Important Information

Kindly complete the questions on this form in BLOCK CAPITALS and tick the relevant boxes. It is important that you provide the following information accurately so that we can process your application accordingly. This application must be completed in the Policy Holder or Insured Member's own handwriting (over 18 years old). If you need to make a correction, please highlight the change and add the date on it. For full details of the policy's terms and conditions, please refer to the table of benefits and membership handbook, available from GIG representative upon your request. We look forward to welcoming you as a member of GIG Gulf.

*If you have any questions when completing this form, please contact your GIG sales team representative.

Important information about your membership declaration

- It is essential that you provide the complete information before you sign on your medical application form and your medical health declaration.
- This form must be received by GIG Gulf within (30 days) from the declaration date. If we receive this form after 30 days from the signed declaration date, or with incomplete information, we will not be able to register your details and enrol you into the Health Insurance plan.
- It is advisable that you fill in your form with an up to date medical history before you sign and date this form.
- Claims will not be payable if you do not fully disclose any facts which could influence our assessment of this application and if you are in any doubt as to whether any facts, you should disclose them.
- You are advised to keep a record of all information you disclose to us in connection with this application, including letters
- Medical information will be kept confidential. Personal data collected from you and your family will be used by GIG Gulf to process your claims, administer your policy and may be used to detect and prevent fraud or improper claims. It will only be disclosed to those involved with your treatment or care and, if applicable, to any person or organisation who may be responsible for meeting your treatment expenses.
- All membership documents and confirmation of how we deal with any claim you may make will be sent to the principal member.
- In the interest of continuously improving our service; your calls will be recorded and may be monitored.
- Prior to signing the application, please make sure that you have read, understood and agreed to the policy terms and conditions.

Policy holder details (please keep us informed of any change in your address)

First name:	Middle name:
Last name:	Gender: ☐ M ☐ F
Date of birth: DD/MM/YYYY	P.O. Box:
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widow	
Address:	
Email:	Passport number:
Telephone number: Country Code Area code Number	Mobile number: Country Code Area code Number
Occupation:	Nationality:
Name of company (Employer):	Place of visa issuance:
National ID number:	
VISA UID Number:	

Existing or previous medical insurance

Do you have any health insurance currently in the G.C.C., or have previously received an Insurance quotation from GIG/AXA? ☐ Yes ☐ No

☐ GIG/AXA Gulf	Policy/quote number:	Policy expiry date: DD/MM/YYYY
☐ Other insurers	Policy/quote number:	Policy expiry date: DD/MM/YYYY

Your partner and family members (husband/wife & children to be insured with GIG)

Title	Name	Nationality/ passport number	Relationship	Sponsor	Date of birth	ID Number	Place of Visa issuance
			Wife/Husband/ Son/Daughter		DD/MM/YYYY		
			Wife/Husband/ Son/Daughter		DD/MM/YYYY		
			Wife/Husband/ Son/Daughter		DD/MM/YYYY		
			Wife/Husband/ Son/Daughter		DD/MM/YYYY		
			Wife/Husband/ Son/Daughter		DD/MM/YYYY		

Confidential medical history

Declarations must be made in writing on this application. Verbal declarations are not acceptable. This section requests your health and medical history details, past and present, including each family member named in the section above. Please tick Yes or No to every single question for every person included in this application. If you tick Yes to a question, please provide full details in the following section. Please ensure you declare any known or suspected condition, and any discomfort or symptoms experienced before your policy starts, even if professional advice has not yet been sought. Any declared condition shall be covered under the pre-existing limit as per the plan terms and conditions.

Please note that GIG reserves the right to decline your claim and not pay it, if you do not provide us with full details of any existing medical condition.

Section A: Please answer all questions below and if any of them is answered with "yes", provide details in section B:

	Principal	Dependant 1	Dependant 2	Dependant 3	Dependant 4	Dependant 5
Name						
Height (cm)						
Weight (kg)						
Do you smoke?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
1. Are you under any medical supervision, having undiagnosed and/or self-observed discomfort, signs, or symptoms, undergoing any medical/surgical treatment, was advised for the same or have been admitted to the hospital in the last five years?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
2. Do you have any chronic or pre-existing medical condition*, including undiagnosed and/or self-observed discomfort, signs, or symptoms?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
3. Are you taking any medication or have been advised to take for a period more than seven days?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
4. Do you have any bone, joint or spine disease/complaints?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
5. Have you been diagnosed, investigated, treated for, or having self-observed discomfort, signs, or symptoms of any type of tumor, lump, or cancer?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
6. Do you have/had a medical condition which is not listed in the questions above.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
7. **For females only:** a. Are you currently pregnant?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
b. If you answered yes on the above question, have you faced any complications up to date?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

c. Provide the date of your last menstrual period. If more than one month, please elaborate in Section B	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY	DD/MM/YYYY
d. Are you currently trying to get pregnant or undergoing any form of fertility treatment?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section B. Please provide details of all questions answered yes in the previous section and elaborate on any other health conditions that we need to be aware of.

*Chronic illness: a condition with one or more of the following criteria: last 3 months or more, leaves residual disability, is caused by non-reversible pathological alteration, requires special training of the patient for rehabilitation, or may require long period of supervision or observation, e.g. diabetes mellitus, hypertension, coronary artery disease etc.

*Pre-existing condition: an illness or health condition that was known and existed prior to submitting the application.

Your membership declaration

I hereby apply to be insured into the GIG Health Insurance program together with my family members listed above. I as the main applicant, confirm on behalf of myself and proposed family members that the disclosed information given on this application form is complete, true and correct to the best of our knowledge. I understand and acknowledge any pregnancy not declared at the time of this application's coverage will be at the sole discretion of the insurer. The insurer has the right to not cover any maternity claims to any undeclared pregnancy. I also acknowledge and understand any pregnancy, which arises within forty calendar days from the date of this application; coverage will also be at the discretion of the insurer. I am the undersigned and I confirm that I have received and read the terms and conditions of this policy, read and understood the table of benefits, list of exclusions and the full terms and conditions of the opted for Health plan. I agree that GIG Gulf rules and internal guidelines would apply to me and to the eligible dependents included in my membership.

I/We understand and agree that GIG reserves the right to request for medical examination and investigations report/s regardless of the declaration provided to complete the enrollment process.

I/We confirm that in case a complaint arises and coverage for the insured is denied due to any misrepresentation of facts stated in the application, it will be the sole responsibility of me, the undersigned. I agree to indemnify and not hold GIG responsible for any denials, penalties and fines incurred due to misrepresentation of facts.

I/We understand that any change on my plan benefits which upgrades or downgrades my Health Insurance plan would only be possible at the time of renewal subject to GIG Gulf's acceptance, the completion of a new application form in addition to any other forms or reports that may be requested by GIG Gulf. We formally request Gulf Insurance Group (Gulf) B.S.C. (c) ("GIG") to collect, use, store, transfer and/or disclose any relevant information whether within or outside of GCC (including sensitive health information and personal data) from any third party/partner in the due course of pricing and servicing our insurance policy and thereby authorize them to disclose all such relevant information to GIG.

A photocopy of this authorization and all other related subsequent documents including communications in relation to this contract shall be considered as effective and valid as the original.

We have been notified and agreed to the terms of GIG's Data Use Statement which can be found at https://www.giggulf.bh/privacy.

GIG has taken steps to ensure that your information is held securely. You have the right to access your personal data held by GIG. If you believe that your personal data held by GIG is inaccurate you have the right to ask for this to be rectified.

Duty of Disclosure

(Any false declaration may result in no coverage, cancellation of insurance policy and/or no refund)

I, as the main applicant, confirm on behalf of myself and proposed dependents that the disclosed information given on this application form to the best of our knowledge.

I understand and acknowledge that:

- I have a legal duty to disclose any material facts impacting the insurers' ability to appropriately and accurately underwrite this application, such as any existing medical conditions whether known, active or dormant, treated, undergoing treatment or suspected, including but not limited to any self-observations, any discomfort or symptoms, experienced prior to inception of the policy.
- I understand that my duty to disclose includes any and all information related to existing medical conditions, self-observed discomfort, signs or symptoms before the start of the policy, even if it is not intended to use the policy for its relevant treatment and claim for medical costs inside and/or outside the area of cover of the medical plan.
- It is my responsibility to provide the insurer with all the information requested and to ensure that it is true, complete, and not misleading in any way.
- Declarations must be made in writing on this application. Verbal declarations are not acceptable.
- For undeclared pre-existing conditions the insurer can and reserves the right to decline to pay claims in relation to the condition and/or symptom.
- No indemnity will be paid by the insurer under the proposed insurance policy for medical expenses arising prior, or during the course of this application.
- Any fact which would influence the insurer in accepting or declining a risk or in fixing the premium or terms and conditions of the contract is material and must be disclosed by us to the insurer before the contract is concluded. Failure to disclose material information may invalidate the proposed insurance policy.
- In case of any doubts about what is material information, I should seek clarification from the insurer and not assume that the insurer is aware of any such material facts.
- Only duly declared conditions will be eligible for cover, as per the terms and conditions of the policy therefore any sub-limits, exclusions as applicable will apply.
- In the event the insurer discovers an undeclared pre-existing condition/symptom due to a claim submission or in reference to my medical records, thereby leading to the insurer's decision to reject cover, the insurer may suspend and possibly cancel the policy without refund due to undeclaration and misrepresentation of health information by us. If I subsequently wish to cancel the policy, I understand that the standard cancellation clause applies, which means for certain plans this results in becoming ineligible for any pro-rata refund.
- If I wish to dispute whether the condition or symptom is pre-existing at the inception of this policy, it should be disputed and settled with the treating Doctor/Facility who conducted the examination and reported the onset date.
- This duty of disclosure applies not only at inception but also on changes to cover.
- For any change in circumstances, I will advise the insurer, as soon as reasonably practicable, of any changes in our circumstances that may affect the services or the cover to be provided by the insurer under our insurance policy.

Signature:	Date: DD/MM/YYYY