ADNIC
شركة أبوظبي الوطنية للتأمين
ABU DHABI NATIONAL INSURANCE COMPANY

APPLICATION FORM FOR SHIFA INDIVIDUAL PLANS

1. POLICYHOLDER DETAILS

Last name ..... First name .....

Title ..... Date of birth ..... dd/mm/yyyy .....

Marital status ..... Sex ☐ M ☐ F

Occupation ..... Height (Cm) ..... Weight (Kg) .....

Monthly Gross Salary ☐ Less than AED 4,000/- ☐ Greater than AED 4,000/-

Nationality ..... Passport no. ..... Emirate of Visa Issuance .....

Address .....

Town/City ..... Country/State .....

Mobile number ..... Email .....

2. COMPANY DETAILS (if applicable)

Company name .....

Address .....

Town/City ..... Country/State .....

Email .....

3. DEPENDENTS TO BE INCLUDED IN THE PLAN

Please enter the details of all the dependents to be covered under this policy. This can include your legal spouse and your unmarried, financially dependent children under the age of 18. The place of residence of the legal spouse and the unmarried financially dependent children must be with the Policyholder unless the Insurance company approves the other arrangements.

Last name	First name	Relation	Sex		Height (Cm)	Weight (Kg)	Date of birth (d - m - y)	Emirate of Visa Issuance
			☐ M	☐ F			/ /	
			☐ M	☐ F			/ /	
			☐ M	☐ F			/ /	
			☐ M	☐ F			/ /	
			☐ M	☐ F			/ /	

Policyholder is the person/company who has the right to confirm, alter or renew this insurance cover on behalf of all the insured members under the same policy, and who is responsible for the premium payment against insurance cover under this policy.

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4. PLAN DETAILS Please tick your choice.

Direct Billing Facility overseas		N/A				N/A
Plan Type		☐ Bronze	☐ Silver	☐ Gold	☐ Platinum	☐ Domestic Worker
Deductible						
	☐ AED 30	☐	☐	☐	N/A	AED 50
	☐ AED 50	☐	☐	☐	N/A	
	☐ Nil	N/A	N/A	N/A	Included	
Outpatient Pharmaceutical Co-insurance						
	☐ 20%	☐	☐	☐	N/A	30%
	☐ 10%	N/A	N/A	☐	N/A	
	☐ Nil	☐	☐	☐	Included	
Dental Care		N/A	☐	☐	☐	N/A
Vision Care		N/A	N/A	☐	☐	N/A
Please note that amending, upgrading or downgrading a cover plan is not applicable during policy term after issuing the policy. Any changes will apply only at renewal						

5. MINI QUESTIONNAIRE

Please complete the questionnaire with regards to whole family:

1 Any of the applicants had previous Health Insurance with ADNIC. ☐ YES ☐ NO
(If yes, please share the policy number).....

2 Any of the applicants do have any chronic or pre-existing medical condition. ☐ YES ☐ NO
(E.g., Diabetes Mellitus, Hypertension, Heart Disease, Cancer, Tumour, Cysts, Kidney diseases, Knee related issues, etc.)

3 Any of the applicants have undergone any special examinations /tests such as X-Rays, MRI, Ultrasound or any other tests during the past 12 months (excluding the tests done as part of UAE residency). ☐ YES ☐ NO

4 Is there any other existing medical condition requiring medical attention soon or later to be disclosed for any of the applicants? ☐ YES ☐ NO

5 For Married Females aged less than 50 only:

a) Are you currently pregnant? ☐ YES ☐ NO
If Yes, have there been any complications till date? .....

b) Provide the date of your last menstrual period .....

c) Are you currently trying to get pregnant or undergoing any form of fertility treatment? ☐ YES ☐ NO

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6. DETAILED QUESTIONNAIRE

To be completed only if:

a) You are opting for Platinum Plan.

b) The age of any of the member exceeds 49.

c) You have made any declaration under Section 5. MINI QUESTIONAIRE

In order to apply for this insurance, please complete all parts of this Questionnaire and the annexures, if any. The insurance cover begins when ADNIC confirms the same in writing.

You must provide full, accurate and true answers to all questions listed below. Material facts which you know or ought to know should be fully and accurately disclosed. Failure to do so, may result in rejecting your claim and/or terminating your insurance cover.

If you are in any doubt about what you should disclose, please do not hesitate to contact us. Making sure that we are informed completely, is for your own protection.

If the space provided is inadequate, please provide the details using additional information sheet, duly signed and dated.

Signing of this Questionnaire is not the commencement of insurance coverage. The commencement of insurance coverage will be confirmed upon acceptance of this Questionnaire and issuance of the Insurance Policy.

Please keep a copy of this Questionnaire for your record along with any correspondence/information provided to us and policies/ endorsements which may be issued to you subsequently.

Please answer each of these questions fully and accurately, for each person included on your application. If the answer to one of the questions below is 'Yes', please provide details in the additional information box on the last page.

Name **Date of birth** dd/mm/yyyy	**Policyholder**	**Spouse/Partner**	**Child 1**	**Child 2** ....
Do you suffer from or have you suffered from any illnesses, disturbances or problems connected with:				
a. The respiratory organs, such as asthma, recurrent or chronic bronchitis, pneumonia, pulmonary tuberculosis or other disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. The heart or vascular system, such as high blood pressure, circulatory problems, heart attack, heart defect, heart failure, palpitations, apoplexy, phlebitis, varicose veins or other disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c. The nervous system or a mental disorder, such as epilepsy, dizziness, paralysis, neuritis, depression or other disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d. The digestive system, such as hiatus hernia, gastric or duodenal ulcers, or other disorders of the stomach or intestines, such as inflammations, haemorrhages, haemorrhoids, jaundice, diseases of the liver, gall bladder, pancreas?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e. The urinary tract of sexual organs, such as kidneys, ureters, bladder or prostate, urinary tract, blood or albium in the urine or other disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f. The metabolism or blood, such as diabetes mellitus, elevated cholesterol, gout, thyroid gland or hormonal disturbances, anemia, coagulation disturbances or other disorders?	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No
g. The immune system or infectious diseases, such as AIDS, HIV, sexually transmitted diseases, hepatitis, tropical diseases or other disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h. The skin, such as eczema, allergies, psoriasis, fungal diseases, skin cancer or other disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i. The musculoskeletal system, (bones, joints, spine, intervertebral discs, muscles, ligaments, tendons), such as disorders of the back, neck and shoulders, arthritis, rheumatism or other disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j. The eyes, such as decreased visual acuity or refraction power, retinal disease or other disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k. The ears, hearing difficulties, inflammation or other disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l. Other illnesses, disturbances or problems not listed above, such as congenital defects, deformities, tumours, cancers, etc?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
m. Is a hospital stay or operation planned?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
n. Have you been treated by or consulted any of the following in the last 5 years: - psychotherapist? (e.g. psychiatrist, psychologist) - chiropractors, physiotherapists?	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No

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ADDITIONAL INFORMATION

If you answered 'Yes' to any of the questions above, please provide details here. Please provide the precise question number(s), name of the person, diagnosis, dates and duration of illness/injury/treatment and the names and addresses of attending physicians and medical facilities.

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DECLARATION

I/WE HEREBY DECLARE THAT THE STATEMENTS/ INFORMATION GIVEN BY ME/US IN THE QUESTIONNAIRE ARE FULL, ACCURATE, TRUE AND AS PER THE PROPOSER'S KNOWLEDGE & CONFIRMATION ONLY. IT IS HEREBY UNDERSTOOD AND AGREED THAT THE STATEMENTS, ANSWERS AND PARTICULARS PROVIDED IN THIS QUESTIONNAIRE AND AS PER THE ATTACHEMENTS ARE THE BASIS ON WHICH THE INSURANCE POLICY IS BEING ISSUED/EFFECTED. IF AFTER THE INSURANCE POLICY IS AFFECTED, IT IS FOUND THAT ANY FACT IN THE STATEMENTS, ANSWERS OR PARTICULARS IN THIS QUESTIONNAIRE IS INCORRECT, UNTRUE, INACCURATE, MISREPRESENTED OR NON-DISCLOSED IN ANY RESPECT, ADNIC SHALL HAVE NO LIABILITY UNDER THE INSURANCE POLICY AND/OR SHALL HAVE THE RIGHT TO TERMINATE YOUR INSURANCE COVER FROM INCEPTION.

I UNDERSTAND AND ACKNOWLEDGE ANY PREGNANCY NOT DECLARED AT THE TIME OF THIS APPLICATION'S COVERAGE WILL BE AT THE SOLE DISCRETION OF THE INSURER. THE INSURER HAS THE RIGHT NOT TO COVER ANY MATERNITY CLAIMS TO ANY UNDECLARED PREGNANCY. I ALSO ACKNOWLEDGE AND UNDERSTAND ANY PREGNANCY, WHICH ARISES WITHIN FORTY CALENDAR DAYS FROM THE DATE OF THIS APPLICATION; COVERAGE WILL ALSO BE AT THE DISCRETION OF THE INSURER.

IF THERE IS ANY CHANGE IN HEALTH CONDITION FOR THE MEMBERS INCLUDED IN THIS PROPOSAL FORM BEFORE THE FINAL UNDERWRITING DECISION IS RELEASED, WE ARE OBLIGED TO INFORM THE INSURANCE COMPANY OF THE SAME. I UNDERSTAND THAT FAILURE TO DO SO MAY RESULT IN THE REJECTION OF ANY CLAIM RELATED TO THAT CONDITION AND OR TERMINATION OF MY INSURANCE COVER.

Signature of Policyholder ..... Spouse Signature.....
(Signature must be preceded by the handwritten words **Read & Approved**)

Date ..... Signature of Proposer .....

Signing of this proposal form is not the commencement of insurance coverage. The commencement of insurance coverage will be confirmed upon acceptance of the proposal.