الوطنية للتأمين على الحياة والعام
NATIONAL LIFE & GENERAL INSURANCE
Ominvest Group
مجموعة أومينفست

Individual Health Insurance

Medical Application cum KYC Form (MAF)

Please note that:

- The application should accompany the following documents:
  a) Copy of passport with valid visa page
  b) Copy of both sides of Emirates ID
  c) Certificate of Continuity (COC)
- Any alteration/ overwriting in the application must be signed by the applicant.
- This Medical Assessment form is valid for 1 month (30 days) from the date of completion and the form being signed by the applicant

Section (1) Personal Details

Name of Main Applicant (exactly as appearing in the passport - IN CAPITAL LETTER):

Mr.		Ms.		Mrs.	

First Name Middle Name Last Name

All Family Members (Main Applicant as the first name)

Name	Relation E/S/C	D.O.B DD/MM/YYYY	Nationality	Sex M / F	Height CM	Weight KG	Blood Type

Source of Income (Occupation or Profession):	
Mobile No:	
Landline No:	
Address: (Building, Street, PO Box, City, Emirate)	
E-mail ID:	
VAT Number (Optional)	

الوطنية للتأمين على الحياة والعام
NATIONAL LIFE & GENERAL INSURANCE
Ominvest Group مجموعة اومينفست

Section (2) Products

NLG Eazy Health- Basic Plus	Annual Limit – AED 150,000 PA, Pharmacy Limit – AED 2,500 PA	☐
NLG Eazy Health- Chrome	Annual Limit – AED 150,000 PA, Pharmacy Limit – AED 5,500 PA	☐
NLG Eazy Health- Bronze	Annual Limit – AED 150,000 PA, Pharmacy Limit – AED 5,500 PA	☐
NLG Eazy Health- Silver	Annual Limit – AED 150,000 PA, Pharmacy Limit – AED 7,500 PA	☐
NLG Eazy Health- Gold	Annual Limit – AED 250,000 PA, Pharmacy Limit – AED 10,000 PA	☐

Section (3) Health Questionnaire

- Has your health insurance request been ever declined or accepted on substandard terms?
  Yes☐ / NO☐
  if yes, then please provide details.
- Is there any eligible family member not included in this insurance request?
  Yes☐ / NO☐
  if yes, then please provide details.
- Have you insured with NLGIC earlier or on an ongoing policy? If yes please provide policy/card number:
  Yes☐ / NO☐
  if yes, then please provide details.
- If proposed insured member is currently pregnant, **kindly fill the additional pregnancy questionnaire**.

Please answer all questions mentioned below as either Yes or No:

No.	Details	Declaration									
		Applicant		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1.	Are you under any medical observation/undergoing any medical/ surgical/ treatment or have been advised for the same? if yes, then please provide details _______________________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2.	Do you have any chronic illness/ Pre-existing medical condition (s)? A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics: It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests. It needs ongoing or long-term control or relief of symptoms. It may require rehabilitation or the patient to be trained to cope with it. It continues indefinitely. Symptoms / medical condition may recur or likely to recur. if yes, then please provide details _______________________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

3.	Are you taking any medication (pharmaceutical/alternative medicine) or have been advised? if yes, then please provide details ________________________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4.	Do you have any physical problems/ disability for which you are undergoing physiotherapy or have been advised for? if yes, then please provide details ________________________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.	Have you been admitted in the hospital in the last 10 years? if yes, then please provide details ________________________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.	a) Are you currently pregnant? (This question apply only to married females) If yes, have there been any complications to date?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	b) Are you currently trying to get pregnant?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	c) Are you undergoing any form of fertility treatment?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	d) Last Menstrual period date? (If above "b" or "c" is yes)										
7.	Do you have any previous surgical history or are you advised to undergo any kind of surgeries in the near future? if yes, then please provide details ________________________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8.	Have you undertaken any lab/blood tests, imaging tests viz. scan/MRI in the last 5 years other than routine health check-up or pre-employment check-up? if yes, then please provide details ________________________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9.	Have you been ever diagnosed/treated and cured or undergoing treatments for cancer? if yes, then please provide details ________________________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10.	Is there any other medical condition or disorder or any symptoms that you should be declared, and you are unable to relate to the above-mentioned Questions? if yes, then please provide details ________________________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11.	Have you, or your family members been in close contact with anyone who has been either quarantined or diagnosed with novel coronavirus (SARS-CoV-2/COVID-19) in the last 14 days? if yes, then please provide details ________________________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12.	Have you, or your family been ever served a notice of quarantine in any form imposed by local health authorities / Government / airport authority or such other authorities for possible exposure to novel coronavirus (SARS- CoV2/COVID-19)? If yes, please provide more details like location, dates, quarantine period ________________________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13.	Have you ever been tested positive for the novel coronavirus (SARS-CoV-2/COVID-19)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	If yes, provide the date of positive diagnosis. And also details of subsequent tests. ______________________________										
14.	Are you awaiting the result of a test which has already been submitted for the novel coronavirus (SARS-CoV-2/COVID-19)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15.	COVID-19 Vaccination details Have you been vaccinated for COVID19?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	If Yes, Date of administration of the first dose & second dose										
16.	Please state current consumption of ▪ Tobacco: _______day/week ▪ Alcohol: ________ day/week If you do not smoke cigarettes now but did so previously, when did stop? ____ Any Additional Information: _______________										
17.	Have you ever been insured with National Life and general insurance company? If yes I. Which Year_______________ II. Card No__________________ III. EID______________________										

Please fill below details if you have answered any question as "YES" from above.

Diagnosis status (Please tick whichever is applicable)

- ❖ Cured / No Symptoms
- ❖ Ongoing Symptoms
- ❖ Ongoing Hospitalization
- ❖ Pending Hospitalization
- ❖ Ongoing treatment
- ❖ Pending treatment

Please give the name of the Medical Practitioner(s) most frequently visited in last 5 years.

____

Please specify the medication generic names, the brand name as well as the daily/weekly quantity:

In case you are suffering from hypertension, please specify your recent Systolic and Diastolic readings below:

- ❖ Systolic Reading
- ❖ Diastolic Reading

In case of diabetes, please specify whether insulin dependent, also specify/attach latest HbA1c result.
(Yes☐ / NO☐)

Section (3) Duty of Disclosure

When you apply with NLGIC, you have a legal duty of disclosure to NLGIC. This means that:

- All the statements you make to NLGIC (both written and oral) including the answers in this application must be true and correct.
- You must disclose everything that you know, or could reasonably be expected to know, that is relevant to NLGIC decision on what basis they accept your application and how much it will cost.
- This duty of disclosure continues from the time you complete this application until the commencement date of this you also have the same duty of disclosure to NLGIC at the time you extend, vary or reinstate your contract.

If you do not comply with your duty of disclosure, and NLGIC would not have accepted your application on the same terms if you had made full disclosure, then NLGIC may:

- Decline any claim you make; and/or
- Retain all payments made and recover any benefits paid; and/or
- Alter the terms of any benefits under the policy; and/or
- Remove any benefits under the policy; and/or
- Void your contract from inception.

I/we declare that I/we have read and understood the above declaration and agree to be bound by these terms and conditions to be signed below by every person to be covered by this contract and all Policy Owners (to be signed by the parent/legal guardian if the applicant is a child under 18 years).

Date: Applicant’s Signature:

Politically Exposed Person (PEP):

A Politically Exposed Person is someone who has been entrusted with a prominent public function in the State or any other foreign country, such as heads of states or governments, senior politicians, high ranking government officials, judicial or military officials, senior executives of corporations owned by the state, senior officials of political parties, persons entrusted or were previously entrusted with prominent jobs in international organizations.

Please provide details of Politically Exposed Person (PEP), if any:

Name of PEP as per Passport/Valid ID	Designation of PEP

FATCA Declaration:

For the purposes of the U.S. Foreign Account Tax Compliance Act (FATCA) and on the instructions of the Central Bank of UAE, all individuals applying for insurance must certify as to whether they are U.S. or non-U.S. persons. Please note that as part of our underwriting procedures, we will review other documentation provided by you or documentation which is publicly available and may seek further information from you on the FATCA classification you have selected below:

Please select one of the following:

1. I am not a U.S. citizen or a U.S. tax resident (Yes/ No)
2. I am a U.S. citizen or a U.S. tax resident and my US taxpayer identification number (TIN) is- ______

I __________________acknowledge and declare that the above-mentioned information is correct and true and complete to the best of my knowledge and belief. I agree to provide supporting evidence and provide updates in case any of the aforementioned information changes. In case National Life & General Insurance Company SAOG ("Insurer") has any reason to believe that the disclosed information is incorrect, the Insurer reserves the right to take suitable action against me.

Declaration

I/We hereby declare with respect to both, myself and my dependents that to the best of my knowledge and belief, the statement on application are full, true and correct and have declared all material facts related to this application.

I/We understand that non-disclosure or misrepresentation of any material fact may invalidate the quoted terms. I/We agree that all the documents issued in connection with the policy shall be read together.

The Coverage of Health Services provided by the Insurer is described in the policy wording. By signing this for, I/We acknowledge that I/We read, understood and agree to the terms and conditions as stated in the policy wording.

I hereby declare and agree, with respect to, myself that I am aware of the general terms of this insurance and I accept them. With the above, I authorize my doctor, health institution or other organization or person that has any information about my health and/or activities to provide the Insurer with the said information. This shall include hospital and any other records pertaining to medical advice, diagnosis, treatment or disturbances. A photocopy of this authorization has the same validity as the original.

I/We agree that after acceptance of the quoted premiums in the quotation, I/We shall be liable to pay all the premiums to the Insurer as per the specified and selected plan of our choice.

I do hereby confirm that the source of income which is being used for the payment of the premium is from legitimate business sources. I do hereby certify that the documents provided along with this form are correct and complete, to the best of my knowledge. We further undertake to update the Insurer whenever there is any change in the information provided above.

I authorize the Insurer to share information pertaining to my proposal including records of proposer or insured for the purpose of underwriting and/or claim settlement and with any government and/or regulatory authority.

Sanction Limitation and Exclusion Clause

No insurer shall be deemed to provide cover and no insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, Japan, United Kingdom or United States of America.

Date: Signature: