



رؤية جديدة / للتأمين
redefining / insurance

Health Secure 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 : <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss	First Name:
Middle Name:	Last Name:
Date of Birth: DD/MM/YYYY	P.O.Box:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow	
Home Location	Work Location
Emirate/City: Area:	Emirate/City:
Address:	Area:
Email:	Passport Number:
Tel: Country Code Area code Number	Mobile: Country Code Area code Number
Occupation:	Industry:
Do You: <input type="checkbox"/> Live in Abu Dhabi <input type="checkbox"/> Work in Abu Dhabi <input type="checkbox"/> Have a residence Visa/work permit in Abu Dhabi <input type="checkbox"/> N/A	
For Northern Emirates only:	
Salary Band: <input type="checkbox"/> Less than or equal to AED 4,000 <input type="checkbox"/> AED 4,000 to AED 12,000 <input type="checkbox"/> 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:

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: <input type="checkbox"/> Less than or equal to AED 4,000 <input type="checkbox"/> AED 4,000 to AED 12,000 <input type="checkbox"/> 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 INSURANCEDo 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If you have answered 'yes' to the question above, have you treated yourself or been treated by anybody else?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Has any of those symptoms or discomfort come back?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If you have answered 'yes' to the question above, have you treated yourself or been treated by anybody else?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you suffer from any of the below, if yes, then please provide medical reports:					
a. Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Blood vessel (Veins and arteries) diseases disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Chronic obstructive pulmonary disease (COPD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Cancer of any type	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Nervous system surgeries	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Diseases of the brain's veins and arteries	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. In the last 5 years have you been hospitalized or undergone surgery of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. For female applicants; are you currently pregnant or undergoing any form of fertility treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you ever had any complications associated with conception, a pregnancy and/or given birth by caesarean section?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. If there is any major condition that we should know about (in good faith you must declare it).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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

5 YOUR SIGNATURE AND DECLARATION

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 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).

[illegible]

11	9	9	4	9	9	9
----	---	---	---	---	---	---

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)
P.O. Box 290, Dubai UAE
Call Centre - 8004845, Fax: +971 4 324 2375
E-mail: info.dubai@axa-gulf.com, Website: www.axa-gulf.com

Call Centre - 8004845. Fax: +971 4 324 2375

E-mail: info.dubai@axa-gulf.com, Website: www.axa-gulf.com

Agent: Kanoo Group (Insurance Agent) L.L.C

100%

رؤية جديدة / للتأمين
redefining / insurance

