APPLICATION TO **Al-Buhaira National Insurance Co.** SHARJAH - U.A.E. NO. 0072

PART I

Use Black or Dark Ink **IMPORTANT NOTICE: This application is subject to approval by the Company's Home Office.**

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

(1) Print Full Name of Proposed Insured — Mr. / Mrs. / Miss — **First Name** — **Middle Name** — **Last Name**

(2) Mailing Address: P.O. Box — City or Town — Country — Res Tel. No .... Off. Tel. No ....

Send Premium Notices to:

(3) Date of Birth	Age Last Birthday	Place of Birth	Nationality	Sex	Passport Number

(4) Marital Status	Height cm	Weight kg	Weight Change past year	☐ Gain..........Kg ☐ Loss..........Kg	Cause, If weight changed?

(5) Name and Address of Employer	Occupation and Nature of Business	Describe Duties (Give exact Details)

(6) Exact amount of monthly earnings ? ....
☐ Salaried ☐ Self-Employed ☐ Other

(7) Beneficiary Details: (Full Name(s),Mention Date of Birth if the Beneficiary is Minor)

Primary Beneficiary: .... Relationship: ....

Contingent Beneficiary: .... Relationship: ....

(8) Family Members of Proposed Insured to be Covered ? ☐ Yes ☐ No ☐ For Life ☐ For Medical

Full Name	Sex	Nationality	Passport No.	Relation to Applicant	Date of Birth	Age	Height (cm)	Weight (kg)

(9) Health Status:
The following questions must be answered by the applicant and each member applying for insurance. Please ensure that you provide full and complete details as false declaration and/or lack of declaration shall cause cancellation of the insurance policy from the effective date without premium refund.

	YES	NO
(a) Has the proposed insured or any family member to be covered ever had, been told they had, or received medical advice or treatment for:		
(i) Cancer or tumor, leukemia, syphilis, tuberculosis, diabetes or sugar in urine, epilepsy, mental or nervous trouble, brain disorder?		
(ii) Cardio vascular ailments such as Heart attacks, Heart trouble, chest pains, High blood pressure, dyslipidemia, vein or artery trouble, rheumatic fever, Pneumonia, asthma, disease of lungs, breathing trouble, HIV, AIDS or AIDS related conditions?		
(iii) Stomach, Gall bladder, Liver, intestinal or rectal trouble, albumin or blood in Urine, Kidney or Bladder trouble?		
(iv) Arthritis, rheumatism, back or spinal trouble or other disease of bones, joints or muscles?		
(v) Any deformity, impairment of sight or hearing, loss of , or loss of use of limb, hernia or rupture?		
(vi) Excessive use of habit forming drugs or alcoholic substance?		
(vii) Additional questions for females age 15 or over : a) Disorder of the breast or female organs or complications of pregnancy? b) Are you pregnant now ? If so, How long ? Months.		
(viii) Any other disease, injury, operation or treatment not listed above or any symptoms of ill health within the past 5 years?		
(b) Please answer the following questions: i. Do you practice sports? Yes / No If Yes, Which: .... How often: .... ii. Do you smoke? Yes / No If Yes, How many per day: .... iii. Do you consume alcohol? Yes / No If Yes, How much per day:		

(10) Family History: (Father, Mother, Siblings of all individuals listed in the Member Schedule)

Has anybody in your family had symptoms or been diagnosed or received treatment for:		
a) Congenital disorder or genetic disease		
b) Multiple sclerosis or nervous system and/or sense organ disease		
c) Muscular dystrophy, diabetes, hemophilia or cancer		

If you answered "Yes" in Section **9 & 10**, Please specify the diagnosis details, treatment details and whether your condition is:
(1) Under Treatment (2) Recovered needing follow-up (3) Recovered with no follow-up

Name of the patient / Relation to proposed insured	Relevant question in Section 9 & 10	Name of illness / ailment and treatment received.	Result* 1 2 3	Treating doctors, hospitals etc (Please, indicate complete address of hospital or doctor)
			☐ ☐ ☐	
			☐ ☐ ☐	
			☐ ☐ ☐	

(11) Medical practitioner(s) most frequently used in the last 5 years:

Name: ....
Address: ....
Phone: .... Fax: ....

Name: ....
Address: ....
Phone: .... Fax: ....

(12) Amount of issued or pending individual or group life insurance on the Proposed Insured?

Insurer	Amount	Plan	ADB	W.P.	Date of Issue

(13) Amount of issued or pending individual or group medical insurance on the Proposed Insured?

Insurer	Room rate	Doctor's Visit	Max. Amt	Ded. Amt	Annual Limit

(14) Does the Proposed Insured contemplate making any flights as a pilot, student pilot or member of the crew of any aircraft?

(15) Is the insurance hereby applied for intended to replace any other life or medical insurance on the Proposed Insured or any named family member?
.... (If so, give details: ....

(16) Has any insurance applied for by or covering Proposed Insured or any named family member been declined, rated up, cancelled or modified?
.... (If so, state who, when, by which insurer and why) ....

(17) AGREEMENT:

The proposed insured and the Applicant, if the Applicant is other than the proposed insured, represent, each to the best of his knowledge and belief, that all statements and answers given in this application are true, complete and correctly recorded, and expressly agree as follows:
(1) This application shall consist of Part I - Application form and Part II - Medical Examiner Report(if required by the company) and shall be the basis for any policy issued on this application. (2) Any Policy issued on this application shall not take effect unless all of the following conditions are met: (a) The full first premium is paid, (b) The policy is delivered to the owner during the lifetime of the persons to be covered by such policy and (c) all of the statements and answers given in this application continue to be true and complete as of the date of delivery of the policy; (3) No information acquired by any representative of the Company shall be binding upon the company unless set out in writing to this application; (4) No agent or medical examiner is authorized to accept risks or to make, modify or discharge any contract of insurance or waive any of the company's rights or requirements; (5) Acceptance of a policy issued on this application shall constitute a rectification of any modifications made by the Company as recorded under Home Office Endorsements; (6) a) If the applicant is not the Proposed Insured, any life insurance issued on this application shall be owned by the Applicant, and the power to exercise all rights, privileges, options and elections granted or conferred by the provisions of such policy are hereby vested solely in the Applicant; b) Any health insurance policy issued on this application shall be owned by the Proposed Insured.

(18) Authorization:

I authorize any physician, hospital, clinic, insurance company, or other organization, institution or person having any records or knowledge of me or my family members to be covered, or of our health to give Al Buhaira National Insurance Co. (or its representative), any and all information about us with reference to our health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. A photographic copy of this authorization shall be as valid as the original.

....
Signature of Proposed Insured (Signature of Payor, if PI is under Age 15)

I certify that I have truly and accurately recorded herein the information supplied by the signatory(s) to this application.

....
Signature of Applicant (Owner) if other than Proposed Insured.

....
Name of Payor/Applicant (Owner)

....
Licensed Resident Agent Agent No.

....
Relationship to the Insured Telephone No.

Application Schedule

	Policy No	Kind of Policy	Currency	Premium
LIFE INSURANCE POLICY	....	....	....	....
	Additional Benefit Riders		Amount	....
	Accidental Death Benefit (ADB) ☐		....	....
	Permanent Total Disability (PTD) due to accident ☐		....	....
	Permanent Partial Disability (PPD) due to accident ☐		....	....
	Premium Payable Mode ☐ Annual ☐ Semi-Annual	Amount collected	Total 1st Premium Renewal Premium	....
MEDICAL INSURANCE POLICY	Choice of Plan ☐ Plan A ☐ Plan B ☐ Plan C	Choice of Network ☐ General ☐ Restricted	Deductible ☐ AED 50 ☐ AED 100	Premium ....
	Additional Optional Benefits Required			
	Maternity Benefit ☐			....
	Dental Benefit ☐			....
	Optical Benefit ☐			....
	Premium Payable Mode	Amount collected	Total 1st Premium	....