expacare



DUBAI CHOICES APPLICATION FORM

For Individuals

Please use BLOCK CAPITALS and Black Ink when completing the form.

When selecting which benefit levels are required, please ensure that you are aware of any financial limits, cover restrictions or exclusions that may apply. Full details can be found either within the quotation that we provided, or alternatively within the Choices membership guide, copies of which are available upon request.

1.	MAIN APPLICANT / PO	OLICYHOLDER					
	First name:		Last name	e:			
	Nationality:		Country of	of overseas resi	dence:		
	Residential address:						
	Telephone:		Email:				
	Occupation and Industry/n	nature of business:					
	Name and address of Emp	loyer:					
	Male Female		Date of b	irth: DD / N	MM / YY		
2.	FAMILY MEMBERS TO	BE INCLUDED ON CO	VER				
	PARTNER / SPOUSE						
	First Name	Last Name	Nationality	Country of Residence	Occupation	Male / Female	Date of Birth DD / MM / YY

CHILD DEPENDANTS

	First Name	Last Name	Nationality	Country of Residence	Occupation	Male / Female	Date of Birth DD / MM / YY
Child Dependant 1							
Child Dependant 2							
Child Dependant 3							
Child Dependant 4							

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	Main Applicant / Policyholder	Spouse or Partner	Child Dependant 1	Child Dependant 2	Child Dependant 3	Child Dependant
Height: (Please specify cm or inches)						
Weight: (Please specify kg or pounds)						
Have you smoked any tobacco products in the last year? If yes, please specify how much you smoke per week:	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Do you consume alcohol? If yes, please specify how many units you consume per week? e.g. 1 pint of beer = 2.5 units, 1 bottle wine = 10 units	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No (
Approximately how many hours do you exercise per week?						
Number of days absent from work due to ill health in the last year?						
YOUR DOCTOR Please give details of your regular phys the last two years: Name:	sician or a physic	cian with whom	n you have mos	it recently cons	ulted and prefe	erably in
Please give details of your regular phys the last two years:	sician or a physic	cian with whom	n you have mos	it recently cons	ulted and prefe	erably in
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Please give details of your regular physical the last two years: Name: Address:					ulted and prefe	-
Please give details of your regular physical the last two years: Name: Address: Telephone:		Email:				-
Please give details of your regular physical the last two years: Name: Address: Telephone: THE DATE YOU WANT COVER T		Email:				-
Please give details of your regular physical the last two years: Name: Address: Telephone: THE DATE YOU WANT COVER TO BROKER DETAILS	O START:	Email: D / MM / YY Broker coo	Please note the			-
Please give details of your regular physical the last two years: Name: Address: Telephone: THE DATE YOU WANT COVER TO BROKER DETAILS Broker name: AREA OF COVER Area 2 – Worldwide excluding USA, Broker physical ph	O START:	Email: D / MM / YY Broker cod	Please note the			
Please give details of your regular physical the last two years: Name: Address: Telephone: THE DATE YOU WANT COVER TO BROKER DETAILS Broker name: AREA OF COVER Area 2 – Worldwide excluding USA, Broker physical ph	O START: Dermuda and all i	Email: D / MM / YY Broker cod slands of the C	Please note the le (if known):			-
Please give details of your regular physical the last two years: Name: Address: Telephone: THE DATE YOU WANT COVER TOWN TOWN TOWN TOWN TOWN TOWN TOWN TOWN	O START: Dermuda and all i	Email: D / MM / YY Broker cod slands of the C	Please note the le (if known):			3

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9.	CHOICES OPTION 1 - DUBAI MODULE Please SELECT ONE of the Dubai Modules.	
		SELECT ONE ONLY
	Dubai Module Basic	SELECT
	Dubai Module - Maternity 1*	SELECT
	Dubai Module - Maternity 2*	SELECT
	*The Dubai Module Maternity 1 or Maternity 2 are only available on individual plans after the first	st renewal date.
10.	. CHOICES OPTION 2 - OUT-PATIENT TREATMENT Please SELECT ONE of the levels of out-patient treatment below.	
		SELECT ONE ONLY
	Extended out-patient	SELECT
	Advanced out-patient	SELECT
	Please SELECT from the additional benefits listed below.	
		SELECT ONE ONLY
	Dental Basic	SELECT
	Dental treatment and wellness benefit	SELECT
	Dental treatment, wellness benefit and optical	SELECT
12.	. CO-PAY (OPTIONAL)	
	20% co-pay subject to a max of AED 50 per visit (applies to Consultations and diagnostic services with doctors or specialists only)	
	20% co-pay subject to a max of AED 100 per visit (applies to Consultations and diagnostic services with doctors or specialists only)	
	10% co-pay applying to all outpatient services and prescription drugs	
	20% co-pay applying to all outpatient services and prescription drugs	
13.	. PAYMENT DETAILS	
	a) Payment Currency is USD (please note this determines the currency of the policy)	
	b) Payment method:	
	I will be paying by bank transfer	
	c) Payment Frequency: * An administration fee of 2% on six-monthly and 4% on quarterly options will be charged. Six-mo	onthly* Quarterly*

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14. MEDICAL QUESTIONNAIRE

Do you or anyone to be covered currently have a health insurance policy with another insurance company?	Yes	No 🗌
If yes, please specify which company:		
Have you or anyone to be covered ever had a health insurance policy?	Yes	No 🗌
If yes, please specify which company and confirm how long you were on cover:		
Have you or anyone to be covered ever been declined or had exclusions applied on another health care policy?	Yes	No 🗌
If yes, please provide details for each applicant in the Medical History Section, Part 3 on page 5.		
Are you opting for cover that includes dental treatment?	Yes	No 🗌
If yes, please provide details of the last time you and anyone else to be covered went for a dental check-up.		
Was all necessary work concluded?	Yes	No 🗌

15. MEDICAL HISTORY - PART 1

Have you or any named dependant in the last 5 years:

- seen a doctor, specialist or healthcare professional;
- experienced any signs or symptoms;
- been admitted to hospital, had any operations or investigations; including x-rays, biopsies and blood tests;

For any of the following? (If 'Yes' for any question please provide full details in Medical History - Part 3)

	Main Applicant / Policyholder	Spouse or Partner	Child Dependant 1	Child Dependant 2	Child Dependant 3	Child Dependant 4
	NAME	NAME	NAME	NAME	NAME	NAME
Heart and Circulatory Disorders. e.g. chest pain (angina), abnormal heart beat, varicose veins, high blood pressure, circulation problems, blood lipid or cholesterol problems.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Respiratory Disorders. e.g. asthma, bronchitis, COPD, pneumonia, tuberculosis, chest infections, cystic fibrosis.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
3. Skeletal & Muscular Disorders. e.g. back, shoulder or neck problems, disc disorders, osteoporosis, cartilage, tendon, or ligament disorders, joint replacements, fractures, bunions.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Digestive Disorders. e.g. Crohn's disease, colitis, irritable bowel syndrome, changes in bowel habit, rectal bleeding, indigestion/reflux, hernia, cirrhosis, jaundice, liver/pancreas or gall bladder problems, haemorrhoids.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Blood Disorders. e.g. anaemia, leukaemia, hepatitis, HIV, deep vein thrombosis (DVT), abnormal blood tests.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Neurological Disorders. e.g. epilepsy, seizures, multiple sclerosis, meningitis, migraines, headaches, dementia	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
7. Psychiatric Disorders. e.g. depression, stress, anxiety, eating disorders, schizophrenia, addictions (including drug or alcohol dependency).	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Ear, Nose, Throat or Eye Problems. e.g. cataracts, glaucoma, blepharitis, ear infections, hearing problems, vertigo, tinnitus, tonsillitis, or sinus problems.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Dental or Maxillofacial Problems. e.g. wisdom teeth problems, gingivitis, dental/gum infections, abscesses.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Urinary Problems. e.g. urinary tract infections, urinary/ kidney stones, incontinence or urgency, renal failure, bladder or kidney problems.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

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15. MEDICAL HISTORY - PART 1 CONTINUED

Endocrine (glandular) Disorders. e.g. diabetes, thyroid problems, pituitary, adrenal or hormonal problems.	Yes No					
12. Allergies or Skin Problems. e.g. psoriasis, eczema, acne, moles, warts, lipomas, hypertrophic/keloid scars.	Yes No					
Male Disorders. e.g. abnormal PSA result, infertility, sexually transmitted infections, prostate or testicular disorders.	Yes No					
14. Female Disorders. e.g. menstrual problems, fibroids, endometriosis, polycystic ovaries, abnormal smear test, menopausal symptoms, sexually transmitted infections, infertility, breast lumps, child birth or pregnancy problems.	Yes No					
15. Autoimmune & Infective Disorders. e.g. AIDS, myasthenia gravis, malaria, Lupus, Sjogrens syndrome.	Yes No					
16. For any medical condition not listed in questions 1-15 above. Please provide full details in Medical History - Part 3.	Yes No					

15. MEDICAL HISTORY - PART 2

Please answer the following question for you or any named dependant. (If 'Yes' for any question please provide full details in Medical History - Part 3)

	Main Applicant / Policyholder	Spouse or Partner	Child Dependant 1	Child Dependant 2	Child Dependant 3	Child Dependant 4
17. Do you take any medication on a regular basis, prescribed or otherwise? Please list in Medical History - Part 3.	Yes No	Yes No No	Yes No	Yes No	Yes No	Yes No
18. Have you ever had any past history of any joint replacements, heart conditions or strokes?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
19. Have you ever been a) diagnosed with any conditions, or b) suffered symptoms for any undiagnosed condition, not mentioned in Medical History - Part 1?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
20. Have you ever been diagnosed with any cancerous or pre cancerous condition? If any please advise in Part 3.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
21. Are you currently pregnant?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
22. Are you undergoing any form of fertility treatment?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
23. Do you currently have any planned or pending check ups, investigations or treatment?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

15. MEDICAL HISTORY - PART 3

If you have answered 'Yes' to any of the questions 1-23 please provide full details below.

Name	Question number	Symptom or medical condition and area of body affected. e.g. skin rash on back	Date when symptoms started.	Date when symptoms finished.	What treatment did you receive and when? Please confirm dates and detail any medications provided.	What was the outcome? e.g. ongoing, still under review, complete recovery, recurrent or likely to recur?

If you need further space please include details on a separate sheet.

15. MEDICAL HISTORY - PART 3

ASTHMA - If you have answered 'Yes' to question 2 relating to asthma, please answer the following.

How many consultations have you had relating to Asthma in the last 24 months?	How many Asthma attacks have you experienced in the last 24 months regardless of whether hospital treatment was required?	Have you ever required emergency care, or been admitted to hospital for an event caused by, related to, or made worse by your Asthma?)Please provide details)	What are the triggers for your Asthma?	Do you have planned or pending treatment or consultations relating to your Asthma?	What medication (name and dosage), are you prescribed for your Asthma?
) /

SUPPLEMENTARY PR	PECNANCY OLIECTIONNAIDE	
	nt or showing signs and symptoms of pregnancy or planning to get pregnant? nant please answer the below questions.	Yes No
Name of the Pregnant Fe	emale:	
Last Menstrual period da	ate:	
Do you have earlier histo	ory of Caesarean Section, Premature Delivery or Premature babies? Or any other	complications related t
maternity, till date? :		
	y treatment or taken any medications for infertility to achieve this pregnancy?	
Do you have any of the b	e latest ultrasound report and specify if there are any abnormal findings or more	e than one foetus seen.
Do you have any or the k	below conditions?	
Do you have any or the s	below conditions? Medical Condition	YES/NO
Any Heart Disease or hypertensic	Medical Condition	YES/NO Yes No
	Medical Condition	
Any Heart Disease or hypertension	Medical Condition	Yes No
Any Heart Disease or hypertension	Medical Condition	Yes No Yes No
Any Heart Disease or hypertension Autoimmune Diseases Diabetes/gestational diabetes	Medical Condition	Yes No Yes No Yes No
Any Heart Disease or hypertension Autoimmune Diseases Diabetes/gestational diabetes Thyroid Diseases	Medical Condition on	Yes No Yes No Yes No Yes No

16. DATA PROTECTION FAIR PROCESSING NOTICE

In your dealings with us you may provide information that includes data that is known as personal data.

The personal data we collect will include data relating to your name, address, email address, IP address, date of birth, nationality, country of residence, occupation, credit card details and medical information.

We will process your personal data to allow us to administer your health insurance policy and any associated claims and for actuarial analysis.

It will also be used to manage future communications between ourselves in relation to your policy and claims.

We will only use your data for the purpose for which it was collected. We will only grant access to or share your data where we are required or entitled to do so by law under lawful data processing. This is within our firm or other firms associated with us, our authorised partners, your broker if you have appointed one, third party service providers such as insurers, assistance companies and claims administration providers.

If you require further information on how we process your data and our lawful bases for doing so, please contact us.

17. AUTHORISATION FOR RELEASE OF MEDICAL INFORMATION

Expacare Limited requires your authority for release of medical information about you as we may require further information to support your application, or for future claims.

I hereby authorise any organisation or person who has or may have information concerning my health to furnish Expacare or their respective representatives with:

- 1. All records of any treatment or discussion of my health
- 2. All information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment) and employment history
- 3. A medical certificate in the form attached completed by any health provider who Expacare may require.

18. AUTHORISATION AND DECLARATION

I am applying to be covered under the Expacare Choices plan as chosen on this application form together with the dependants listed in this application.

I declare that to the best of my knowledge and belief, the information given on this form and any additional information supplied is true and complete and that the information completed is full and accurate. I understand and accept that in the event of this application form being fraudulent in whole as or in part, the policy may be invalidated and I will be liable for prosecution.

I understand that if I provide inaccurate or incomplete information, or do not provide the information asked for in this application and make a claim, which Expacare view as being treatment for a pre-existing medical or related medical condition (including pregnancy), my claim may be rejected.

If you are in any doubt as to whether information is relevant or not, or do not know the answer, or how to answer, any specific question, then please contact us for guidance.

I understand that Expacare will advise me of any medical conditions which they will exclude from cover based on the information I have provided to them.

I will tell Expacare about any change in the information given in this application which occurs between the date of signing and the date that cover starts.

I understand that the answers provided are necessary in order for Expacare to process my application and I understand that Expacare will process my personal data, including medical data in relation to my insurance policy.

I authorise and herewith agree that Expacare Limited may forward data obtained from the form to the Insurer or its authorised Claims Administrator or any Reinsurer for the purpose of assessing the risk and handling the reinsurance.

I authorise any doctor, physician or practitioner who has examined or observed me or any of the applicants for diagnosis, treatment, disease or ailment, to give to the Insurance Company full particulars of these, including any prior medical history and medical records.

By signing this application form, I authorise Expacare to deal with my broker, if one is appointed. I also agree that they have authority to see medical information that I have disclosed in this application and in addition any subsequent medical information that Expacare obtain in the course of dealing with my application and policy.

Signature of main applicant/policyholder:	DATE: (DD/MM/YY)
Signature of Spouse/Partner:	DATE: (DD/MM/YY)
Signature of Child Dependant 1:	DATE: (DD/MM/YY)
Signature of Child Dependant 2:	DATE: (DD/MM/YY)
Signature of Child Dependant 3:	DATE: (DD/MM/YY)
Signature of Child Dependant 4:	DATE: (DD/MM/YY)

Parents/guardians may sign the form on behalf of any dependants aged 0-17