Please attach a current passport photograph for each person covered by this application. Please write the individuals name on the reverse of the photo.

Insured by

AXA INSURANCE (Gulf) B.S.C(c)

AXA International Healthcare Series Application form

Re-insured by

AXA HEALTHCARE

For official use only.
Date received

Please complete this form using Block Capitals and by ticking the relevant boxes. It is important that you provide the following information so that we can properly assess your application. If, therefore, you do not answer the questions we shall take that failure to answer to mean that you have nothing to disclose. **This application must be completed by you or your parent/legal guardian in your/their own handwriting. If you need to make a correction, please initial the change.**

Agents signature: ______
Print name: ______
Agency Code: ______

1. Your personal details (please keep us informed of any change of your address)

Title:	Surname:	
Full forenames:		Date of birth: day month year
Address:		
Email		Passport number:
Telephone number:	Fax number:	Mobile number:
Occupation:	Name of company/employer:	
Nationality:	Country where you are residing for most of the year:	

2. Your choice of Plan

☐ Global 1 ☐ Global 2 ☐ Regional 1 ☐ Regional 2 ☐ Local

Cover will commence when we have received your written acceptance of any underwriting terms and you premium.

3. Existing or any previous membership number

If you have ever been a member, or applied for membership of an AXA or AXA healthcare scheme, you must declare it.

I have previously applied ☐ I am a previous member ☐

AXA ☐ AXA healthcare ☐

Number: ☐☐☐☐☐☐☐☐☐☐

Scheme name: Date:

4. Additional family members to be covered

1	Title:	First name and other initials:	Surname:		Nationalilty:
	Relationship to you: (wife/husband, son/daughter)	Date of birth: Day Month Year	Membership number:	Passport number:	Residing in:
2	Title:	First name and other initials:	Surname:		Nationalilty:
	Relationship to you: (wife/husband, son/daughter)	Date of birth: Day Month Year	Membership number:	Passport number:	Residing in:
3	Title:	First name and other initials:	Surname:		Nationalilty:
	Relationship to you: (wife/husband, son/daughter)	Date of birth: Day Month Year	Membership number:	Passport number:	Residing in:
4	Title:	First name and other initials:	Surname:		Nationalilty:
	Relationship to you: (wife/husband, son/daughter)	Date of birth: Day Month Year	Membership number:	Passport number:	Residing in:

5. Method of payment tick one box only

Annually

Dirhams ☐

If paying by credit card please complete and sign the credit card authorisation overleaf.

*Please note, half yearly payment can only be made by cheque. We will require a post-dated cheque for the second half of the half yearly payment option at the same time as your first premium payment.

6. Medical practitioner(s) most frequently used in the last 5 years

Name:	
Address:	
Telephone number	Fax number

Please continue on an additional sheet if required.

For AXA use only

(Underwriting terms pertaining to this application)

Underwriter's stamp

Underwriting terms accepted by applicant

Yes ☐ No ☐

Authorised signature: ______
Print name: ______
Date: ______

AXA Use Only. Membership number

☐☐☐☐☐☐☐☐☐☐

AXA Use Only. Effective date

☐☐☐☐☐☐☐☐☐☐

If the above details are different for any additional persons please list on a separate sheet.

7. Confidential medical history **(Declarations must be made in writing on this application. Verbal declarations WILL NOT be accepted)**

Please Note: (i) NO LIABILITY WILL BE ACCEPTED FOR ANY MEDICAL CONDITION WHICH ORIGINATED BEFORE THE DATE OF ENROLMENT OR WHICH WAS FORESEEABLE AT THE TIME OF APPLICATION unless such medical condition has been declared to and accepted by AXA in writing. (ii) Failure to notify AXA Insurance of a medical condition may result in claims for benefit being refused or cover withdrawn. If you are in any doubt you should disclose the medical condition.

Please ensure that you fully disclose any known or suspected conditions and symptoms experienced by anybody included in this application. This applies even if professional advice has not yet been sought. Typical examples are varicose veins, allergies, backache, foot disorders e.g. bunions, piles, gynaecological problems (including any irregularities of menstruation), complications of pregnancy, digestive irregularities, skin problems, trouble with heart, limbs, eyes, nerves etc any ear, nose or throat problems or any pains, swellings, lumps or fever.

Part A **You must declare your medical history even if you have been insured with us or anyone else before.**

Please consider the following five questions as they apply to each of the people named. Answer each question by clearly ticking one of the corresponding Yes/No boxes.	Applicant		1st Family member		2nd Family member		3rd Family member		4th Family member	
	Name		Name		Name		Name		Name	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has any in-patient stay in a hospital or nursing home taken place within the last five years?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Has any specialist/medical practitioner been consulted within the last five years?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Have you experienced any symptoms but not consulted a medical practitioner in the last five years?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Has any medical practitioner been consulted and/or provided prescriptions for any drugs or medication within the last two years?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Does any chronic/long-term medical or dental condition exist or has there been any other known disability, abnormality or recurrent illness or injury during the last five years?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Is there any known or foreseeable need to consult any doctor or other health professional?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If there is any major condition falling outside the 5 year period mentioned above that we should know about, in good faith you must declare it.

Part B (Please use block capitals throughout).

1. Name of patient:	2. Relevant section of Part A:	3. Nature of illness/disability and treatment received:	4. When did it start:		5. How long did it last:	6. Need for any further treatment or consultation:	7. Present state of health in this respect:
			Month	Year	Duration		

Please continue on a separate sheet if necessary. This part applies if you have indicated Yes replies in Part A. Please disclose all medical conditions (or undiagnosed symptoms) to which these replies are intended to apply. Use column 3 to list them separately and give the further detailed information required by columns 4 to 6.

8. Your signature and declaration

Declaration: I declare that to the best of my knowledge and belief the statements on both sides of this application form are full, true and correct, that I shall read the AXA Insurance Healthcare Series Membership Agreement when received and that I agree to be bound by it. In the event of any dispute, I agree to follow the AXA insurance (Gulf) B.S.C(c) arbitration process in the first instance. I agree that the acceptance of my application shall be on the basis of these statements. I agree that AXA may contact my/our medical practitioner(s) for further details of my/our medical history and authorise such practitioner(s) to release any information AXA may require.

Signature: ✗ ______________________ Print name: ✗ ______________________ Date: ✗ ______________________

Please note: You are advised to keep a record of all information supplied in connection with this application, including any letters you send to us in connection with it. If you would like a copy of this application please let us know within three months. After completing this application form and signing the Declaration, please return to your nearest AXA office or broker office if you are using one.

Credit Card Authorisation Form

To AXA Insurance Dept. I authorise you, to charge my Credit Card Account an appropriate amount in respect of premiums for my subscription.

AXA Membership Number
(to be completed by AXA)

Please complete in Block Capitals
Name (as it appears on your credit card)

Please tick as appropriate: MasterCard ☐ Visa ☐

My credit card number is: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expiry date: ☐☐ ☐☐

Signature ✗.................... Date ✗....................

Please charge the above card