RAKINSURANCE
Simply Better

Proposal Form
Individual and Family RAKCARE

Completing the Proposal Form

- Please answer all questions in full leaving no blank spaces.
- If you have insufficient space to complete any of your answers, please attach a separate signed and dated sheet and identify the question number concerned.
- It is agreed that the whenever used in this proposal form, the term Applicant shall mean the Principal Applicant and all named family members.
- All information provided by the Applicant will be maintained in strictest Confidence by RAK Insurance
- **You must provide full, accurate and true answers to all questions listed below. Material facts which you know or ought to know should be fully and accurately disclosed. Failure to do so may result in rejecting all your claims and/or terminating the insurance policy from inception.**
- **Signing of this proposal form is not the commencement of insurance coverage. The commencement of insurance coverage will be confirmed upon the written acceptance of this Proposal Form by RAK Insurance and issuance of the Insurance Policy.**

PLEASE READ AND ANSWER THE PROPOSAL FORM CAREFULLY.

General Information

Full name			
Residence address			☐ Dubai ☐ Abu Dhabi ☐ Northern Emirates
Work address			☐ Dubai ☐ Abu Dhabi ☐ Northern Emirates
Telephone/Mobile no.		E-mail address	
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widowed		

Member Details (Please provide information for the principal applicant and all family members)

Full Name	Relationship	Nationality	Date of Birth	Sex M/F	Height (cm)	Weight (kg)	Profession	Blood Group	Residence

Is there any family member (Spouse and Child) who is not included here? ☐ Yes ☐ No	
If Yes, please specify the reason	

Section A - Insurance History

Have you ever been declined or accepted for life and/or health insurance on sub-standard terms? ☐ Yes ☐ No	
If Yes, please specify the reason	

Section B - Individual Medical History – Please answer for all members of the family included on this proposal form

Have you ever been diagnosed, treated, or had symptoms related to the following
(if Yes, please specify CURRENT MEDICATIONS, diagnostic details, treatment received and recovery status on attached supplemental information sheet)

In case the answer is YES to any of the conditions/diseases below, please specify in full details (preferably by a Medical Physician) or attach the latest medical report

1. Musculoskeletal and / or Connective Tissue System? (Fractures, joint or cartilage, back, deformities, bone infections, osteoporosis, arthritis, rheumatism, etc.)	☐ Yes ☐ No
2. Cancer, Neoplasms, Tumours? (Specify type, location, treatment, whether malignant or benign)	☐ Yes ☐ No
3. Blood and Blood Forming Organ Systems? (Anaemia, thalassemia, bleeding disorders, blood cell disease, spleen, lymph node, etc.)	☐ Yes ☐ No
4. Digestive System? (Reflux, ulcers, diverticulitis, bleeding-infection-obstruction-perforation of the oesophagus, stomach, intestines or colon, teeth/gums/mouth/jaw, liver, gallbladder or pancreas, anal/rectal polyps?	☐ Yes ☐ No
5. Endocrine, Nutritional, Metabolic and/or Immunity System? (Diabetes, thyroid or pituitary gland, adrenal gland, ovary or testes, hormones, gout, multiple sclerosis, cystic fibrosis, metabolic disorders, immune problems, etc.)	☐ Yes ☐ No

In case of diabetes please specify whether insulin dependent:	
Section B - Individual Medical History (continued)	
6. Nervous System or Sense Organs? (Ear injury/infection, vertigo, hearing, eye injury/disease, retina, glaucoma, vision, muscular dystrophy, brain/nerve degeneration, meningitis, paralysis, seizures, epilepsy, neuralgia, etc.)	☐ Yes ☐ No
7. Genitourinary System? (Kidney/bladder infections, renal failure, kidney stones, endometriosis, menstrual cycle, salpingitis, ovarian cysts, prostate, impotence, testicle infections, sperm abnormalities, fertility, etc.	☐ Yes ☐ No
8. Respiratory System? (Sinusitis, allergies, tonsillitis/laryngitis, bronchitis, emphysema, pneumonia, etc.)	☐ Yes ☐ No
9. Cardiovascular System? (Stroke, cerebral ischemia, rheumatic fever, atherosclerosis, aneurysm, embolism, peripheral vascular disease, hypertension, heart valve disease, irregular heartbeat, pulmonary embolism, phlebitis, varicosities, etc. In case you are suffering from hypertension please specify your Systolic Diastolic readings below: Systolic: _________ Diastolic: _________	☐ Yes ☐ No
10. Skin-Subcutaneous Tissue? (Dermatitis, acne, seborrhoea, pruritus, etc.)	☐ Yes ☐ No
11. Hernia	☐ Yes ☐ No
12. Haemorrhoids	☐ Yes ☐ No
13. Fissures	☐ Yes ☐ No
14. Tonsils	☐ Yes ☐ No
15. Adenoids	☐ Yes ☐ No
16. Varicose	☐ Yes ☐ No
17. Thyroids	☐ Yes ☐ No
18. Uterine Fibroids	☐ Yes ☐ No
19. Hysterectomy and Ovarian cyst	☐ Yes ☐ No
20. Endometriosis	☐ Yes ☐ No
21. Varicoceles	☐ Yes ☐ No
22. Hydrocele	☐ Yes ☐ No
23. Gall bladder disease	☐ Yes ☐ No
24. Kidney Stones	☐ Yes ☐ No
25. Stomach ulcers	☐ Yes ☐ No
26. Knee condition/injuries and/or any related treatment	☐ Yes ☐ No
27. Ankle condition/injuries and/or any related treatment	☐ Yes ☐ No
28. Back condition/injuries and/or any related treatment	☐ Yes ☐ No
29. Neck condition/injuries and/or any related treatment	☐ Yes ☐ No
30. Congenital disease or malformations	☐ Yes ☐ No
31. Have you ever undergone surgery to remove a body organ or structure? (Specify body organ/ structure, date & place of surgery)	☐ Yes ☐ No
32. Are you HIV positive or have any medical condition or symptom indicative of HIV infection or AIDS?	☐ Yes ☐ No
33. Infectious and parasitic diseases	☐ Yes ☐ No
34. Mental / psychiatric disorders	☐ Yes ☐ No
35. Pregnancy, complications of pregnancy, child birth and the puerperium including abortions	☐ Yes ☐ No
36. Injury and poisoning	☐ Yes ☐ No
37. Previous medical / surgical hospitalisations, procedures and operations	☐ Yes ☐ No
38. Any (chronic) disease (s), symptoms and complaints not mentioned above	☐ Yes ☐ No
39. Any pre-existing disease(s), symptoms and complaints within the last ten years	☐ Yes ☐ No
40. Psychological and mental disease (bipolar disorder, anxiety disorder, schizophrenia, stroke, cerebral aneurism	☐ Yes ☐ No

Section C - Family Medical History (Father, Mother, Siblings)	
Has any member of your family been diagnosed, received treatment or had symptoms related to any of the following (if Yes, please specify CURRENT MEDICATIONS, diagnostic details, treatment received and recovery status on attached supplemental information sheet)	
a. Inherited disorder or genetic disease?	☐ Yes ☐ No
b. Haemophilia?	☐ Yes ☐ No
c. Muscular Dystrophy?	☐ Yes ☐ No
d. Multiple Sclerosis?	☐ Yes ☐ No
e. Cancer?	☐ Yes ☐ No
f. Mental illness or disorders?	☐ Yes ☐ No
g. Nervous system and / or sense organ disease?	☐ Yes ☐ No
h. Illness of the cardiovascular system?	☐ Yes ☐ No
i. Diabetes?	☐ Yes ☐ No
Section D - Lifestyle	
Do you smoke?	☐ Yes ☐ No
If Yes, what do you smoke and how many times per day?	
Do you practice any kind of routine exercise?	☐ Yes ☐ No
If Yes, how long for and how many times a week?	
Do you undergo routine medical check-ups?	☐ Yes ☐ No
If Yes, how many times per year?	
How often do you consult a physician per year?	
How many hours do you sleep per day?	
How many hours do you work per day?	
How many times do you travel per year?	
Do you drink alcohol	☐ Yes ☐ No
If yes, what type and how many units per day or week?	
Have you ever taken any drugs?	☐ Yes ☐ No
If Yes, have you been treated for an addiction and when?	
Section D – Maternity Related	
Are you currently pregnant? If yes, have there been any complications to date?	☐ Yes ☐ No
Last menstrual period date	
Are you currently trying to get pregnant?	☐ Yes ☐ No
Are you undergoing any form of fertility treatment?	☐ Yes ☐ No

FALSE INFORMATION

All material facts must be disclosed. Failure to do so may invalidate any insurance policy from inception. A material fact is one which is likely to influence an insurer in the assessment and/or acceptance of the proposal. If you are unsure as to whether a fact is material or not, it should be disclosed to RAK Insurance.

Any person who, knowingly and with intent to defraud any insurance company or other person, files a proposal for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

DECLARATION AND SIGNATURE

I/We hereby declare that the statements/information given by me/us in this Proposal Form are full, accurate and true. It is hereby understood and agreed that the statements, answers and particulars provided in this Proposal Form and as per the attachments are the basis on which the insurance policy is being issued/effected. If after the insurance policy is effected, it is found that any fact in the statements, answers or particulars in this Proposal Form is incorrect, untrue, inaccurate, misrepresented or non-disclosed in any respect, RAK Insurance shall have no liability under the insurance policy and/or shall have the right to terminate the insurance policy from inception.

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. The company is hereby authorised to make any investigation and inquiry in connection with this Proposal Form that it deems necessary and I and all applicants contained in this Proposal Form do hereby waive our right of medical confidentiality to the benefit of RAK Insurance and its representative.	
Applicant Signature	Date

Additional Information

- **Please note that each page of this Proposal Form should be signed by the Applicant or his/her legal representative.**
- **This proposal and any information provided by the applicant does not constitute a contract or effect insurance cover for the applicant and any members identified.**
- **In case of acceptance of the applicant by RAK Insurance, any conditions or exclusions and acceptable premium payment methods will be communicated to the applicant.**
- **Only upon RAK Insurance acceptance of the conditions, exclusions and provision of an acceptable premium payment methods will the cover be instigated and the relevant Insurance Policy and membership cards, if included, be provided.**

Supplemental Information Sheet Please specify CURRENT MEDICATIONS, diagnostic details, treatment received and recovery status or any information deemed necessary			
Section	Question	Member	Supplemental Information

Applicant Signature	Date