



Completing the Proposal Form

- Please answer all questions in full leaving no blank spaces.
If you have insufficient space to complete any of your answers, please attach a separate signed and dated sheet and identify the question number concerned.
It is agreed that the whenever used in this proposal form, the term Applicant shall mean the Principal Applicant and all named family members.
All information provided by the Applicant will be maintained in strictest Confidence by RAK Insurance
You must provide full, accurate and true answers to all questions listed below. Material facts which you know or ought to know should be fully and accurately disclosed. Failure to do so may result in rejecting all your claims and/or terminating the insurance policy from inception.
Signing of this proposal form is not the commencement of insurance coverage. The commencement of insurance coverage will be confirmed upon the written acceptance of this Proposal Form by RAK Insurance and issuance of the Insurance Policy.

PLEASE READ AND ANSWER THE PROPOSAL FORM CAREFULLY.

General Information

Form with fields for Full name, Residence address, Work address, Telephone/Mobile no., E-mail address, Plan Name, and Marital Status. Includes checkboxes for location (Dubai, Northern Emirates, Abu Dhabi).

Member Details (Please provide information for the principal applicant and all family members)

Table with 10 columns: Full Name, Relationship, Nationality, Date of Birth, Sex M/F, Height (cm), Weight (kg), Profession, Blood Group, Residence.

Is there any family member (Spouse and Child) who is not included here? Yes No

If Yes, please specify the reason

Section A - Insurance History

Have you ever been declined or accepted for life and/or health insurance on sub-standard terms? Yes No

If Yes, please specify the reason

Section B - Individual Medical History - Please answer for all members of the family included on this proposal form

Have you ever been diagnosed, treated, or had symptoms related to the following (if Yes, please specify CURRENT MEDICATIONS, diagnostic details, treatment received and recovery status on attached supplemental information sheet)

In case the answer is YES to any of the conditions/diseases below, please specify in full details (preferably by a Medical Physician) or attach the latest medical report

- 1. Musculoskeletal and / or Connective Tissue System?
2. Cancer, Neoplasms, Tumours?
3. Blood and Blood Forming Organ Systems?
4. Digestive System?
5. Endocrine, Nutritional, Metabolic and/or Immunity System?
In case of diabetes please specify whether insulin dependent:



Section B - Individual Medical History (continued)

6. Nervous System or Sense Organs? (Ear injury/infection, vertigo, hearing, eye injury/disease, retina, glaucoma, vision, muscular dystrophy, brain/nerve degeneration, meningitis, paralysis, seizures, epilepsy, neuralgia, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Genitourinary System? (Kidney/bladder infections, renal failure, kidney stones, endometriosis, menstrual cycle, salpingitis, ovarian cysts, prostate, impotence, testicle infections, sperm abnormalities, fertility, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Respiratory System? (Sinusitis, allergies, tonsillitis/laryngitis, bronchitis, emphysema, pneumonia, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Cardiovascular System? (Stroke, cerebral ischemia, rheumatic fever, atherosclerosis, aneurysm, embolism, peripheral vascular disease, hypertension, heart valve disease, irregular heartbeat, pulmonary embolism, phlebitis, varicosities, etc.) In case you are suffering from hypertension please specify your Systolic Diastolic readings below: Systolic: _____ Diastolic: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Skin-Subcutaneous Tissue? (Dermatitis, acne, seborrhoea, pruritus, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Haemorrhoids	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Fissures	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Tonsils	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Adenoids	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Varicose	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Thyroids	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Uterine Fibroids	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Hysterectomy and Ovarian cyst	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Endometriosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Varicoceles	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Hydrocele	<input type="checkbox"/> Yes <input type="checkbox"/> No
23. Gall bladder disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
24. Kidney Stones	<input type="checkbox"/> Yes <input type="checkbox"/> No
25. Stomach ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
26. Knee condition/injuries and/or any related treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
27. Ankle condition/injuries and/or any related treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
28. Back condition/injuries and/or any related treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
29. Neck condition/injuries and/or any related treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
30. Congenital disease or malformations	<input type="checkbox"/> Yes <input type="checkbox"/> No
31. Have you ever undergone surgery to remove a body organ or structure? (Specify body organ/ structure, date & place of surgery)	<input type="checkbox"/> Yes <input type="checkbox"/> No
32. Are you HIV positive or have any medical condition or symptom indicative of HIV infection or AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No
33. Infectious and parasitic diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No
34. Mental / psychiatric disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
35. Pregnancy, complications of pregnancy, child birth and the puerperium including abortions	<input type="checkbox"/> Yes <input type="checkbox"/> No
36. Injury and poisoning	<input type="checkbox"/> Yes <input type="checkbox"/> No
37. Previous medical / surgical hospitalisations, procedures and operations	<input type="checkbox"/> Yes <input type="checkbox"/> No
38. Any (chronic) disease (s), symptoms and complaints not mentioned above	<input type="checkbox"/> Yes <input type="checkbox"/> No
39. Any pre-existing disease(s), symptoms and complaints within the last ten years	<input type="checkbox"/> Yes <input type="checkbox"/> No
40. Psychological and mental disease (bipolar disorder, anxiety disorder, schizophrenia, stroke, cerebral aneurism)	<input type="checkbox"/> Yes <input type="checkbox"/> No



Section C - Family Medical History (Father, Mother, Siblings)

Has any member of your family been diagnosed, received treatment or had symptoms related to any of the following (if Yes, please specify CURRENT MEDICATIONS, diagnostic details, treatment received and recovery status on attached supplemental information sheet)

Table with 2 columns: Question (a-i) and Yes/No checkboxes. Questions include: Inherited disorder or genetic disease?, Haemophilia?, Muscular Dystrophy?, Multiple Sclerosis?, Cancer?, Mental illness or disorders?, Nervous system and / or sense organ disease?, Illness of the cardiovascular system?, Diabetes?

Section D - Lifestyle

Table with 2 columns: Question and Yes/No checkboxes. Questions include: Do you smoke?, Do you practice any kind of routine exercise?, Do you undergo routine medical check-ups?, Do you drink alcohol?, Have you ever taken any drugs?

FALSE INFORMATION

All material facts must be disclosed. Failure to do so may invalidate any insurance policy from inception. A material fact is one which is likely to influence an insurer in the assessment and/or acceptance of the proposal. If you are unsure as to whether a fact is material or not, it should be disclosed to RAK Insurance.

Any person who, knowingly and with intent to defraud any insurance company or other person, files a proposal for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

DECLARATION AND SIGNATURE

I/We hereby declare that the statements/information given by me/us in this Proposal Form are full, accurate and true. It is hereby understood and agreed that the statements, answers and particulars provided in this Proposal Form and as per the attachments are the basis on which the insurance policy is being issued/effectuated. If after the insurance policy is effectuated, it is found that any fact in the statements, answers or particulars in this Proposal Form is incorrect, untrue, inaccurate, misrepresented or non-disclosed in any respect, RAK Insurance shall have no liability under the insurance policy and/or shall have the right to terminate the insurance policy from inception.

The company is hereby authorised to make any investigation and inquiry in connection with this Proposal Form that it deems necessary and I and all applicants contained in this Proposal Form do hereby waive our right of medical confidentiality to the benefit of RAK Insurance and its representative.

Table with 2 columns: Applicant Signature and Date

Additional Information

- Please note that each page of this Proposal Form should be signed by the Applicant or his/her legal representative.
This proposal and any information provided by the applicant does not constitute a contract or effect insurance cover for the applicant and any members identified.
In case of acceptance of the applicant by RAK Insurance, any conditions or exclusions and acceptable premium payment methods will be communicated to the applicant.
Only upon RAK Insurance acceptance of the conditions, exclusions and provision of an acceptable premium payment methods will the cover be instigated and the relevant Insurance Policy and membership cards, if included, be provided.

