



DUBAI CHOICES APPLICATION FORM

For Groups (including Corporate Advantage Plan)

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. COMPANY DETAILS

Legal Company name: *Proof of Company registration is required.*

Trading address:

Registered address (if different from trading address):

Type of business/nature of business:

Company website address:

Company contact:

Job title:

Tel: Email:

2. BROKER DETAILS

Broker name:

Broker code:

3. PREFERRED START DATE: DD / MM / YY

4. AREA OF COVER

Area 2 – Worldwide excluding USA, Bermuda and all islands of the Caribbean

Area 3 – Worldwide (not available for US Nationals residing in the US)

5. NETWORK

Silver Classic Silver Premium Gold

6. CHOICES CORE PLAN AND CANCER TREATMENT AND CHRONIC CARE

	COMPULSORY
Choices Core Plan and Cancer Treatment and Chronic Care	<input checked="" type="checkbox"/> SELECT

7. CHOICES OPTION 1 - DUBAI MODULE

Please SELECT ONE of the Dubai modules.

	SELECT ONE ONLY
Dubai Module Basic	<input type="checkbox"/> SELECT
Dubai Module - Maternity 1	<input type="checkbox"/> SELECT
Dubai Module - Maternity 2	<input type="checkbox"/> SELECT

The Dubai module Maternity 1 and Maternity 2 are only available on Corporate Advantage Plans after the first renewal date.

8. CHOICES OPTION 2 - OUT-PATIENT TREATMENT

Please SELECT ONE of the levels of out-patient treatment below.

	SELECT ONE ONLY
Extended out-patient	<input type="checkbox"/> SELECT
Advanced out-patient	<input type="checkbox"/> SELECT

9. CHOICES OPTION 3 - ADDITIONAL BENEFITS

Please SELECT from the additional benefits listed below.

Dental, Wellness and Optical Treatment

	SELECT ONE ONLY
No cover required	<input type="checkbox"/> SELECT
Dental treatment and wellness benefit	<input type="checkbox"/> SELECT
Dental treatment, wellness benefit and optical	<input type="checkbox"/> SELECT

10. 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

11. UNDERWRITING METHOD

Medical History Disregarded (MHD) Simplified Medical Underwriting (for ALL Corporate Advantage Plans)

12. DETAILS OF PREVIOUS INSURANCE

No previous medical insurance (Go straight to next section).

Name(s) of previous insurer: _____ Previous renewal date: DD / MM / YY

Have there been any claims over USD 50,000 for any one condition: Yes No

If Yes have details been provided to Expacare Yes No

Past 3 years claims information (if available) must be submitted.

13. PAYMENT DETAILS

Payment must be received from the Company.

Payment Currency is USD (please note this determines the currency of the policy).

Payment method: _____ Bank transfer

Payment Frequency: Annual Six-monthly* Quarterly*

* An administration fee of 2% on six-monthly and 4% on quarterly options will be charged.

14. ELIGIBILITY

a) Compulsory Membership for all employees within a defined eligibility criteria (see Section b)

Or Voluntary Membership

b) Defined eligibility All expatriate employees Management only

Other (please state): _____

c) Please select whether the Policy should include cover for: Employees or Employees and Dependants

- Any future people added to the scheme must be an eligible employee or a spouse/dependant of an eligible employee.
- Persons on cover: Please ensure that we have been provided with full details (First name, Last name, Gender, Nationality, Country of Residence, Date of Birth DD / MM / YY, Area of Cover) of all members to be covered on the scheme.
- Over Age Dependants: We require confirmation in writing from their place of study that any child aged 19 and over is in full time education. Children will be removed from cover on the renewal date following their 25th birthday.

Members covered by the scheme within your defined eligibility are employed by the company. All expatriate employees are included in this application and all future expatriate employees within this criteria will be included on a compulsory basis.

Discuss with your Expacare contact

15. DUTY OF FAIR PRESENTATION

We wish to remind clients of their duty of fair presentation. The duty on insureds and potential insureds is one of fair presentation of the risk, which requires:

- disclosure of every material circumstance which the insured knows or ought to know, or
- failing that, disclosure which gives the Insurer sufficient information to put a prudent insurer on notice that it needs to make further enquiries for the purposes of revealing those material circumstances, in a manner which would be reasonably clear and accessible to a prudent insurer. A material circumstance is one which would influence the judgment of a prudent insurer in determining whether to take the risk and, if so, on what terms.

You must satisfy yourself as to the accuracy and completeness of the information you provide to insurers. This will still apply where any amendment is made to the insurance.

If you breach your duty of fair presentation, Insurers are generally limited to "proportionate remedies", linked to what they would have done if the risk had been fairly presented. This may result in the imposition of different terms, or the proportionate reduction of claims where a higher premium would have been charged. In circumstances where Insurers would not have entered into the contract on any terms it can avoid the contract and refuse all claims, but must return the premium. If the breach is deliberate or reckless Insurers can avoid the policy, refuse all claims and keep the premium.

Please refer to our Membership Guide, in particular the Section headed 'Duty of Fair Presentation', for more information.

Are you aware of any person to be covered having any on-going serious condition, including but not limited to any type of cancer, heart condition or stroke?

Yes No

Are you aware of any person to be covered having any medical condition likely to result in, or already requiring planned/pending in-patient treatment?

Yes No

Is any person to be covered currently pregnant?

Yes No

If Yes, please provide full details:

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.

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. DECLARATION

I declare that I am authorised by the Company to enter into this Contract of Insurance with Expacare Limited. I understand that I am signing this form on behalf of a number of persons to be covered and I will make them aware of the declaration that I have signed and will inform them of how their data and medical information will be used in relation to this insurance contract. I confirm that all main members covered by the scheme are employed by the company and that it is our responsibility to inform members when cover is cancelled. I confirm that we will check and inform Expacare of any amendments that need to be made to the membership. I declare that the Company has made a fair presentation of the risk, by disclosing all material matters to Expacare which we know or ought to know or, failing that, by giving the Insurer (via Expacare) sufficient information to put a prudent Insurer on notice that it needs to make further enquiries in order to reveal material circumstances.

By signing this application form, I authorise Expacare to deal with our broker, if one is appointed.

Signed:

Position:

Dated: DD / MM / YY