THE NEW INDIA ASSURANCE COMPANY LIMITED
P.O. Box : 5701, Dubai, U.A.E. Tel: +971 4 3525563 / 3522539, Fax : +9714 3518544
E-mail : newindia@nia-dubai.com Website : www.nia-dubai.com
(Registered in the Insurance Companies Register under Federal Law (6) of 2007)

ذي نيو انديا اشورنس كومبني ليمتد
ص.ب.: ٥٧٠١، دبي، ا.ع.م.، هاتف : ٣٥٢٢٥٣٩ / ٣٥٢٥٥٦٣ ٤ ٩٧١+، فاكس : ٣٥١٨٥٤٤ ٤ ٩٧١+
بريد الكتروني: newindia@nia-dubai.com الموقع: www.nia-dubai.com
(مسجلة في سجل شركات التأمين بموجب القانون الاتحادي رقم (٦) ب ٢٠٠٧ م)

APPLICATION FORM FOR EUROMED SERIES

Date:

Please Select Your TPA: neuron ☐ NEXtCARE Your Health Managed with Care ☐

Sr. No.	Member Name	Nationality	Gender (M/F)	Marital Status - Married	DOB (dd/mm/yyyy)	RELATION (Insured/ Spouse/ Child)
1				☐ Yes ☐ No		
2				☐ Yes ☐ No		
3				☐ Yes ☐ No		
4				☐ Yes ☐ No		
5				☐ Yes ☐ No		
6				☐ Yes ☐ No		

Visa Issued From: ☐ Abu Dhabi / Al Ain ☐ Dubai ☐ Other Emirates

Plan Selection: PLEASE ☑

Sum Insured : AED 100,000	Sum Insured : AED 150,000	Sum Insured : AED 250,000	Sum Insured : AED 500,000	Sum Insured : AED 1 Million
☐ SILVER CLASSIC (Non-Dubai Visa members only)	☐ RI'AYAH (Dubai Visa members only)	☐ GOLD (Dubai Visa members only)	☐ DIAMOND (Dubai Visa members only)	☐ PLATINUM (Dubai Visa members only)
	☐ RI'AYAH PLUS (Dubai Visa members only)	☐ GOLD PLUS (Dubai Visa members only)	☐ DIAMOND PLUS (Dubai Visa members only)	☐ PLATINUM PLUS (Dubai Visa members only)
		☐ GOLD CLASSIC (Non-Dubai Visa members only)	☐ DIAMOND CLASSIC (Non-Dubai Visa members only)	☐ PLATINUM CLASSIC (Non-Dubai Visa members only)

If opting for **EUROMED PLATINUM**, please select from the below options:

☐ Including USA & Canada

☐ Excluding USA & Canada

Contact Details: **ALL DETAILS ARE MANDATORY**

Address With P.O. Box & Emirate	
Landline	
Mobile	
Fax	
Email	

Would you like The New India Assurance Company Limited to send health related SMS and Mail? ☐ **Yes** ☐ **No**

Signature: _____

Note: Please enclose Medical History Form, Passport copy with Visa page, Emirates ID & color photograph.

All members of the family to be covered under the same plan only.

***All requested details are mandatory.**

The validity for this proposal is for 1 month from the date this application form is filled up.

RAIS HASSAN SAADI INSURANCE AGENTS LLC

CONFIDENTIAL MEDICAL HISTORY
To be completed by the Proposer/Insured Person

Declarations must be made in writing on this enrolment form, verbal declarations will not be accepted.

Please note:

i. **No liability will be accepted for any medical conditions which is present or was foreseeable at the time of enrolment unless such medical condition has been declared and been accepted by NIA in writing.**

ii. **Failure to notify NIA of a medical condition may result in claims for benefit being refused or cover withdrawn, if you have any doubt you should disclose the medical condition.**

Name:	
DOB (dd/mm/yyyy):	Gender: ☐M ☐F
Height (cm):	
Weight (kg):	
Marital Status: Single☐	Married ☐

*Please answer the following questions with ☑ for **yes** or **no***
(A dash is not sufficient) and give full details, if answer is yes.

Are you in Good health and free from any physical and mental disease or medical complaints?	YES☐	NO☐
Do you smoke? If yes, how many cigarettes/other form of tobacco a day?	YES☐	NO☐
Any other habits? (e.g.: drinking, chewing tobacco etc.)	YES☐	NO☐
1. In the last 2 years have you experienced (or are you now experiencing) any symptoms or discomfort that have persisted for more than 7 days such as but not limited to; ☐fever, ☐pain, ☐migraine, ☐headache, ☐cough, ☐vomiting, ☐diarrhea, ☐fatigue, ☐dizziness, ☐bleeding, ☐itching, ☐toothache? Please select relevant box. Please mention the discomforts you faced specifically.	YES☐	NO☐
2. a. In the last 2 years have you noticed any lumps or other mass, changes in moles or other skin problems?	YES☐	NO☐
b. Have you had any loss of function such as but not limited to; movement, hearing, vision or speech?	YES☐	NO☐
c. Any visual aid including glasses OR contact lenses?	YES☐	NO☐
3. In the last 12 months have you been advised by a medical practitioner or other expert to change your diet, undertake more physical exercise or change your lifestyle in other way due to Vitamin deficiency.	YES☐	NO☐
4. Have you ever been diagnosed with any form of below condition and/or undergone or been advised to undergo any screening to rule out a potential health conditions?	YES☐	NO☐
a. Diabetes	YES☐	NO☐
b. Blood vessel (Veins and arteries) diseases disorders	YES☐	NO☐
c. Asthma/Breathing trouble after: ☐Walking, ☐Jogging, ☐Exercising, ☐During winter	YES☐	NO☐
d. Cancer of any type	YES☐	NO☐
e. Have you ever undergone any surgical treatment for: Bypass/Angio/Renal (please specify)	YES☐	NO☐
f. Fistula, Piles, Hernia, Varicose Veins	YES☐	NO☐
g. Slipped disc or other spinal disorder (fainting episode, blackout, fit) or paralysis of any kind.	YES☐	NO☐
h. Any disease of bones or joints	YES☐	NO☐
i. Any condition pertaining to stomach, kidney or abdominal organs	YES☐	NO☐
j. High blood pressure	YES☐	NO☐
k. Any other complaints requiring physicians or specialist's consultation, investigation or treatments.	YES☐	NO☐
5. Are you taking any regular Medications for Hypothyroidism/Diabetes/Sclerosis/Epilepsy? Please specify.	YES☐	NO☐
6. In the last 5 years have you been hospitalized or undergone surgery of any kind? If 'yes' please share type of surgery.	YES☐	NO☐

7. For female applicants; are you currently pregnant?	YES ☐	NO ☐
a. If yes, have there been any complications to date?	YES ☐	NO ☐
b. Last menstrual period date: _____		
c. Are you currently trying to get pregnant?	YES ☐	NO ☐
d. Are you undergoing any form of fertility treatment?	YES ☐	NO ☐
e. Have you ever had any complications associated with conception, a pregnancy and/or given birth by caesarean section?	YES ☐	NO ☐
f. Count of deliveries (Childbirth) prior to this Insurance. Caesarean_____ Normal_____		
g. Any disease of the uterus, ovaries or breast or any specific Gynecological disorders.	YES ☐	NO ☐
h. As an applicant, I understand and acknowledge any pregnancy not declared at the time of this application, the coverage will be at the sole discretion of the insurer. The insurer has the right to not to 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.	AGREE ☐	
8. Kindly declare any illness which you endured but not been treated for. _____		
9. Have you ever suffered from dental problems? Teeth refilling/dentures/crown filling/ tooth surgery in last 5 years. If yes, please give details.	YES ☐	NO ☐
10. Please specify in detail external disorders of limbs, if any.	YES ☐	NO ☐
11. Do you currently hold valid UAE Driving license.	YES ☐	NO ☐
12. Do you practice ☐Daily Walking, ☐Daily Exercise, ☐Meditation, ☐Regular outdoor games Please ☑ relevant box.	NONE ☐	
13. Any one in family (Father/Mother/Uncle/Aunty/Sister/Brothers) had ☐Cancer, ☐Heart Attack. If yes, at what age?_____		
14. Were you ever insured before?	YES ☐	NO ☐
If yes, please provide the name of Insurance Company :_____ Period of insurance : _____		

- Please continue on a separate sheet if necessary for further detailed information.
- If you answered yes to any of the questions mentioned above, please provide us with the latest medical report for the related medical condition.

MEDICAL PRACTITIONER(S) MOST FRQEUENTLY VISITED IN THE LAST 2 YEARS
Name:
Address:
Telephone No.:

I hereby declare and warrant that the above statements are true and complete. I hereby authorize the Insurers to seek medical information from any Hospital/Medical Practitioner who has at any time attended or may attend concerning any disease or illness which affects my physical or mental health. I agree that this proposal shall form the basis of the contract should the insurance be effected. If after the insurance is effected, it is found that the statements, answers or particulars stated in the Proposal form and its Questionnaires are incorrect or untrue in any respect, the Insurance Company shall incur no liability under this insurance.
I have read the Prospectus and I am willing to accept the coverage subject to the terms, conditions and exceptions prescribed by the Insurance Company herein.
DATE (DD/MM/YYYY): …….

MEMBER NAME:

N.B.: This should be signed by insured. In case of minor, guardian or proposer may sign.
All details are mandatory.

Signature_____

Rais Hassan Saadi Insurance Agents L.L.C.: Chief Agents For Dubai & Northern Emirates
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