GLOBALCARE

Alfalah Insurance

Full Medical Underwriting (FMU) Application Form

Please complete this form using Block Capitals and by ticking the relevant boxes.
It is important that you provide the following information so that we can properly assess your application.

This application must be completed by you in your own handwriting. If you need to make a correction, please initial the change.

Section A - Your Personal Details (Main Applicant/Policyholder)

Title ☐ Mr. ☐ Ms. _____

Family Name

First Name

Permanent Residential Address

Correspondence Address (To be completed only if you wish to receive your correspondence in a different address from that of the Residential Address)

Name of Company/Employer | Occupation

Date of Birth (D D M M Y Y Y Y) | CNIC Number | Passport Number

Nationality (if you have dual citizenship, please state the countries)

Email Address | Mobile Number

Country where you are residing for most of the year

Section B - Your Personal Health Plan

Cover will commence from the date shown on your membership statement provided your application has been received and accepted by us. Choose **ONE** level of cover, deductible and area of cover that you require and tick (√) the relevant boxes. Your choice applies to your dependents insured under the policy. For Group Members, this must be in line with the chosen option by your Company/Employer.

Choice of Level of Cover ☐ Diamond USD $1 million ☐ Sapphire USD $750,000 ☐ Emerald USD $500,000 ☐ Pearl USD $250,000

Area of cover ☐ Worldwide (excluding Sanctioned countries) ☐ Worldwide excluding USA (excluding Sanctioned countries)

Section C - Your Existing or Previous Health Insurance Plan

Have you ever been insured or applied for membership under any health insurance? If yes, please provide us with the details below.

☐ Yes ☐ No

Name of insurer(s) and plan(s) | Date of policy expiry (D D M M Y Y Y Y)

Section D - Currency & Premium Payment

Currency: PKR

Method of payment ☐ Direct Debit ☐ Cheque / Banker's Draft ☐ Interbank Transfer IBNT No. _____

Choose one payment mode ☐ Annually

Section E - Additional family members to be covered (Spouse / Children) *

1	Title ☐ Mr. ☐ Ms.				
Family Name					
First Name					
Relationship to you (spouse, partner, son/daughter)			Date of Birth	D D M M Y Y Y Y	
CNIC Number	Passport Number	Nationality	Occupation	Residing In	
2	Title ☐ Mr. ☐ Ms.				
Family Name					
First Name					
Relationship to you (spouse, partner, son/daughter)			Date of Birth	D D M M Y Y Y Y	
CNIC Number	Passport Number	Nationality	Occupation	Residing In	
3	Title ☐ Mr. ☐ Ms.				
Family Name					
First Name					
Relationship to you (spouse, partner, son/daughter)			Date of Birth	D D M M Y Y Y Y	
CNIC Number	Passport Number	Nationality	Occupation	Residing In	
4	Title ☐ Mr. ☐ Ms.				
Family Name					
First Name					
Relationship to you (spouse, partner, son/daughter)			Date of Birth	D D M M Y Y Y Y	
CNIC Number	Passport Number	Nationality	Occupation	Residing In	

* For more family members, please continue and use another separate Application Form, if necessary.

Section F - Confidential Medical History

(Declarations must be made in writing on this application. Verbal declarations will not be accepted)

Pre-existing condition refers to any medical condition preceding the member plan's policy commencement date, or policy reinstatement date, whichever date is later:

a. for which the Insured Person has been diagnosed; or

b. for which the Insured Person has sought or received medication, advice, or Treatment, or,

c. which the policyholder and/or the insured person should reasonably, based on the Company's independent appointed Medical Practitioner's opinion, have known about, or

d. for which the Insured Person has experienced symptoms even if the Insured Person has not consulted a Medical Practitioner or was not diagnosed before the start of the cover.

Please note:

i. You must declare your/applicants' medical history even if you have been insured with us or anywhere else before.

ii. NO LIABILITY WILL BE ACCEPTED FOR ANY PRE-EXISTING MEDICAL CONDITION WHICH ORIGINATED BEFORE THE DATE OF ENROLMENT OR WHICH WAS FORESEEABLE AT THE TIME OF APPLICATION, unless such medical condition has been declared to and accepted by us in writing before the cover commence.

iii. Any failure to notify us in writing of a medical condition may result in claims for benefit being refused or cover withdrawn. If you are in any doubt, you should disclose your Pre-existing medical condition. Please ensure that you fully disclose any known or suspected conditions and symptoms experienced by any applicants included in this form. This applies even if professional advice has not yet been sought.

Part A - Medical Declaration and Insurance History

	Please answer all the following questions for each of the applicant / family member. If the answer is Yes, please provide details in Part B Additional Information below.	Applicant Name	2nd family member Name	3rd family member Name	4th family member Name	5th family member Name
1	Please provide your current height (in metres) and weight (in kilograms)	Height(m) Weight(kg)	Height(m) Weight(kg)	Height(m) Weight(kg)	Height(m) Weight(kg)	Height(m) Weight(kg)
2	Have you or any of the applicants smoked more than 20 sticks of cigarettes or tobacco per day?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3	Have you, or any of the applicants, ever had any Life, Critical Illness, Medical or Disability insurance application, reinstatement or renewal cancelled, declined, postponed, or accepted with an increased premium, special terms or an exclusion due to health/medical reasons?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4	Are you currently seeking medical advice for a symptom or condition but yet to receive a diagnosis or plan to undergo any form of inpatient treatment, surgery or procedure? Please answer 'Yes' if you are waiting for: • An appointment with a medical professional (including GPs or medical specialists) • Referral to a hospital or clinic for surgery, tests or investigations • Results following test or investigation • A confirmed diagnosis • A planned or pending inpatient treatment, surgery or procedure	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5	In the last 5 years, have you, or any of the applicants ever been diagnosed or had treatment or been told to have any health condition or suffered from any intermittent or recurring illness or experienced symptoms (regardless whether a medical practitioner has been consulted) or had any investigation (e.g. a scan/blood tests/x-rays, etc.) relating to:					
a	Heart conditions or problems e.g. angina, heart attack, heart failure, heart valve problem, abnormal heart beat, heart murmur, palpitation, atrial fibrillation, supra ventricular tachycardia (SVT), coronary artery disease, ischemic heart disease, stroke including transient attack (TIA), cerebrovascular accident (CVA), heart surgery or hypertension (or high blood pressure), hypotension (or low blood pressure), hypercholesterolemia (or high cholesterol)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b	Diabetes, thyroid diseases, metabolic diseases or endocrine diseases?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c	Hepatitis, cirrhosis, gastritis, esophagitis, stomach / duodenal / gastric / intestinal ulcer or polyp, piles/haemorrhoids, fistula, chronic diarrhoea, irritable bowel disease, rectal bleeding or any other liver, pancreas, bowel, gallbladder or digestive disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d	Albumin, protein, blood, sugar or pus in urine, kidney stones, urinary tract infection, prostate problem, urinary incontinence, or any other disease or disorder of the kidney, bladder, urinary tract or prostate disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Part A - Medical Declaration and Insurance History (continued)

		Applicant	2nd family member	3rd family member	4th family member	5th family member
e	Epilepsy, fits, paralysis, stroke, weakness of limb, numbness, poliomyelitis, migraine, prolonged headache, loss of balance, dizziness, fainting spells, head / brain injury, alcohol or drug dependence or any other brain / neurological diseases?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f	Gout, arthritis, slipped-disc, spondylosis, back / neck pain, osteoporosis, Systemic Lupus Erythematosus (SLE), muscular dystrophy, cerebral palsy, Parkinson's disease or any disease or disorder of the spine, bones, limbs, foot, joints, muscles or connective tissues?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g	Depression, anxiety, anorexia or bulimia or any other mental, psychiatric diseases or conditions?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h	Asthma, bronchitis, pneumonia, persistent cough, tuberculosis, pneumothorax, nasal bleeding, nasal polyps, sinusitis, chest or breathing discomfort, Covid 19 / Coronavrius / SARs-CoV2 or any other lung or respiratory disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i	Cataracts, glaucoma, detached retina, sinusitis, otitis media, vision / hearing problem or any disease or disorder of the nose, eyes, ears or throat?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j	Circulatory disorders, aneurysms, varicose veins or deep vein thrombosis?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k	Anaemia, thalassemia, haemophilia or any disease or disorder of the blood?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l	Any skin problem or drug allergy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
m	Any physical infirmity or defect, premature birth or any congenital or hereditary disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
n	Any form of cancer, lymphoma, leukaemia, skin cancer, melanoma, sarcoma, brain tumour, skin lesion, mole, growth, lumps, cyst or nodule?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
o	Any other conditions, disease, injury or illness not listed above?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6	In the last 5 years, have you or any of the applicants had, or been advised to undergo any medical tests or investigations or intend to have or are waiting for any tests or investigations in the coming year? (For example: blood test, urine test, X-ray, ECG, ultrasound, imaging scan, biopsy, mammogram, pap smear, prostate check). If Yes, please provide details and submit a copy of the results, if any. (**Note:** You are not required to make a declaration if any of these tests were part of your routine, executive health screen or pre-employment check-up and all results are normal, and you are in good health free from any medical condition.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Part A - Medical Declaration and Insurance History (continued)

		Applicant	2nd family member	3rd family member	4th family member	5th family member
7	Have you or any of the applicants seen a medical practitioner or health professional in the past year that you or any of the applicants have not told us in any of the questions mentioned above? This includes, for example, a physiotherapist, practice nurse.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8	Have you or any of the applicants been prescribed or taken any form of treatment or medication, for a period of more than seven days that you have not told us in any of the questions mentioned above? **Note:** You are not required to make a declaration if your declaration was for the common cold and flu you have recovered, for routine vaccinations (including travel vaccinations).	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9	For female applicants: i. Have you had any complications during pregnancy or childbirth? ii. Are you currently pregnant? If yes, please state the number of months currently in pregnancy.	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No

10 Please provide the name and address of your/applicants personal registered physician.

Name of Applicants	Name of Registered Physician & Specialization	Address of Registered Physician

Part B - Additional Information

This part applies if you have indicated 'Yes' replies to any question under Part A. Please disclose all medical conditions (or undiagnosed symptoms) to which these replies are intended to apply. You must declare any condition you or any dependent has had during your/their lifetime which may have an impact on your/their future health. If you are in any doubt as to whether a condition may be relevant to this application, you must declare it in good faith. We reserve the right to request for a Medical Examiner's Report (MER) at your own expense. (If you require additional space for your declaration, please GO TO PART C - Other Additional Information

Question No	Name of patient

Nature of illness and final diagnosis

When did it start? M M Y Y Y Y

When did it stop? M M Y Y Y Y

Number of episode(s) between the start date and end date

Treatment prescribed

Name of hospital and attending doctor

Present state of health in this respect

Part B - Additional Information (continued)

Question No	Name of patient
Nature of illness and final diagnosis	
When did it start? M M Y Y Y Y	When did it stop? M M Y Y Y Y
Number of episode(s) between the start date and end date	
Treatment prescribed	Name of hospital and attending doctor
Present state of health in this respect	

Question No	Name of patient
Nature of illness and final diagnosis	
When did it start? M M Y Y Y Y	When did it stop? M M Y Y Y Y
Number of episode(s) between the start date and end date	
Treatment prescribed	Name of hospital and attending doctor
Present state of health in this respect	

Question No	Name of patient
Nature of illness and final diagnosis	
When did it start? M M Y Y Y Y	When did it stop? M M Y Y Y Y
Number of episode(s) between the start date and end date	
Treatment prescribed	Name of hospital and attending doctor
Present state of health in this respect	

Question No	Name of patient
Nature of illness and final diagnosis	
When did it start? M M Y Y Y Y	When did it stop? M M Y Y Y Y
Number of episode(s) between the start date and end date	
Treatment prescribed	Name of hospital and attending doctor
Present state of health in this respect	

Part C - Other Additional Information

Please use this section if you need more space to answer any questions.
If you don't need more space Now go to Section D & E for Declaration & Signature.
In your answers, please include:
- Question number
- Member name

Section G - Consent for processing of personal data

By signing and returning this form you indicate that you have authority to give consent on behalf of your employees, any family members covered by your policy and, on your own and their behalf, you consent to the use of personal information as set out in the Privacy Notice below.

Your policy membership application is, insured by Alfalah Insurance Company Limited and reinsured by AXA PPP healthcare Limited. Some aspects of the administration of your policy is undertaken by AXA Global Healthcare (UK) Limited or AXA Life & Health Reinsurance Solutions Pte. Limited, jointly AXA Global Healthcare (part of AXA Group), one of the world's largest insurance brands. The AXA - Global Healthcare privacy policy can be found at:
https://www.axaglobalhealthcare.com/globalassets/shared/documents/agh-privacy-policy.pdf.

Please make sure that your insured family members) have read this summary on AXA – Global Healthcare Data Privacy Policy.
We want to reassure you that we will never sell personal member information to third parties. We will only use your employees' information in ways we are allowed to by law, which includes only collecting as much information as we need. We will obtain your consent to process information such as your insured family members medical information when it is necessary to do so.
We collect information about your insured family members who are covered by this plan from you and/or them, you/their healthcare providers, your intermediary or insurance broker if you have one and third-party suppliers of information.
We process you/their information mainly for managing your/their membership and claims, including investigating fraud. We also have a legal obligation to do things such as report suspected crime to law enforcement agencies. We also do some processing because it helps us run our business, such as research, finding out more about you, statistical analysis for example to help us decide on premiums and marketing.

We may disclose your employees' information to other people or organisations. For example, we will do this to:
- Manage their claims, e.g. to deal with their doctors;
- Facilitate the provision of benefits or otherwise manage your policy with your intermediary or insurance broker;
- Help us prevent and detect crime and medical malpractice by talking to other insurers and relevant agencies; and
- Allow other AXA companies to contact you if you have agreed.

To be able to manage your policy we may transfer and access your and your employee's information from countries anywhere in the world including India and the USA where some administration is undertaken and Switzerland where AXA has a European data centre. Before doing so we will ensure that your data is protected and disclosed only to authorized individuals for servicing your policy or claim. Any internal transfer of your data will be undertaken only in accordance with the relevant data protection laws and regulations.
Where our using your information relies on your consent, you can withdraw your consent, but if you do we may not be able to process claims or manage your plan properly.

We will inform you if a data breach occurs and your personal and medical information are disclosed to unauthorised parties. The notification will be provided within 72 hours of the confirmation of the incident.
In some cases, you have the right to ask us to stop processing your employees' information or tell us that you don't want to receive certain information from us, such as marketing communications. You can also ask us for a copy of information we hold about your employees'/their family members and ask us to correct information that is wrong.

Section H - Signature and Declaration

a	I declare that: • to the best of my knowledge and belief the statements on this application form are full, true and correct; • I shall read the Policy document, Exclusions, General Terms, Conditions and Agreement when received and that I agree to be bound by it unless I cancel the enrolment within 14 days of acceptance of my application.
b	I agree that the acceptance of my application shall be on the basis of these statements.
c	I understand that if there are changes in the information I have given before the start date of my/our policy, I must inform you in writing immediately.
d	I understand that once the policy has started, you will not pay for treatment of any medical condition (or related medical condition) which the member(s) already had when they joined unless fully disclosed on this application and accepted by you. This includes any such medical condition(s) or symptoms, whether or not being treated and any previous medical condition(s) which recurs, or which I should reasonably have known about even if I/We had not consulted a doctor.
e	I understand that as the legal holder of this insurance policy, all correspondence about this application, including claims correspondence, will be sent to me unless I write to tell you otherwise. I also understand that policy documents, written communications and membership details will be issued in English unless you and I have specifically agreed, in writing, to communicate in a different language.
f	I understand that some countries require residents, whether expatriates or otherwise, to take out health cover through a local provider or to hold cover which meets certain compulsory requirements and that the cover provided by you may not meet these country specific requirements and therefore additional cover may be necessary. I further understand that in some situations there may be consequences in the form of tax penalties or otherwise where a resident does not hold the required local cover in addition to their international medical insurance policy. If I have any concerns about any additional cover requirements in my principal country of residence (as defined in Section A About the Policyholder), I understand that it will be my responsibility to check with the local authorities to determine whether there are any further healthcare requirements with which I am expected to comply.
g	By signing and returning this form I confirm that the declarations set out in this application are correct and that I have the authority to enter this policy on behalf of any family members.

Section I - Signature and Declaration

Please note: You are advised to keep a record of all information supplied in connection with this application, including any letters you send to us in connection with it. If you would like a copy of this application, please let us know within 90 days. After completing this application form and signing the Declaration, please return to Alfalah Insurance Company Limited. The declaration is valid for 30 days from the date of the signature.

I shall disclose to the Company any change in health and/or medical consultation and/or material facts of all applicants that occur after signing this application form but before the policy is issued.

Signature of Policyholder	Name of Policyholder	Date D D M M Y Y Y Y
Signature of Insurance Intermediary	Name of Intermediary	Insurance Intermediary's Code

For Office Use Only

(Underwriting terms pertaining to this application)
(Underwriter's signature/date)
Insurer's Medical Advisors comments
Medical Advisor's signature/date