Application Form

Full Medical Underwriting

MyHEALTH Qatar Individual Medical Plans

Seib
تأمين وإعادة تأمين
INSURANCE & REINSURANCE

April International

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 Qatar 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 ◯ Smoker: Yes ◯ No ◯

Height (cm): Weight (kg):

Occupation:

(Specify nature of duties)

Marital Status:

Passport Number:

Nationality: Q.I.D. Number:

Residential Address:

Country:

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 ◯
Smoker	Yes ◯	No ◯	Yes ◯	No ◯	Yes ◯	No ◯	Yes ◯	No ◯
Height & Weight	cm	kg	cm	kg	cm	kg	cm	kg
Occupation (Specify nature of duties)								
Marital Status								
Relationship to Applicant								
Passport Number								
Nationality								
Q.I.D. Number								
Email address*								

*Family members aged 18+ may provide their email address to receive access to our digital tools and telehealth services.
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	**Choose your modules** The following modules form the base of your policy. Each member has the flexibility to select the cover they want.				
	Important Note • Hospital & Surgery module is mandatory while the remaining Outpatient, Dental & Optical and Maternity & Newborn Care are optional modules. Each applicant must select their preferred level of cover for the applicable modules.				
MODULES	**APPLICANT**	**FAMILY MEMBER 1**	**FAMILY MEMBER 2**	**FAMILY MEMBER 3**	**FAMILY MEMBER 4**
Hospital & Surgery	◯ Essential ◯ Extensive ◯ Elite	◯ Essential ◯ Extensive ◯ Elite	◯ Essential ◯ Extensive ◯ Elite	◯ Essential ◯ Extensive ◯ Elite	◯ Essential ◯ Extensive ◯ Elite
Annual Deductible	◯ Nil ◯ USD 500 ◯ USD 1,500 ◯ USD 3,000 ◯ USD 5,000 ◯ USD 10,000	◯ Nil ◯ USD 500 ◯ USD 1,500 ◯ USD 3,000 ◯ USD 5,000 ◯ USD 10,000	◯ Nil ◯ USD 500 ◯ USD 1,500 ◯ USD 3,000 ◯ USD 5,000 ◯ USD 10,000	◯ Nil ◯ USD 500 ◯ USD 1,500 ◯ USD 3,000 ◯ USD 5,000 ◯ USD 10,000	◯ Nil ◯ USD 500 ◯ USD 1,500 ◯ USD 3,000 ◯ USD 5,000 ◯ USD 10,000
Outpatient	◯ Essential ◯ Extensive ◯ Elite	◯ Essential ◯ Extensive ◯ Elite	◯ Essential ◯ Extensive ◯ Elite	◯ Essential ◯ Extensive ◯ Elite	◯ Essential ◯ Extensive ◯ Elite
	Co-insurance selection ◯ Nil co-insurance ◯ 20% co-insurance for all Outpatient benefits	Co-insurance selection ◯ Nil co-insurance ◯ 20% co-insurance for all Outpatient benefits	Co-insurance selection ◯ Nil co-insurance ◯ 20% co-insurance for all Outpatient benefits	Co-insurance selection ◯ Nil co-insurance ◯ 20% co-insurance for all Outpatient benefits	Co-insurance selection ◯ Nil co-insurance ◯ 20% co-insurance for all Outpatient benefits
Dental and Optical	◯ Essential ◯ Extensive ◯ Elite	◯ Essential ◯ Extensive ◯ Elite	◯ Essential ◯ Extensive ◯ Elite	◯ Essential ◯ Extensive ◯ Elite	◯ Essential ◯ Extensive ◯ Elite
Maternity and Newborn Care For women aged 19-45	◯ Essential ◯ Extensive ◯ Elite	◯ Essential ◯ Extensive ◯ Elite	◯ Essential ◯ Extensive ◯ Elite	◯ Essential ◯ Extensive ◯ Elite	◯ Essential ◯ Extensive ◯ Elite
	• **Important:** Available to women aged 19 to 45 who have selected an Extensive or Elite Inpatient Plan with a nil deductible, together with an optional Outpatient Plan.				
Step 2	**Personalise your Cover** Select your preferred network and area of cover that will apply to all selected modules.				
Network Selection	◯ Standard ◯ Premium	◯ Standard ◯ Premium	◯ Standard ◯ Premium	◯ Standard ◯ Premium	◯ Standard ◯ Premium
Area of Cover	◯ Worldwide excluding USA ◯ Worldwide	◯ Worldwide excluding USA ◯ Worldwide	◯ Worldwide excluding USA ◯ Worldwide	◯ Worldwide excluding USA ◯ Worldwide	◯ Worldwide excluding USA ◯ Worldwide

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	○ QAR		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 Qatar:			
Sort Code		BIC (Swift) Code	
IBAN			
Corresponding Bank Details (if applicable)			

4. PAYMENT METHODS

All premiums must be settled in QAR using the following conversion USD1=QAR 3.65. Any shortfall will be borne by the client.

PREMIUM PAYMENT METHOD		
	BANK TRANSFER	CREDIT CARD (Visa / Mastercard / Amex)
Annual Payment	○	○

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 in this form.
If you choose to pay your premiums by bank transfer, you will receive Seib IBAN by email sent to the address you provided in this form.

5. NOTICE TO CUSTOMERS RELATING TO THE PERSONAL DATA

In pursuant to Qatar Financial Centre Data Protection Regulations 2021, I expressly consent to SEIB Insurance & Reinsurance Company LLC. and third-parties including related entities, employees, agents, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data including sensitive personal data, as the case may be, relating to myself or other individuals that I have furnished via any means in the past, present & in the future, for one or more of the purposes described in **Seib Privacy Notice**, including but not limited to considering whether to provide insurance, carrying out due diligence, pricing, administering and servicing policies, communications, renewals, reinsurance, collections, claims, accounting, audit, legal, compliance, research, analysis, information-sharing, surveys, data storage & backups. If there is any personal data relating not to myself but to other individuals that I have furnished via any means in the past, present & in the future, I warrant that I have obtained prior consent from these data subjects (or if they are lacking in legal capacity, from their legal representatives, guardians or parents as the case may be) for Seib and its Appointees to collect, use and disclose their personal data for the abovementioned purposes and on the same terms herewith. I warrant that all personal data I have provided are accurate and complete, and I shall inform Seib of any changes to the personal data to my knowledge as soon as practicable.

☐	Please tick this box if you do not wish to receive any marketing communications from APRIL.
☐	Please tick this box if you do not wish to receive any marketing communications from SEIB Insurance & Reinsurance Company LLC. or companies with whom it maintains marketing arrangements.

CUSTOMER DECLARATIONS	
1.	I/We hereby confirm that all information, statements, records, employee/member data, census details, eligibility information, and supporting documents submitted in connection with this medical insurance application, renewal, endorsement, or continuation of cover are true, accurate, complete, and not misleading in any material respect and consent to disclose personal data to APRIL and Seib.
2.	I/We acknowledge that I/we have made my own independent decision in applying for the product selected with the premium information and key product features informed by APRIL or my intermediary. I/we confirm that the relevant insurance product features are suitable for my/our current medical protection needs and the premiums are affordable.
3.	I/We (and my dependents where applicable) have read, understand, and accept Seib Privacy Notice and APRIL Privacy Notice, and if my dependents are minors, I am providing such consent as parent or legal guardian of such minors.
4.	I/We (and my dependents where applicable) consent and authorize the Insurer to seek medical information from any medical practitioner, hospital, clinic, health related facility, pharmacy, insurance agency, insurance company or administrator having advice or documents pertaining to the care, advice, treatment, diagnosis or prognosis of any medical condition.
5.	I/We (and my dependants where applicable) have read, understand, and agree to the Brochure, Policy Terms and Conditions, and Benefit Schedule.
6.	I/We (and my dependents where applicable) agree to receive the policy documents and communications via the email provided above.

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. I will notify APRIL 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 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 SEIB Insurance & Reinsurance Company LLC. In the event that the provided information is not true or complete, I understand and further agree that the premium could be changed; the insurance contract could be declared void; or the insurance company is entitled to deny its responsibility for any material misrepresentation of non-disclosure. I understand that no insurance shall be in force until and unless the application has been accepted and the appropriate premium paid.

APPLICANT 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-QT 2026/02

Underwritten by:

Seib Insurance and Reinsurance Company LLC

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