Application Form

Full Medical Underwriting

MyHEALTH Individual Medical Plans

Download our Easy Claim mobile app for quicker claims reimbursement!

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april-international.com

Please print only if necessary

سلامة
SALAMA
الشركة الإسلامية العربية للتأمين (ش.م.ع.)
ISLAMIC ARAB INSURANCE CO.(P.S.C.)

PLANS DESIGNED BY
april International
INSURANCE MADE EASY

YOUR APPLICATION, STEP BY STEP.

This is your application form. Complete it, sign it, send it.

An underwriting offer will be provided in **2 working days or less**.

ONCE OUR OFFER HAS BEEN ACCEPTED, IN 5 WORKING DAYS, YOU WILL RECEIVE:

- Your full member's pack (by email)
  This includes relevant documentation such as claim forms, instructions, terms and conditions, and benefit schedules.
- You will be able to download your member card containing emergency contact numbers for requesting assistance services or before admission to hospital on our Easy Claim app.

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

APPLICANT'S DETAILS

Family Name : _____

First Name(s) : _____

Date of Birth : DD / MM / YYYY _____ Gender : Male ◯ Female ◯

Height (cm) : _____ Weight (kg) : _____ Smoker : Yes ◯ No ◯

Occupation : (Specify nature of duties) _____

_____

Passport Number : _____

Nationality : _____ UID Number : _____

Marital Status : _____ 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

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

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 Applicant				
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 Applicant's Residential Address.

2. YOUR COVER

STEP 1 — SELECT YOUR COVER

The following modules form the base of your policy. Each member has the flexibility to select the cover they want.

If dependants will have the same cover as the Applicant, please tick here ○ and complete cover options for the Applicant only.

MODULES	APPLICANT	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
	• If you select Hospital & Surgery Core, your Outpatient module will be also Core by default.				
Network Selection	○ Green ○ Classic ○ Premium	○ Green ○ Classic ○ Premium	○ Green ○ Classic ○ Premium	○ Green ○ Classic ○ Premium	○ Green ○ Classic ○ Premium
	• Should you visit a medical facility which 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.				
Area of Cover	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide
	• The area of cover chosen will apply to all modules selected. • 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. • The "Worldwide" area of cover is not available if you selected "Core". • Please refer to clause 4 of the Policy Terms and Conditions.				
Outpatient	○ Core	○ Core	○ Core	○ Core	○ Core
	Essential with ○ nil coinsurance ○ 15% coinsurance	Essential with ○ nil coinsurance ○ 15% coinsurance	Essential with ○ nil coinsurance ○ 15% coinsurance	Essential with ○ nil coinsurance ○ 15% coinsurance	Essential with ○ nil coinsurance ○ 15% coinsurance
	Extensive with ○ nil coinsurance ○ 15% coinsurance	Extensive with ○ nil coinsurance ○ 15% coinsurance	Extensive with ○ nil coinsurance ○ 15% coinsurance	Extensive with ○ nil coinsurance ○ 15% coinsurance	Extensive with ○ nil coinsurance ○ 15% coinsurance
	Elite with ○ nil coinsurance ○ 15% coinsurance	Elite with ○ nil coinsurance ○ 15% coinsurance	Elite with ○ nil coinsurance ○ 15% coinsurance	Elite with ○ nil coinsurance ○ 15% coinsurance	Elite with ○ nil coinsurance ○ 15% coinsurance
	• **Important:** 15% co-insurance with a maximum of USD20 per visit is only available when the Premium network is selected.				

STEP 2 — SELECT ANY OPTIONAL MODULES THAT YOU WISH

The following modules are optional. Each member has the flexibility to select the cover they want.

If dependants will have the same cover as the Applicant, please tick here ○ and complete cover options for the Applicant only.

MODULES	APPLICANT	FAMILY MEMBER 1	FAMILY MEMBER 2	FAMILY MEMBER 3	FAMILY MEMBER 4
Dental and/or Optical Optical included with Elite plan only	○ Core ○ Essential ○ Extensive ○ Elite	○ Core ○ Essential ○ Extensive ○ Elite	○ Core ○ Essential ○ Extensive ○ Elite	○ Core ○ Essential ○ Extensive ○ Elite	○ Core ○ Essential ○ Extensive ○ Elite
	• If you select Hospital & Surgery and Outpatient Core, your optional Dental module will be Core by default.				
Maternity Boost	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite
	• **Important:** The maternity boost is available to women between 19 to 45 years. It is not available if you have selected Core Hospital & Surgery and Outpatient.				

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		Fax	
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. PAYMENT METHODS

PREMIUM PAYMENT METHOD

	CREDIT CARD (Visa / Mastercard / Amex)	CHEQUE OR BANK DRAFT	BANK TRANSFER
Annual Payment	○	○	○
Semi-Annually (No Surcharge)	○	Not Available	Not Available
Quarterly (No Surcharge)	○	Not Available	Not Available

Important Notice for Semi-Annual & Quarterly Payments: This is an annual policy. You are responsible for the entire annual premium even if you choose to pay by instalments. The premium payment frequency cannot be changed during the policy year, only at renewal provided you notify us in writing.

CREDIT CARD PAYMENT

If you choose to pay your premiums by credit card, you will receive a payment link by email sent to the address you provided on this form.

CHEQUE OR BANK DRAFT

- Cheques should be drawn on a UAE clearing bank and made payable to “SALAMA Islamic Arab Insurance Co. (P.S.C.)”.
- Please indicate the policyholder’s name, policy number and debit note number on the back of the cheque.
- Please send payment to:

  SALAMA Islamic Arab Insurance Co. (P.S.C.)
  4th Floor, Spectrum Building, Oud Metha,Sheikh Rashid Road, Dubai.U.A.E.
  Tel: 800-SALAMA (800-725262)
  Email : ops.uae@salama-april.com

BANK TRANSFER

- Please send full payment (inclusive of all bank charges) to:

  United Arab Emirates Dirham (AED) Account

  Beneficiary Bank

Account Title :	ISLAMIC ABAB INSURANCE CO. - SALAMA
Account no.(AED) :	001-520-6700500-04
Bank :	DUBAI ISLAMIC BANK
Swift Code :	DUIBAEAD
Bank Address :	MAIN BRANCH DUBAI, P.O.BOX 1080, DUBAI, UAE
IBAN :	AE30 0240 0015 2067 0050 004

1. All bank charges will be borne by the remitter.
2. Please indicate your Policy Number and Debit Note number as a payment detail to your banker.
3. Please email ops.uae@salama-april.com the bank remittance advice or instruction slip with your Policy Number, name and debit note number to us for our accounting records and to issue an Official Receipt.

No cash or partial cash payments are allowed.

5. 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 Salama for the purposes required by the contract of insurance I have entered into. PLEASE TICK ☑

SIGNATURE

Name : _____

Title : _____

DECLARATION BY APPLICANT

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 SALAMA Islamic Arab Insurance Co. (P.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 SALAMA Islamic Arab Insurance Co. (P.S.C.). I understand that no insurance shall be in force until and unless the application has been accepted and the appropriate premium paid.

Date : _____

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

Underwritten by:

SALAMA Islamic Arab Insurance Co. (P.S.C.)
4th Floor, Spectrum Building, Oud Metha, Sheikh Rashid Road, Dubai.U.A.E.
Tel: 800-SALAMA (800-725262)
Email: info@salama.ae

Designed by:

APRIL Hong Kong Limited
9th Floor, Chinachem Hollywood Centre
1-13 Hollywood Road, Central
Hong Kong
Tel: +971 4390 0740
Email: contact.uae@salama-april.com

MH DB 2023/02

سلامة
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الشركة الإسلامية العربية للتأمين (ش.م.ع.)
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SUBMIT

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