WEHBE INSURANCE SERVICES LLC
Ministry of Economy – Registration No 106 of Year 1997

GoodHealth
Individual Application Form

E&OE

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Application Form

(effective 1st October 2004)

Agent / Broker Name and Stamp

Please read through the following before completing this application and complete in block capitals.

All information supplied will be treated in strict confidence. **You** must disclose all material facts. Failure to do so may invalidate the **Policy.** A material fact is one which is likely to influence the assessment and acceptance of this application. If **You** are in any doubt whether a fact is material it should be disclosed.

As the applicant **You** should answer all the questions and sign the declaration on behalf of all persons included in this application. A copy of this application can be supplied to **You** on request within three months of completion. **You** should keep a record of all information (including copies of all letters) supplied to us for the purpose of entering into this contract.

1. Details of Applicant (First Person)

Family Name:

First Name(s): Title:

Marital Status: M / F Date of Birth: day month year Height m/ft Weight kg/lb

Industry:

Occupation:

Nationality:

Country of Residence:

Residential Address:

Town/City:

Country/State:

Postcode:

Correspondence Address:

Town/City:

Country/State:

Postcode:

Home Telephone:

Mobile:

Home Email:

Business Telephone:

Fax:

Business Email:

Insured by

Administered by

2. Dependant's Details

Please note children to be included under this plan must be under 18 years of age or under 23 years of age if they are in full time education and are fully dependant upon **You.**

Dependant 1

Family Name:

First Name(s):

Other Initials: Title: Sex: M / F Height m/ft Weight kg/lb

Relationship to Applicant: Date of Birth: day month year

Occupation:

Nationality:

Dependant 2

Family Name:

First Name(s):

Other Initials: Title: Sex: M / F Height m/ft Weight kg/lb

Relationship to Applicant: Date of Birth: day month year

Occupation:

Nationality:

Dependant 3

Family Name:

First Name(s):

Other Initials: Title: Sex: M / F Height m/ft Weight kg/lb

Relationship to Applicant: Date of Birth: day month year

Occupation:

Nationality:

Dependant 4

Family Name:

First Name(s):

Other Initials: Title: Sex: M / F Height m/ft Weight kg/lb

Relationship to Applicant: Date of Birth: day month year

Occupation:

Nationality:

If **You** have any further **Dependants** please provide details on a separate sheet.

3. Commencement Date

Subject always to Section 9 of this application form, the commencement date of this **Policy** will be the date on which this application is accepted in writing by **Us.**

Please note the commencement date can be no more than 30 days from the date of completion of this application by **You.** Under no circumstances will **Policies** be backdated.

Commencement Date: day month year

4. Product Options

This plan enables **You** to choose various options to suit **Your** personal requirements. Please clearly tick the option **You** have selected. **Your Policy** will be issued on this basis.

If no boxes are ticked in this section it will be assumed that cover is required as per the Foundation product option.

Benefits	Major Medical 001	Foundation 002	Lifestyle 003	Lifestyle Plus 004
Standard **Excess**	NIL	$100	$100	$100
Maximum **Benefit** per **Insured Person** per **Period of Cover**	$1,600,000	$1,600,000	$1,600,000	$1,600,000
In-Patient & **Day-Patient** Cover	✓	✓	✓	✓
Post Hospitalisation **Out-Patient** Cover	✓	✓	✓	✓
Evacuation & Repatriation	✓	✓	✓	✓
Out-Patient Care	-	✓	✓	✓
Primary Care	-	✓	✓	✓
Routine Management of **Chronic** Conditions	-	-	✓	✓
Evacuation Extension	-	-	✓	✓
Home Nursing Extension	-	-	✓	✓
Routine Dental	-	-	-	✓
Restorative Dental	-	-	-	✓
Pregnancy & Childbirth	-	-	-	✓
Your Selection – please tick **Your** choice	☐	☐	☐	☐

ALL limits and excesses expressed in $ shall in all instances mean US $.

Excess Options - Please select where **You** wish to change from the standard **Excess** applicable by ticking the appropriate box

	Major Medical 001	Foundation 002	Lifestyle 003	Lifestyle Plus 004
Nil	Standard	☐	☐	☐
$50	N/A	☐	☐	☐
$250	N/A	☐	☐	☐
$500	N/A	☐	N/A	N/A
$1,000	☐	☐	N/A	N/A
$2,000	N/A	☐	N/A	N/A
$5,000	☐	☐	N/A	N/A

Additional Options - Please tick **Your** choices.

	Major Medical 001	Foundation 002	Lifestyle 003	Lifestyle Plus 004
USA **Elective Treatment - [005]**	N/A	☐	☐	☐
Extended **Evacuation - [006]**	☐	☐	N/A	N/A
Medical History Disregarded - **[007]** *Only available to compulsory group schemes of 10 employees or more.*	☐	☐	☐	☐
Extension to Lifestyle Plus - **[008]** *Only available to compulsory group schemes of 5 employees or more.*	N/A	N/A	N/A	☐

5. Premium Payment

Tick which payment method **You** require and complete all details relevant to that method. All premiums must be paid annually.

☐ **a. Cheque Payment** All cheques must be payable to "Royal & Sun Alliance" Please ensure that the name of the Applicant (as declared in Section 1 of this form) is clearly stated on the reverse of the cheque.

☐ **b. Bank Transfer** (for UAE only) Please ensure the name of the Applicant (as declared in Section 1 of this form), is clearly stated on any transfer. **Our** Bank details for Bank Transfer are as follows:

	Dirham Account	Sterling Account	US Dollar Account
Account Name:	Royal & Sun Alliance Insurance	Royal & Sun Alliance Insurance	Royal & Sun Alliance Insurance
Bank Address:	Citibank, Dubai, UAE	Citibank, Dubai, UAE	Citibank, Dubai, UAE
Account Number:	500027 002	500027 029	500027 037
Swift Code:	citiaead	citiaead	citiaead

We cannot accept liability for any bank transfer which does not clearly identify the Applicant

☐ **c. Credit Card** Currency which the card will be debited in, is UAE Dirhams   Visa ☐   Mastercard ☐

Credit Card Number:

Cardholder's Name: Expiry Date: month year

Cardholder's Statement Address:

Cardholder's Authorisation Signature: Date: day month year

For payment method by c, please note **Your** premium will be collected on receipt of this application, which may be in advance of the commencement date.

6. Medical Practitioner Details

Please give the details, including name, address and qualifications of **Your** usual **Medical Practitioner,** and in respect of anyone else included in this application.

Please use a separate sheet if this space is insufficient.

7. Pre Existing Condition(s)

Benefits will not be available for any **Medical Condition** or **Related Condition** for which **You** have received medical **Treatment,** had symptoms of, or to the best of **Your** knowledge existed, or sought **Advice** prior to **Your Date of Entry,** until two consecutive years have elapsed, after the **Date of Entry,** during which no **Treatment** or **Advice** was given in respect of that **Medical Condition** or any **Related Medical Condition.**

8. Medical Questionnaire

Please reply to the following questions by ticking Yes or No. In case **You** have ticked Yes, please provide details.

	Yes	No
a. Have **You,** or anyone included in this application, been admitted to **Hospital** or other similar establishment in the last five years?		
b. Have **You,** or anyone included in this application, been prescribed with a course of any drugs or medication, or **Treatments** for a period in excess of seven days in the last two years?		
c. Have **You,** or anyone included in this application, any known or foreseeable need to consult with a **Medical Practitioner** or any other health care professional and/or to be required to be prescribed any drugs or medication and/or to be admitted to a **Hospital** or other similar establishment?		
d. Are **You,** or anyone included in this application, suffering from any disability, abnormality, recurrent illness, major illness or injury, not already noted above?		

Please use this space to provide any additional information, or a separate sheet of paper if there is insufficient space:

9. Declaration

I understand and accept Section 7 on Pre-Existing Condition(s).

I declare that the answers given are to the best of my knowledge full, true and complete and have checked and found correct any answers and statements in this application that are not in my own handwriting.

I have declared all material facts which relate to this application.

I declare that I have read, understood and agree to accept and conform to the terms of the **Policy**, unless I cancel this **Policy** within 15 days from the commencement date.

I confirm and agree that the personal information collected or held by Royal & SunAlliance, whether contained in this application form or otherwise obtained may be used by Royal & SunAlliance, or disclosed to or transferred to any organisation for the purpose of 1) assessing this application and providing on-going insurance and customer service, 2) processing and giving effect to credit card payment, 3) providing marketing material in respect of insurance related services of Royal & SunAlliance or it's associated companies and 4) processing claims or analysing the insurance.

I authorise any doctor, physician or **Specialist** who I have attended in any capacity to provide Royal & SunAlliance, or their representatives, with any and all information in respect of such attendance and any known medical history.

I agree that where **Medical Treatment** is received within the **Provider Network** by myself or any of my **Dependants** and it is substantiated that the **Treatment** or **Medical Condition** is not refundable within the terms and conditions of the **Policy,** that I, as the **Policyholder,** shall be fully responsible for reimbursement to Royal & SunAlliance within 14 days of receipt of notice of such non-refundability of all funds expended in connection with any claim for such medical **Treatment.**

I understand and confirm that where I have not made repayment of funds disbursed by Royal & SunAlliance in respect of such medical **Treatment** not covered by the **Policy,** the **Policy** shall be suspended until the date of my full settlement of all outstanding amounts due from me to Royal & SunAlliance and in the event that funds so due from me to Royal & SunAlliance have been outstanding and unpaid for a period in excess of 14 days Exclusion 1 of the **Policy** wording shall be re-applied to the **Policy** with effect from the date of full receipt by Royal & SunAlliance of the funds concerned in which event any suspension of the **Policy** pursuant to this subclause shall be lifted with effect from such full receipt date. In no event shall any claim for **Treatment** received during the period of suspension be made or met.
I further accept that where funds have been outstanding to Royal & SunAlliance for a period in excess of 15 days from notification my **Policy** will be cancelled void ab initio, without refund of premium.

Signature of Applicant:

Date: day month year

Contact Details for the Royal & SunAlliance Offices:

Insured by

Royal & SunAlliance Insurance (Middle East) Limited E.C.
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Administered by

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