Check appropriate box:
- ☐ New Enrollee
- ☐ Addition of Dependant
- ☐ Change of Benefit Plan

Benefit Plan:
- ☐ **Emirates**
- ☐ **Emirates Plus**
- ☐ **International**
- ☐ **Global**

NGI
الشركة الوطنية للتأمينات العامة (ش م ع)
NATIONAL GENERAL INSURANCE CO. (PSC)

HealthNet

HEALTH DECLARATION FORM

Please ensure that you have enclosed the following documents:
- ☐ Photograph(s)
- ☐ Passport copy with Visa page
- ☐ Medical Reports (if any)
- ☐ Evidence of other insurance (For spouse/dependant

Please note that
- Any alteration/ overwriting in the application must be signed by the applicant.
- If a pre-existing medical condition/illness is NOT FULLY DISCLOSED we can decline the claim relating to it (& its consequences). If the medical condition is disclosed, we may cover that medical condition. Therefore, it is in your own interest to disclose complete medical history.
- ***Pre-existing Condition*** means any Disease, Illness or injury for which a person receives Treatment or experience symptoms, incurs expense, receives diagnosis from a physician (even if no Treatment is provided) or was aware of at any time prior to applying for insurance.
- NGI reserves the right to request medical evidence of insurability or reject any application as per company's underwriting guidelines.
- In case where your application is approved for insurance, your cover shall start from the date on which your application is approved/ underwritten.

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

First Name Middle Name Last Name

2. Mailing Address:

Street/ Road P.O.Box Postal Code City Country

3. (a) Date of Birth: ____/___/_____ **(b) Place of Birth**: _____**(c) Nationality:** _____
day - month - year

4. (a) Height: _____**cm. (b) Weight:** _____**Kg.(c) Sex:** _____ **(d) Marital Status:** _____

5. Contact No. (a) Work: _____ **(b) Mobile:** _____**(c) e- mail:** _____

6. (a) Employer/ Sponsor's Name: _____ **(b) Date of Joining** _____
(For Group Scheme)

(c) Occupation _____ **(d) Monthly Income (AED):** _____ **(e) Passport No.** _____

7. List of Family Members to be covered under HealthNet Healthcare insurance:
(Please use additional sheet if more space is required)

S.No.	Name	Relationship	Date of Birth (day/ month/ year)	Height (Cm)	Weight (Kg)	Occupation
1			/ /			
2			/ /			
3			/ /			
4			/ /			
5			/ /			

8. Are /Have you or any of your family members to be covered under HealthNet Insurance ever suffered or suffering from Heart Disease/Disorder, High/ Low Blood Pressure; High Cholesterol/ Lipids; Diabetes (High blood sugar level); Paralysis/Stroke, Mental Disorder, or other Disease of the Brain or Nervous System; Cancer or Tumor; Disease/Disorder of the Liver (Hepatitis-B/C, Cirrhosis etc.), Gastritis; Kidney Disease/Disorder; Arthritis/ joint disorder/Backache, Rheumatism; Acquired Immune Deficiency Syndrome (AIDS); or ANY OTHER DISEASE (CONGENITAL OR ACQUIRED), OPERATION OR ILLNESS NOT MENTIONED ABOVE?

☐ **Yes** ☐ **No**

_____
Applicant's Signature
DATE: _____

9. Have you or any of your family members to be covered under HealthNet Insurance ever been or still are afflicted with any illness or medical condition requiring Consultation, Investigations, Medication, Hospitalization or Surgery?

☐ **Yes** ☐ **No**

10. Are you (Married Female applicant)/ your wife (Married Male applicant) pregnant now? If yes, please mention the expected date of delivery/ duration of pregnancy_____/____/_____ ☐ **Yes** ☐ **No**

(day / month/ year)

11. Are/ were you or any of your dependent family members to be covered receiving health insurance coverage from another Insurance company or any other source? ☐ **Yes** ☐ **No**

Please give details of existing and previous insurance:

Name of Insurer: _____Policy Period: __/__/___To__/__/____ Total Annual Benefit: **AED**_____

dd mm yy dd mm yy

12. Do you or any of your family members to be covered under HealthNet Insurance consume alcohol or smoke tobacco? If yes, how much _____ since how long _____.

Quantity month / year

Please give details of any question (8- 10) if answered 'Yes' (Please use additional sheet if more space is required)

Question No.	Name of Patient	Type of Disorder	Date of Onset	Details of Treatment	Present Status of Health	Name & Address: Treating Doctor /Hospital
			/ /			
			/ /			
			/ /			
			/ /			

DECLARATION & AUTHORIZATION:

I hereby declare that what has been stated above is true and complete to the best of my knowledge and belief and I have not withheld any material information. It is understood and agreed that **this declaration which is contained in the application form constitutes the basis of my/our contractual relationship with National General Insurance Co (PSC) under HealthNet Healthcare Insurance and that any non-disclosure or misrepresentation of facts will make my / our insurance coverage void from inception.** I hereby authorize any hospital, physician, surgeon or any other organization to furnish to the National General Insurance Co (PSC) any or all information that may be required concerning my/ our medical history.

_____ _____

Applicant's Signature **Sponsor's Signature**

Self & on behalf of Family Members (For Group Scheme)

DATE: _____ DATE: _____

Underwriting Decision: Agent/ Broker's Name: _____

_____ _____

Underwriter's Signature Authorized Signatory's Signature

DATE: _____ DATE: _____