☐ Single ☐ Divorced ☐ Widowed	
Passport Number:	**Gender** : ☐ Male ☐ Female	
Passport Expiry Date	Residential Location:	Emirate:
E-mail:	Mobile No.:	
Occupation:	Name of Company/Employer:	Address:
EMIRATES ID No	Where was your visa issued:	
Expiry Date:	**Salary** **Commission:**	
UID No:	Policy **I**nception Date:	

ESTABLISHMENT/SPONSOR DETAILS:

Title: ☐ Mr. ☐ Mrs. ☐ Miss	**Sponsor Name / Establishment Name**
Country	Region
Sub region	Work email address
Work Contact Number	Sponsor Type : ☐ Resident ☐ Citizen ☐ Establishment ☐ Property Owner
Main Sponsor UID	

MEDICAL HISTORY

Height(cm)/Weight (kg):	
Q1: Have you ever been diagnosed, treated for any Critical cases Cancer, Renal failure, ascites, Hepatitis B and C, Cerebro-meningitis Respiratory insufficiency ,Liver Failure, Heart open surgeries and Catheterism**.**	☐ Yes ☐ No
Q2: Have you ever been diagnosed, treated for any Chronic condition Chronic Eczema, Psoriasis, Thyrotoxicosis, Hypertension, Addison disease, Cardiac congestive failure, Coronary arteries diseases Atherosclerosis, Tuberculosis, vertebral hernia Cataract, Diabetes and complications, chronic corneal ulcer, emphysema Gastroduodenal Ulcer, intestinal inflammatory disease, Hypothyroidism, esophageal varices, Chronic Pancreatitis, Gout Rheumatoid disease, Anemia, epilepsy	☐ Yes ☐ No
Q3: Are you Pregnant (Females only)	☐ Yes ☐ No

Declaration

Please read the following declarations carefully and sign only if you have understood and accepted them.

(a) I declare that all information in respect of whom I am purchasing the policy 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 shall be the basis of the contract between Orient and me, and that any false, incorrect or misleading statement or non-disclosure of material medical information may render this insurance null and void.

(b) I undertake to inform Orient in writing of any changes in state of health in any of the above occurring between completing the application Form and the start date of the policy.

(c) I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information and I consent to the fact that if Orient considers it appropriate will check statements concerning my health condition and will check with other healthcare insurers, all statements concerning previous or existing contracts applied for. I authorize all such practitioners, physicians, dentists, members of medical professions, employees of hospitals and health authorities as well as medical facilities to provide relevant medical information relating to me, if requested by Orient, its medical advisers, its appointed representatives, or to any third party expert(s) in case of disputes, subject to any legal restrictions which may apply. I also make this statement on behalf of those who cannot assess the meaning of this statement.

(d) I confirm that I have read understood the full definitions, benefits, exclusions and conditions of this policy including the details relating to pre-existing conditions.

(e) I understand that this Application Form is valid for two months from the date of completing and signing it.

(f) 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, the situation will be considered accepted if I enter no protest within 30 days following the issue date of the Insurance Certificate.
- This policy will be subject to the standard policy terms and conditions effective at the time of policy commencement contained within the Benefit Guide.

As the applicant, I sign this declaration and Application Form for and on behalf of person included in this Application Form.

Signature of Applicant:

Applicant's Printed Name:

Date | D D | M M | Y Y |

Mandate Documents

☐ Valid Passport Copy with Valid Visa ☐ Valid Emirates ID ☐ Sponsor Valid Passport with Valid Visa Copy

☐ Sponsor Medical Insurance Declaration (Medical Card Copy)