MEDIGLOBAL HEALTH INSURANCE
Application for Individual Insurance

This plan is underwritten by Al Wathba National Insurance Company (AWNIC). It is distributed, managed and administered, as agent for and on behalf of the Company, by International Medical Group®, Inc. ("IMG®").

شركة الوثبة الوطنية للتأمين
AL WATHBA NATIONAL INSURANCE CO

PLEASE SELECT ONE PLAN OPTION AND DEDUCTIBLE. THIS MUST BE THE SAME FOR ALL FAMILY MEMBERS.	
Check one plan option: ☐ MediSelect ☐ MediElite	**Check one deductible:** ☐ Nil ☐ Dhs 25 ☐ Dhs 50

OPTIONAL BENEFITS - Dental and vision benefits are optional. Please check the appropriate box should you opt for this cover.

Dental - Check one option:		Vision - Check one option:	
☐ **Basic**	☐ **Comprehensive**	☐ **Basic**	☐ **Comprehensive**
☐ Dhs 1500 Annual Limit	☐ Dhs 3500 Annual Limit	☐ Dhs 1000 Annual Limit	☐ Dhs 1000 Annual Limit
☐ Dhs 3000 Annual Limit	☐ Dhs 5000 Annual Limit	☐ Dhs 2000 Annual Limit	☐ Dhs 2000 Annual Limit
☐ Dhs 5000 Annual Limit	☐ Dhs 7500 Annual Limit		

Optional Maternity - for non-residents of Abu Dhabi only: ☐ Yes ☐ No *Available to married females ages 16-45*

SECTION 1. PLEASE COMPLETE FOR ALL FAMILY MEMBERS APPLYING FOR COVERAGE

Name Please print your name below	**Height**	**Weight**	**Date of Birth** mo./day/yr.	**Country of Citizenship**	**Personal Identification Number (Passport, Social Security or Driver's License)**
A. Applicant (Last, First, Middle) ☐ Male ☐ Female					
B. Spouse (Last, First, Middle) ☐ Male ☐ Female					
C. Dependent (Last, First, Middle) ☐ Male ☐ Female					
D. Dependent (Last, First, Middle) ☐ Male ☐ Female					
E. Dependent (Last, First, Middle) ☐ Male ☐ Female					
F. Dependent (Last, First, Middle) ☐ Male ☐ Female					
G. Dependent (Last, First, Middle) ☐ Male ☐ Female					

ADDRESS	
Street Address:	City:
E-mail Address:	State, Country, Postal Code:
Telephone - Work:	Telephone - Home:
Telephone - Mobile:	Fax:

SECTION 2. PLEASE ANSWER ALL QUESTIONS FOR THE APPLICANT AND FOR EACH FAMILY MEMBER APPLYING FOR COVERAGE

Please answer the following questions for the Applicant and every Family Member included on this application. For any questions answered "Yes," please identify the Family Member to whom the answer applies (use the letter that corresponds to the family member from Section 1 in the area provided). Provide complete details of all "Yes" answers in Section 3 of this application.

1. Are you or any other applicant currently disabled, pregnant, or unable to perform normal activities?	☐ YES ☐ NO	
2. Are you or any other applicant presently hospitalized, or scheduled for or in need of hospitalization or surgery?	☐ YES ☐ NO	
3. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder?	☐ YES ☐ NO	
4. Have you or any other applicant ever had, been recommended to have, or are you currently on a waiting list for any organ transplant (other than corneal)?	☐ YES ☐ NO	

5. Do you participate in professional sports?	☐ YES ☐ NO	
6. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past five (5) years? If yes, please explain in Section 3.	☐ YES ☐ NO	
7. During the last twelve (12) months, have you or any family member applying for cover age experienced manifestation or symptoms of, been diagnosed with, or received any consultation, examination, testing or treatment (including medications) for, any medical, health, mental, physical or nervous condition? If yes, please explain in Section 3.	☐ YES ☐ NO	
8. Have you or any family member applying for coverage ever been rejected, cancelled, rated or declined for coverage under any health, life or disability insurance policy? If yes, please explain in Section 3.	☐ YES ☐ NO	
Have you or any family member applying for coverage ever experienced manifestation or symptoms of, suffered from, sought consultation, examination, testing or been treated for, or been diagnosed with, any disease, condition, illness, medical problem, disorder, sickness or other problem arising from, involving, or relating to any of the following:		
9. Heart, cardiac, cardiovascular and/or circulatory, including, but not limited to: congestive heart failure, heart attack, angina, chest pain, arteriosclerosis, atherosclerosis, elevated blood pressure, hypertension, swelling of feet/ankles, thrombosis, phlebitis, rheumatic fever, or heart murmur? If yes, in addition to Section 3, please complete the following: a. Date of most recent blood pressure reading?_____ b. Most recent blood pressure reading: _____AS/_____DS c. Medications taken (Types and Dosage)_____	☐ YES ☐ NO	
10. Blood, blood vessels, spleen, arteries, veins or disorders of the blood, including, but not limited to: anemia, hemophilia, leukemia, hepatitis, lymph glands, or high cholesterol?	☐ YES ☐ NO	
11. Diabetes, hyperglycemia or hypoglycemia? If yes to diabetes, in addition to Section 3, please complete the following: a) Diabetic Type: I___ or II ___ b) Date diagnosed:_____ c) Controlled by diet only? Yes____ No____ d) Medications (Types and Dosage) _____ e) Date of most recent HbA1c Test?_____ f) Results of HbA1c Test (1 - 10)_____	☐ YES ☐ NO	
12. Asthma or allergies? If yes, in addition to Section 3, please specify which one and complete the following: a) Date diagnosed:_____ b) Has hospitalization or emergency room treatment been required? If yes, describe and list date(s):_____ c) Please list known triggers:_____ d) Medications (Types and Dosage):_____ e) Frequency of attacks:_____	☐ YES ☐ NO	
13. Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump, calcification, or growth of any kind?	☐ YES ☐ NO	
14. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid or metabolic disorders, or obesity?	☐ YES ☐ NO	
15. Kidney, urinary tract functions, kidney or bladder stones or infections?	☐ YES ☐ NO	
16. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy pneumonia?	☐ YES ☐ NO	
17. Mental and nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, chemical or drug abuse or dependency, alcoholism, psychiatric counseling and/or support groups, depression, anxiety, chronic fatigue, or eating or sleeping disorders?	☐ YES ☐ NO	
18. Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebral ischemic attacks?	☐ YES ☐ NO	
19. Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease or disorder, vertebrae, degeneration, or any other back or neck condition, rheumatism, arthritis, gout, tendonitis, osteoporosis or inflammation?	☐ YES ☐ NO	
20. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice, diagnosis or treatment?	☐ YES ☐ NO	
21. Congenital, genetic, hereditary or other birth condition or defect including, but not limited to: mental retardation, Down Syndrome, or other chromosome disorder, physical disorder, deformity or defect?	☐ YES ☐ NO	
22. Digestive system, stomach, or intestines, including, but not limited to: esophageal regurgitation, gastritis, ulcers, colon, or rectum disorders?	☐ YES ☐ NO	
23. Reproductive systems, including but not limited to: prostate or elevated PSA level, vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus?	☐ YES ☐ NO	
24. Eyes, ears, nose, mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation, chronic sinusitis, or TMJ?	☐ YES ☐ NO	
25. Any other disease, medical problem, illness, injury or condition of any kind not listed?	☐ YES ☐ NO	

26. Do you or any family member applying for coverage currently use or during the past five years have you used tobacco in any form?	☐ YES ☐ NO	
27. Have you or any family member applying for coverage ever applied for or purchased insurance through IMG? (If yes, please provide certificate number, if any, and details.)	☐ YES ☐ NO	
28. During the last twelve (12) months, have you or any family member applying for coverage been covered under any health or medical insurance plan? If yes, please state the name and location of the insurance company, the policy/plan number, and the applicable dates of coverage.	☐ YES ☐ NO	

FAMILY PRACTITIONER'S DETAILS - THE FOLLOWING INFORMATION MUST BE COMPLETED

Doctor's Name:	**Telephone:**
Address:	
Country:	**Postal/Zip Code:**
Date Last Seen:	**Reason:**

SECTION 3. MEDICAL INFORMATION/PRIOR INSURANCE

For any question answered "YES" in Section 2, please identify each Family Member for whom the answer applies (using the corresponding letter(s) from Section 1), and provide complete details of the medical condition at issue, including the name, address and telephone number of the attending physician(s), hospital(s), clinic(s) and all other health care providers involved, diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. Please attach additional pages as necessary. IMG and the Company reserve the right to request additional medical information prior to acceptance of Application.

Family Member (use letters from Section 1)	Condition(s)/Diagnosis, Prognosis, Past and Present Course of Treatment(s)	Physician/Hospital/Clinic/Health Care Provider Name(s), Address & Telephone	Date(s) of Treatment

If any Family Member applying for coverage has ever been rejected, cancelled, rated or declined for coverage under any health, life or disability insurance policy (see Question 8), please explain below.

SUBSCRIPTION I (we) understand and hereby agree that:
(i) I (we) choose to enroll for insurance under the Individual International Healthcare Insurance as offered by the Company on the date of its receipt hereof. (ii) this Insurance will be provided in accordance with the Policy Wording; and I (we) will read it upon receipt and be bound by it. (iii) This application will be the basis for and form a part of any insurance issued and IMG and the Company can and will rely upon the accuracy and completeness of the information provided herein. (iv) I (we) understand and agree that no coverage will be effective until this Application has been duly accepted in writing by the Company, (v) no modification or waiver relating to this Application or the coverage applied for will be binding upon the Company or IMG unless approved in writing by an officer of the Company or IMG, (vi) any misrepresentation or omission contained herein will void the insurance certificate, and any and all claims and benefits thereunder will be forfeited and waived, (vii) My (our) responses to the statements and questions contained in this Application are true, accurate complete and correctly recorded in all respects, and I (we) will supplement such responses prior to the requested effective date in the vent of any change or addition thereto. (viii) I (we) understand and agree that: (a) marketing brochures and certificate wordings are available prior to application upon request, (b) the insurance agent, broker, website, or other producer, if any, involved with respect to the solicitation of this application is acting solely as my legal agent and representative and is representing my personal interests, and that such person has no authority to bind or speak for, and is not acting as the legal agent or representative of, the Company or IMG, (ix) The subjects, risks, and benefits of insurance for which I (we) enroll for insurance under the Plan are not intended or considered by me (us) to be resident, located or performed in particular country. The law specified in this insurance shall be the law of the United Arab Emirates. The Company as carrier and underwriter of the Plan is solely liable for the insurance coverage and benefits to be provided thereunder, and IMG acts solely as agent for the Company and IMG has no direct or independent liability under the any Certificate of Insurance. (x) The Insurer and IMG, their employees, representatives, agents and any other persons or organizations performing services for them or on their behalf may use, disclose or transfer to any organization any information, including personal information, about me (us) obtained or collected in connection with this Application, (whether contained in this Application or otherwise) for the purpose of: (1) assessing this Application and providing on-going insurance and customer service; (2) processing and giving effect to credit/debit card payments; (3) providing marketing material in respect of insurance related services of IMG or is associated companies; and (4) processing claims or analyzing insurance.

CERTIFICATION (iii) I am (we are) currently in good health and, except for the conditions and other information disclosed herein, I (we) have not been diagnosed with, sought consultation or been treated for, and have not experienced manifestation or symptoms of and do not suffer from any pre-existing condition which I (we) foresee may require treatment in the future or for which I (we) intend to claim under this insurance, and if this Application is signed as guardian or proxy of the applicant, the signer warrants their authority and capacity to so act and bind the applicant. By acceptance of coverage and/or submission of any claim for benefits, the applicant ratifies the authority of the signer to so act and bind the applicant.

MEDICAL RELEASE I (we) authorize any doctor, practitioner of the healing arts, hospital, clinic, health care related facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, employee or benefit plan administrator having information as to my (our) care, advice, treatment, diagnosis or prognosis of any physical or mental condition, and/or employment status, to provide such information to IMG and/or the Company and my producer/broker involved in procurement of this application and/or insurance coverage.

_____

Signature of Applicant, Guardian, or Proxy **Date (mo./day/yr.)**

_____

Signature of Spouse **Date (mo./day/yr.)**