Quote Ref. No:

GROUP MEDICAL INSURANCE APPLICATION FORM

In order to apply for this insurance, please complete all parts of this Proposal and the annexures, if any. The insurance cover begins when ADNIC confirms the same in writing.

You must provide full and true answers to all questions listed below. Material facts related to the below questions which you know or ought to know should be fully disclosed. Failing to do so, may result in the insurance cover not protecting you in the event of a claim and the policy issued may be: Cancelled from inception **OR** Altered with revised terms **OR** Non Payment of Claims related to Non Disclosed Information.

A. Company Information

Policyholder Name: ..……..……..……

Policy Holder Address: ..……..…… PO Box: ……..……..

Phone Number: …….. E-Mail Address: ……...

Total Number of Employees in the Group: …… Nature of Business: ..……...

B. Plan Details

Total Number of Employees Insured: …… Total Number of Dependents Insured: ……..

Policy Start Date: …….. No of Categories: ……

Categorization (Tick as applicable)

Senior Level		Dependents		Mention Eligible Category	
Middle Level		Dependents		Mention Eligible Category	
Junior / Worker Staff		Dependents		Mention Eligible Category	

C. Major Medical Illness History

Do any of the members in your Group suffer from any of the illnesses as listed below:	Yes / No
Cancers (any type) / Tumors?	
Paralysis / Coma?	
Multiple Sclerosis?	
Currently Admitted in NICU or Other any Current In-Patient Hospitalizations?	
Heart Ailments requiring Coronary Artery Bypass Surgery?	
Organ Failure?	
End Stage Kidney / Lung / Liver Disease	
Aplastic Anemia	

If you answered yes to any of the questions mentioned above, please provide us with the latest medical report for the related medical condition of the member.

Quote Ref. No:

Declaration Continued - If you have answered "yes" in Part C above OR If you optionally intend to make an additional declaration; please specify the details of the medical condition(S)

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I declare that to the best of my knowledge and belief the statements on this application form are full, true and correct; I/We have declared all material facts related to this application/quotation form. I/We understand that non – disclosure or misrepresentation of any material fact related to this form questions may invalidate the quoted terms/the health insurance policy and/or coverage. I/We understand that this document is the basis of my/our insurance policy and upon acceptance will become a part of the contract and shall be read together with all the documents issued in connection with the policy

As acceptance of this quotation, we the undersigned hereby request Abu Dhabi National Insurance Co. (hereinafter referred to as ADNIC) to issue a Group Medical Insurance policy, with effect from (Start date) _____ for a period of 12 months for the lives of all our employees and their eligible dependents as per the terms defined in this quotation. We also undertake that in the case of termination of cover, the company shall retain a portion of the premium corresponding to the Short Rate Scale as per ADNIC terms and conditions. For any new addition of members in the scheme during inception or during the course of the policy a Major Illness Declaration as per ADNIC Standards shall be provided.

Signature of Policyholder: ……

Designation of the Signatory ……..

Official Stamp of the Company:

Date: ……