Application Form

Full Medical Underwriting

MyHEALTH Dubai Employee and Family

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1. YOUR DETAILS

IMPORTANT NOTICE

The answers you give to the questions contained in this Application will form the basis of any insurance policy issued and will be incorporated into the contract. It is essential that you give accurate, truthful, and complete information for all persons to be insured, as inaccuracies may jeopardise coverage or invalidate a claim.

A copy of your passport, visa (on the passport) as well as the Emirates ID will be required. Please provide them for any member of the policy at the same time as the application form

EMPLOYEE'S DETAILS

Family Name:

First Name(s):

Date of Birth: DD / MM / YYYY

Gender: Male ◯ Female ◯

Height (cm):

Weight (kg):

Smoker: Yes ◯ No ◯

Marital Status:

Occupation:
(Specify nature of duties)

Passport Number :

Nationality:

UID Number :

Emirates ID Number :

Emirate of Residence :

Residential Address:

Emirate of work:

Country:

Usual Country
of Residence:

If you wish to use a different mailing address please advise us

Tel.:

Mobile:

Email:

Important : this email will be used for sending your policy documents and claims-related communication which may include sensitive medical information.

1. YOUR DETAILS - CONTINUED

FAMILY MEMBERS TO BE INSURED								
	FAMILY MEMBER 1		FAMILY MEMBER 2		FAMILY MEMBER 3		FAMILY MEMBER 4	
Family Name								
First Name(s)								
Date of Birth	DD / MM / YYYY		DD / MM / YYYY		DD / MM / YYYY		DD / MM / YYYY	
Gender	Male ◯	Female ◯	Male ◯	Female ◯	Male ◯	Female ◯	Male ◯	Female ◯
Marital Status								
Relationship to Employee								
Nationality								
Smoker	Yes ◯	No ◯	Yes ◯	No ◯	Yes ◯	No ◯	Yes ◯	No ◯
Passport Number								
UID Number								
Emirates ID Number								
Occupation (Specify nature of duties)								
Height & Weight	cm	kg	cm	kg	cm	kg	cm	kg

Please use separate sheet if necessary. Please advise us if any Family Members to be insured do not live at the Employee's Residential Address.

2. YOUR COVER

Step 1	**Choose your modules** The following modules form the base of your policy. Each member has the flexibility to select the cover they want.
	Important Notes • If you select **Hospital & Surgery Core**, your other modules (Outpatient, Dental and Optical, and Maternity and Newborn Care) will also be **Core** by default. • All modules are mandatory, and each employee must select their preferred level of cover.

MODULES	EMPLOYEE	FAMILY MEMBER 1	FAMILY MEMBER 2	FAMILY MEMBER 3	FAMILY MEMBER 4
Hospital & Surgery	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite
Outpatient	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite
	Co-insurance selection ◯ Nil co-insurance ◯ 20% co-insurance capped at $14 ◯ 20% co-insurance for all Outpatient benefits	Co-insurance selection ◯ Nil co-insurance ◯ 20% co-insurance capped at $14 ◯ 20% co-insurance for all Outpatient benefits	Co-insurance selection ◯ Nil co-insurance ◯ 20% co-insurance capped at $14 ◯ 20% co-insurance for all Outpatient benefits	Co-insurance selection ◯ Nil co-insurance ◯ 20% co-insurance capped at $14 ◯ 20% co-insurance for all Outpatient benefits	Co-insurance selection ◯ Nil co-insurance ◯ 20% co-insurance capped at $14 ◯ 20% co-insurance for all Outpatient benefits
	• If a 20% co-insurance is selected, direct billing is only available within your selected network. • Under **Outpatient Core**, the co-insurance will be **nil** by default.				
Dental and Optical	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite
Maternity and Newborn Care For women aged 19-45	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite

Step 2	**Personalise your Cover** Select your preferred network and area of cover that will apply to all selected modules.				
Network Selection	◯ Green ◯ Classic ◯ Premium	◯ Green ◯ Classic ◯ Premium	◯ Green ◯ Classic ◯ Premium	◯ Green ◯ Classic ◯ Premium	◯ Green ◯ Classic ◯ Premium
	• Should you visit a medical facility that is not within your selected network, a co-insurance will apply as below. - Premium : Nil co-insurance - Classic : Nil co-insurance within the Classic Network | 30% co-insurance if any visit within the Premium network - Green : Nil co-insurance within the Green network | 50% co-insurance if any visit within the Premium network | 30% co-insurance if any visit within the Classic network • If you selected **Core**, your network selection will be **Green** by default. In the UAE and in the GCC countries, your coverage will be limited to the Green Network only. • If an **Outpatient co-insurance** is selected, the above does not apply and your direct billing will be limited to your entitled network.				
Area of Cover	◯ Worldwide excluding USA ◯ Worldwide	◯ Worldwide excluding USA ◯ Worldwide	◯ Worldwide excluding USA ◯ Worldwide	◯ Worldwide excluding USA ◯ Worldwide	◯ Worldwide excluding USA ◯ Worldwide
	• The **Worldwide** area of cover is not available if you selected **Hospital & Surgery Core**. • Services rendered outside of the area of cover are covered up to $20,000 per period of insurance under Core option and up to $50,000 under other levels of cover. Coverage is limited to sudden illness or injury occurring during the first 30 travel days of any trip outside the area of cover. • Please refer to clause 4 of the Policy Terms and Conditions.				

3. UNDERWRITING QUESTIONNAIRE

INSURANCE DETAILS		
Have you or any person to be insured ever applied for, been covered under, or held a policy administered by APRIL? If Yes, please give details.		
	Yes ○	No ○
Do you or any person to be insured currently have health insurance with another company? (including any potential substandard-terms) If Yes, please give details and indicate if it will be continued (and if not, as of what date).		
	Yes ○	No ○
Have you or any person to be insured ever had a policy or application for life, sickness, accident disability, critical illness or medical insurance refused or cancelled, or had any special terms imposed? If Yes, please give details.		
	Yes ○	No ○

MEDICAL DETAILS AND HISTORY Please indicate if you or any person to be insured have or have ever had any of the **signs, symptoms, illnesses or disorders** below by ticking the appropriate box.			
1.	Cancer, leukemia, tumor or neoplasm, cysts, fibrocystic breast disorder, polyp or growths of any kind	Yes ○	No ○
2.	Respiratory system: Asthma, bronchitis, allergies, rhinitis or sinusitis, tuberculosis, or other disorder of the respiratory system	Yes ○	No ○
3.	Circulatory system and blood disorder: Chest pain, raised blood pressure, raised cholesterol, heart condition, or other disorder of the circulatory system or blood	Yes ○	No ○
4.	Gastrointestinal system: Indigestion, gastric reflux, gastric ulcer, hemorrhoids, hernia, or other disorder of the gastrointestinal system	Yes ○	No ○
5.	Musculoskeletal: Bone fracture, joint injury, arthritis, back, neck or muscle pain, or other disorder of the spine	Yes ○	No ○
6.	Tropical illness: Malaria, dengue fever	Yes ○	No ○
7.	HIV/AIDS	Yes ○	No ○
8.	Urinary system: Kidney stones or other disorder of the urinary system or prostate	Yes ○	No ○
9.	Liver: Diabetes, hepatitis, fatty liver, or other disorder of the liver	Yes ○	No ○
10.	Thyroid: Hypothyroidism, Hashimoto's disease, or other disorder of the thyroid	Yes ○	No ○
11.	Brain and nervous system: Stroke, aneurysm, seizures, chronic headache, migraine, or other disorder of the brain or nervous system	Yes ○	No ○
12.	Anxiety, depression, stress, addiction, or other mental, behavioral, developmental disorder	Yes ○	No ○
13.	Gynecological system: Pregnancy (including any complication), fibroid, endometriosis, irregular periods or bleeding, menstrual pain, HPV infection, or an abnormal smear test result, or other disorder of the gynecological system	Yes ○	No ○
14.	Skin: Eczema, dermatitis, psoriasis, wart, or other disorder of skin	Yes ○	No ○
15.	Eyes and ears: Cataract, glaucoma, otitis, hearing loss, or other disorder of eyes or ears	Yes ○	No ○
16.	Congenital, hereditary conditions, birth defects, deformities, or conditions affecting mobility	Yes ○	No ○
17.	Any other disorder/ injury	Yes ○	No ○

3. UNDERWRITING QUESTIONNAIRE - CONTINUED

If you answered "Yes" to any of the above, please provide details in the table below. You may be required to provide a further medical questionnaire or medical reports, depending on the severity and nature of the condition declared.

Person to be insured			
Question No.			
Disease/ Medical Condition/ Sign & Symptom			
Date of first occurrence of sign & symptom	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
Frequency of sign & symptom			
Treatment Details (including name, date, duration of medication, surgery etc.)			
Date of last follow-up medical consultation/ treatment	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
Any on-going, regular, planned or preventive treatment required?			
Any on-going sign or symptom?			

MEDICAL DETAILS AND HISTORY - CONTINUED

18. **Except as disclosed elsewhere in this form, have you or any person to be insured ever been admitted to hospital as an inpatient, or undergone any procedures including endoscopy, biopsy whether as an inpatient or outpatient?** If Yes, please give details.

Yes ○ No ○

19. **In the last five years, have you or any person to be insured been notified of any abnormal test results or awaiting results for any scans or tests performed (e.g. blood or urine test, ECG, endoscopy, X-ray, ultrasound, CT scan, MRI, PET scan etc.)?**
Please also answer "Yes" if there are any inconclusive or uncertain results (retesting or follow up test required) and abnormal findings that may not require treatment at present (e.g. cyst, joint degeneration, calcification, etc.)

Yes ○ No ○

20. **In the last five years, have you or any person to be insured currently taking or been prescribed any medications for a continuous period of more than one month?** If Yes, please state the medicine name, dosage and the approximate cost.

Yes ○ No ○

21. **Are you currently pregnant or show signs and symptoms of pregnancy or planning to get pregnant?**
If the answer is Yes, please complete the supplementary maternity questionnaire
** Any pregnancy, which arises within forty calendar days from the date of this application; coverage will be at the discretion of the insurer*

Yes ○ No ○

22. **Please enter the following details about the usual/family doctor for each person to be insured. If you do not have a usual/family doctor, please provide the names, addresses and contact information of medical providers you and your family members to be insured have seen in the last 3 years. Use a separate sheet if necessary.** If you have never seen a doctor in the past 3 years, please indicate that below.

Name	
Address	
Telephone	
Email	

Please provide more details on a separate sheet if required.

3. UNDERWRITING QUESTIONNAIRE – CONTINUED

ADDITIONAL SPACE FOR FURTHER REMARKS
You may use this space for any further comments about any medical conditions you have or have suffered from. Please remember to enclose any supporting documents with your application.

CLAIM REIMBURSEMENT
Please provide your banking details for claim reimbursement.

Bank Name			
Bank Address			
A/C Name		A/C No.	
Currency	○ AED		For international transfers to a foreign bank, note that your bank may charge you fees for each transaction which will be your responsibility to bear
The following information must be provided for bank accounts outside of Dubai:			
Sort Code		BIC (Swift) Code	
IBAN			
Corresponding Bank Details (if applicable)			

4. NOTICE TO CUSTOMERS RELATING TO THE PERSONAL DATA

☐	We will collect, use, store, and disclose your personal information, including sensitive information (in particular, information relating to your medical history and any medical treatment you may have or have had), in accordance with relevant data protection legislation. We collect and will use your personal information, including sensitive information, for the purpose of carrying out our obligations under this plan. We may share your information, including sensitive information, with other companies, carefully selected third parties including any broker you appoint to act on your behalf, our third party administrator, other providers of services under this plan and authorized healthcare providers, where necessary to carry out our obligations under this plan. This statement also applies to personal information of any beneficiaries detailed on this application form. You have the right to request a copy of your personal information held by us, and beneficiaries under your policy have the right to request a copy of personal information we hold about them. I acknowledge my consent to the collection, use and disclosure of my personal, sensitive and/or health data by HAYAH Insurance Company P.J.S.C. for the purposes required by the contract of insurance I have entered into. **PLEASE TICK☑**

DECLARATION BY EMPLOYEE

I declare that the statements contained in this application form are correctly recorded, and that they are full, complete and true. I further declare that I have not withheld any material fact and that except as declared herein, all persons to be insured are currently in good health. I will notify HAYAH Insurance Company P.J.S.C. immediately if after signing this application and before a policy is issued if I become aware of material facts not disclosed in this form, or if the health of any person to be insured changes such that any answer on this form is not full complete, and true. If a policy is issued to me, this proposal and the statements made herein shall form the basis of the policy between me/us and HAYAH Insurance Company P.J.S.C. I understand that no insurance shall be in force until and unless the application has been accepted and the appropriate premium paid.

SIGNATURE		
	Name :	
	Title :	
	Date :	
	Important :	The application form must be sent to us within **30 days** from this date for your application to be valid.

MH DN 2025/04

Underwritten by:

HAYAH Insurance Company P.J.S.C.
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Designed by:

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