

# Application Form

**Before you start, please consider that:**

- You must complete the Application Form in full and tell us all relevant information.
- If you choose to complete a printed version of this form, **PLEASE COMPLETE IT IN BLOCK CAPITALS.**
- If you already have one of our healthcare plans and you are applying for a cover upgrade or for a new plan, please tell us about any medical conditions you have claimed for since joining us.
- The policyholder must sign Section 7.
- All adult applicants must sign Sections 8 and 11. In line with our legal obligation for processing data, we won't be able to process your application without these signatures. A parent or guardian should complete these sections for any applicants under the age of 18.
- All adult applicants wishing to appoint a broker as the main point of contact for this policy must sign Section 9.

**Just for clarity...**

You will see that we often refer to the following phrases in this form. This is what we mean:

**Home country:** A country for which you (or your dependants, if applicable) hold a current passport or which is your principal country of residence.

**Principal country of residence:** The country where you and your dependants (if applicable) live for more than six months of the year.

**Please select your policy terms by ticking the relevant box below:**

- Moratorium Terms\*
- Full Medical Underwriting Terms\*\*

**\* Moratorium Terms**

refer to a waiting period of 24 months from either the start date or the date shown in the special terms section of the Insurance Certificate that must have passed before claims for any pre-existing medical conditions may become eligible under the plan. This includes the underwriting term CPME/CTT previously MORI. Once the insured members have completed a continuous 24-month period after their start date, their pre-existing medical condition may be covered, provided that they have not had symptoms, needed or received treatment, medication, a special diet or advice, or had any other indications of the condition.

**\*\* Full Medical Underwriting Terms**

refer to the assessment of insurance risk based on information that you give us when applying for cover. Our underwriting team uses this information to decide the terms of our offer.

**If you are applying for a policy with moratorium, the below doesn't apply to you so you can skip to section 1.**

**Are you completing this form to join an existing company policy?** Please state:

Group name

Group number

**If you are already included in your company policy and you want to add a new dependant,** please state your policy number:

**What will happen next:**

- 1. Once you have sent us your application, our Medical Underwriting Team will review the details.
- 2. If you have told us about any medical conditions, we may ask you for more information. We will then assess the information and get back to you with our decision as quickly as possible.
- 3. If any person applying for cover is undergoing dental treatment, please ensure that you complete a dental questionnaire as well. This can be requested by calling our Helpline.

## 1 Applicant's details (The applicant will be the policyholder)

Your contact details will also be used to communicate with you on important things regarding your policy. You must tell us if your contact details change over time, so we can ensure that correspondence reaches you.

We will consider applicants for cover up to the day before their 76th birthday if applying for a policy with full medical underwriting, or up to the day before their 65th birthday if applying for a policy with moratorium.

Mr.  Mrs.  Ms.  Miss  Other

First name

Surname

Date of birth  /  /  Gender at birth: Male  Female

Home country

Nationality

Principal country of residence

Full address in principal country of residence (mandatory)

Primary phone number COUNTRY CODE  AREA CODE

Secondary phone number COUNTRY CODE  AREA CODE

Email address (mandatory, please print)

Occupation (mandatory – if you are a student, please state it)

**Details of any current domestic or international health insurance:**

Name of insurer

Policy number

Start date  /  /

## 2 Your dependants' details

You can add dependants to your policy. Dependants are your spouse/partner and any children financially dependent on you up to the day before their 18th birthday, or up to the day before their 26th birthday if they are in full-time education. If they are aged 18 to 25 and in full-time education, please attach either a letter from the college/university confirming their student status or a copy of their student ID. We will consider adult dependants for cover up to the day before their 76th birthday for policies with full medical underwriting, or up to the day before their 65th birthday for policies with moratorium.

If there is insufficient space for all dependants, please use another Application Form and ensure that all relevant Declaration(s) and Consent(s) are signed and dated.

	Dependant 1	Dependant 2	Dependant 3
Relationship to applicant	Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/>	Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/>	Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/>
First name			
Surname			
Date of birth	<input type="text" value="DD"/> / <input type="text" value="MM"/> / <input type="text" value="YYYY"/>	<input type="text" value="DD"/> / <input type="text" value="MM"/> / <input type="text" value="YYYY"/>	<input type="text" value="DD"/> / <input type="text" value="MM"/> / <input type="text" value="YYYY"/>
Gender at birth	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Occupation (mandatory, please state if student)			
Email address (mandatory for dependants over 18)			
Home country			
Principal country of residence			
Nationality			

### Details of any current domestic or international health insurance

Name of current insurer (if applicable)			
Current policy number (if applicable)			

## 3 Start date of your cover

From what date do you require cover?  /  /

You will have confirmation that your application for cover has been accepted when we issue you the Insurance Certificate. Your cover will be valid from the start date shown on the Certificate.

## 4 Plan details (this section does not need to be completed if you are applying as part of a group scheme)

### Select your area of cover:

The area of cover is subject to full terms and conditions as stated in the Benefit Guide.

Worldwide  Worldwide excluding USA

Next, please select the Core Plan and any optional plans that you require for your policy. Optional plans can only be purchased with a Core Plan; they can't be bought separately. You can find all details of the plans listed below in the Table of Benefits and Benefit Guide.

### Select your Core Plan

	Kuwait Care Pro	Kuwait Care Plus	Kuwait Care
Policyholder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> If you select Kuwait Care, this Core Plan and any optional plans you select will apply to all persons included on your policy.
If you select Kuwait Care Pro or Kuwait Care Plus, you can either select the same Core Plan for all of your dependants (if any) or you can choose between Kuwait Care Pro or Kuwait Care Plus for each of your dependants:			
Dependant 1	<input type="checkbox"/>	<input type="checkbox"/>	
Dependant 2	<input type="checkbox"/>	<input type="checkbox"/>	
Dependant 3	<input type="checkbox"/>	<input type="checkbox"/>	



### Select your Out-patient Plan co-payment

Please note that either an Out-patient Plan co-payment OR a Core Plan deductible can be chosen. Where a co-payment is selected it is payable per person, per Insurance Year. Also, our premiums are expressed in whole numbers (i.e. without any cent), therefore, percentages may be slightly higher or lower than those stated below.

Optional Out-patient Plan co-payments		Discount
No co-payment	<input type="checkbox"/>	0% premium discount
10% co-payment, max. \$14 per visit	<input type="checkbox"/>	10% premium discount
20% co-payment, max. \$28 per visit	<input type="checkbox"/>	20% premium discount

## 5 Pre-existing medical conditions

### If you are applying for a policy with full medical underwriting:

Pre-existing conditions are medical conditions for which one or more symptoms have appeared at some point during your or your dependants' lifetime. This applies regardless of whether you or your dependants sought any medical advice or treatment.

We would deem any such condition to be pre-existing if we could reasonably determine that you or your dependants have known about it. Your policy will cover pre-existing conditions unless we tell you otherwise in writing.

We will also treat as pre-existing any medical conditions that arise between the date you complete the Application Form and the later of the following:

- The date we issue your Insurance Certificate, or
- The start date of your policy.

Pre-existing conditions will be subject to full medical underwriting and if they are not disclosed, they will not be covered. **Therefore, it is important that in the periods outlined above, you inform us if there is any change to your and your dependants' health status or to any material facts (facts likely to influence our assessment and acceptance of this application).** In addition, you will need to provide further information, if requested.

If you already have one of our healthcare plans and are applying for a cover upgrade or for a new policy, please tell us about any medical conditions you have claimed for since joining us.

### If you are applying for a policy with moratorium:

As you are applying for a policy with moratorium terms, we want to clarify the conditions and procedures that will apply to your moratorium cover. Please ensure that you read the definition below which summarises how the moratorium will work – the full terms and conditions are detailed in the Benefit Guide.

Moratorium (MORI) is a waiting period of 24 months from either your start date or the date shown in the special terms section of your Insurance Certificate that must have passed before claims for any pre-existing medical conditions may become eligible under the plan.

Your claim will not be paid if it's relating to a pre-existing medical condition, should one or more of the following have applied within the 24-month period before your start date (or the date shown in your Insurance Certificate):

- It could be reasonably foreseen that the medical condition would occur after your start date.
- The condition clearly showed itself.
- You had signs or symptoms of the condition.
- You asked for advice about the condition.
- You received treatment for the condition.
- To the best of your knowledge, you were aware you had the condition.

Once you've completed a continuous 24-month period after your date of joining, we may cover your pre-existing medical condition provided you've not had symptoms, needed or received treatment, medication, a special diet or advice, or had any other indications of the condition.

## 6 Your health

Please answer the following questions based on your own and your dependants' full medical history. You must disclose all material facts (i.e. facts likely to influence our assessment and acceptance of this application). If you are in any doubt about whether a fact is material, then you should disclose it to us.

Failure to disclose all material facts may invalidate the policy.

This health declaration is valid for two months from the date you complete and sign the form.

	Applicant	Dependant 1	Dependant 2	Dependant 3
Height	<input type="text"/> <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> cm
Weight	<input type="text"/> <input type="text"/> <input type="text"/> kg	<input type="text"/> <input type="text"/> <input type="text"/> kg	<input type="text"/> <input type="text"/> <input type="text"/> kg	<input type="text"/> <input type="text"/> <input type="text"/> kg

Please note: **only** if you are applying for a policy with moratorium, you don't need to complete the rest of this section 6 and you can now skip to section 7.

Have you used any form of tobacco in the past year? If yes, how much per day on average? 1 cigarette = 1 unit, 1 medium cigar = 2 units, 1 gram roll-your-own tobacco = 2 units, 1 pipe bowl tobacco = 2.5 units, 10mg e-cigarette nicotine = 1 unit, if none state NO	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/> <input type="text"/> /day	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/> <input type="text"/> /day	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/> <input type="text"/> /day	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/> <input type="text"/> /day
Do you drink alcohol? If Yes, how many units of alcohol do you drink per week? (1 short = 1 unit, 250ml beer = 1 unit, 1 glass wine = 1 unit, if none state NO)	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/> <input type="text"/> /week	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/> <input type="text"/> /week	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/> <input type="text"/> /week	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/> <input type="text"/> /week

**Has any person included in this application ever suffered from, been in hospital with, or had tests, investigations or treatment of any kind, for the following conditions?**

- Any heart or circulatory disease or disorder, such as, but not limited to, heart attack, coronary artery disease, vascular disease, irregular heartbeat, murmur, chest pain, clots, blood disorder, abnormal blood pressure, high cholesterol, etc. Yes  No
- Any dermatological disease or disorder, such as, but not limited to, psoriasis, dermatitis, eczema, allergy, acne, etc. Yes  No
- Any endocrine disease or disorder, such as, but not limited to, diabetes, pancreatitis, weight problems, gout or thyroid problems or other hormonal imbalances, etc. Yes  No
- Any eye, ear, nose and throat disease or disorder, such as, but not limited to, cataract, glaucoma, detached retina, hearing loss, ear infections, sinus problems, tonsillitis, adenoiditis, myopia with levels greater than -6, etc. Yes  No
- Any gastrointestinal disease or disorder, such as, but not limited to, stomach problems, hernia, haemorrhoids, gall stones, colon polyps, Crohn's disease, colitis, liver problems, etc. Yes  No
- Any infectious or viral disease or disorder, such as, but not limited to, hepatitis A/B/C, herpes, HIV, SARS-CoV-2 / COVID-19, malaria, meningitis, blood infection, sexually transmitted disease, etc. Yes  No
- Any muscular or skeletal disease or disorder, such as, but not limited to back, neck or joint pain, arthritis, fibromyalgia, joint replacement, any cartilage and/or ligament problem, carpal tunnel syndrome, etc. Yes  No
- Any neurological disease or disorder, such as, but not limited to, stroke, multiple sclerosis, epilepsy, neurodegenerative disorder, paralysis, seizures, migraine, Alzheimer's or other form of dementia, etc. Yes  No
- Any oncological disease or disorder, such as, but not limited to, any cancer, leukaemia, lymphoma, tumour, skin lesion, growth, lump, cyst, mole, polyp, naevus, etc. Yes  No
- Any psychiatric or psychological disorder, such as, but not limited to, attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, depression, anxiety, chronic fatigue syndrome, eating disorder, obsessive-compulsive disorders, phobic disorders, alcohol/drug problem, etc. Yes  No
- Any respiratory or lung disease or disorder, such as, but not limited to, chronic obstructive pulmonary disorder, sarcoidosis, asthma, bronchitis, sinusitis, shortness of breath, allergy, etc. Yes  No
- Any urological or reproductive organs disease or disorder, such as, but not limited to, kidney or urinary tract problem, menstrual impairment, fertility problem, fibroids, endometriosis, testicular or prostate problem, etc. Yes  No
- Any congenital disease or disorder present at or before birth, such as but not limited to adrenal hyperplasia, cystic fibrosis, down syndrome, haemophilia, heart defects, Huntington's disease, Klinefelter's syndrome, Marfan syndrome, malformations and spina bifida.  
Please do NOT disclose results of any genetic (DNA or RNA) tests as these are not required for the underwriting process. Yes  No
- Any other accident, injury, disease or disorder not already disclosed. Yes  No

**Please tell us whether you or your dependants:**

- Are currently taking any prescribed or over-the-counter drugs, medication, tablets or other treatment. Yes  No
- Are expecting to have a medical review, have been referred for further tests/investigations, or are awaiting results or any treatment due to accident, injury, disease or disorder. Yes  No
- Have undergone any tests or investigations within the last 10 years which resulted in referral for further medical advice or treatment, such as, but not limited to biopsy, colonoscopy, colposcopy, computed tomography (CT), mammogram, magnetic resonance imaging (MRI), Papanicolaou test (PAP) or prostate-specific antigen test (PSA), echocardiogram (Echo), ultrasound (US), etc. Yes  No

Please do NOT disclose results of any genetic (DNA or RNA) tests, as these are not required for medical underwriting.

r) Have experienced, within the past two years, any recurrent or ongoing symptoms or medical complaints NOT related to a condition already disclosed such as, but not limited to:

Yes  No

- Fever (103°F/39.4°C or above) and/or continuous cough
- Shortness of breath
- Hoarseness
- Severe/ongoing headache
- Mole or skin marking that has bled, changed or become painful
- Tingling
- Blurred or double vision
- Unexpected weight loss
- Bleeding per rectum, change in bowel habit or urine frequency
- Loss of sensation, seizures, loss of consciousness
- Abnormal bleeding
- Joint pain/stiffness

s) Have been, within the past 30 days, recommended or decided to self-isolate?

Yes  No

**Please complete the following question only if you are purchasing dental cover.**

t) Is any person included in this application currently undergoing or have they been advised to undergo any dental treatment, dental surgery, dental prosthesis, orthodontics or periodontics?

Yes  No

If yes, please complete our Dental Questionnaire. You'll find it here:

[www.allianzcare.com/en/international-individual-health-insurance/paper-applications/](http://www.allianzcare.com/en/international-individual-health-insurance/paper-applications/)

**Additional information for 'Yes' answers**

If you answered Yes to any part of the questions from a) to t) above, please provide details in the table below. Please tell us if a full recovery has been made or if you or your dependants have any medical condition or disease related to or arising from the original diagnosis. Please enclose supporting up-to-date medical reports/test results if possible.

Question	Name of the person affected by the medical condition	Diagnosis – where applicable state the area of the body affected (e.g. left arm, right foot)	Exact date of onset of the condition	Frequency and severity of symptoms	Date of last symptoms	Investigations, blood tests or readings (please include the dates, results and any diagnosis)	Past and current treatment (please include name, dosage and frequency of usage of medication and provide dates of when treatment started, how often it was required and when it ended)	Current status (e.g. any complications, complete recovery, recurrent or ongoing)

*If there is insufficient space in the table above, please use another Application Form*






## 9 Broker appointment (if applicable)

I authorise \_\_\_\_\_


INSERT NAME OF BROKER

For office use only — Agent details and stamp


to act on my behalf in relation to the administration of this policy. This may include the disclosure of sensitive medical information. This authorisation will remain in place until I ask Warba Insurance and Reinsurance Company KSC in writing to revoke it.

 Applicant's signature


/   /

 Dependant 1's signature

/   /

 Dependant 2's signature

/   /

 Dependant 3's signature

/   /

## 10 Your personal data

Allianz Care's Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process your personal data. You should read it before submitting any personal data to us. To read our Data Protection Notice, visit: [www.allianzcare.com/en/privacy.html](http://www.allianzcare.com/en/privacy.html)

Alternatively, you can contact us on +353 1 630 1301 to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, you can always contact us by email at: [AP.EU1DataPrivacyOfficer@allianz.com](mailto:AP.EU1DataPrivacyOfficer@allianz.com)

## 11 Data consent

We need your consent to collect and process your health and other personal data. **If you do not give explicit consent, we may not be able to provide you with your policy or process any claims you may be entitled to make.** If you agree, we will process your data for the following reasons and activities.


A parent or guardian should complete the consent for any member under the age of 18.

**I (the applicant), and the dependants named below agree with the following:**


Name of applicant	Name of dependant 1	Name of dependant 2	Name of dependant 3

- **Permission to collect, store and use my health data:** Warba Insurance and Reinsurance Company KSC may collect, store and use my health data to administer the policy, for example to provide me with a quote for insurance cover, underwrite the risks to be insured or process any claims. Warba Insurance and Reinsurance Company KSC may store my health data in accordance with the Consumer Code of the law applying to this insurance policy or with any other applicable law requiring the retention of the data.
- **Permission to obtain my data from third parties.** To provide me with insurance cover, underwrite the risks to be insured or process any claims, Warba Insurance and Reinsurance Company KSC may obtain my health and other data from physicians, nursing and hospital staff, other medical institutions, care homes, statutory health insurance funds, my plan sponsor, professional associations and public authorities. I agree to release all individuals at these institutions and Warba Insurance and Reinsurance Company KSC from their respective confidentiality obligations relating to my health data or other data that they have to share and use for the purposes stated above.
- **Sharing my data outside of Warba Insurance and Reinsurance Company KSC.** Warba Insurance and Reinsurance Company KSC may share my health and other data with the experts or institutions set out below. They will only use the data to the same extent and for the same purposes as Warba Insurance and Reinsurance Company KSC. I understand that Warba Insurance and Reinsurance Company KSC has put in place arrangements with these institutions to protect my data. I agree to release all individuals at these institutions and Warba Insurance and Reinsurance Company KSC from their respective confidentiality obligations relating to my health data and other data that they have to share and use for the purposes set out below:
  - With independent medical experts to enable them to assess insurance risks and any benefits to be paid to me or to the third party providing treatment or service to me under my insurance policy.
  - With service providers that perform certain services on behalf of Warba Insurance and Reinsurance Company KSC, such as risk assessments and claims handling, where:
    - these services involve the collection and use of my health and other data, and
    - Warba Insurance and Reinsurance Company KSC would not be able to administer my policy or pay any claims due to me without such data.
  - With co-insurers to distribute the coverage of the insurance risk jointly with other companies to which Warba Insurance and Reinsurance Company KSC issues the policy, and to handle claims jointly.
  - With other insurers/reinsurers that may be covering the same insurance risk at the same time (multiple insurance) to:
    - distribute the payment of any compensation that may be owed to me, or
    - collaborate in the detection or prevention of fraud and financial crime.


**If I change my mind about my preferences above, including withdrawing my consent to any of these items, I can let Warba Insurance and Reinsurance Company KSC know by emailing [AP.EU1DataPrivacyOfficer@allianz.com](mailto:AP.EU1DataPrivacyOfficer@allianz.com)**

 Applicant's signature


/   /

 Dependant 1's signature

/   /

 Dependant 2's signature

/   /

 Dependant 3's signature

/   /

## 12 Marketing preferences

I (the applicant) and my dependants agree that Warba Insurance and Reinsurance Company KSC may collect, use and disclose my personal data to provide me with marketing information. I understand that my personal data will only be used for the following reasons and activities, which I have expressly agreed to by ticking the boxes below.

Name of applicant	Name of dependant 1	Name of dependant 2	Name of dependant 3

Information that Warba Insurance and Reinsurance Company KSC sends about their products and services, including updates on their latest promotions and new products and services.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Information sent directly by the business partners of Warba Insurance and Reinsurance Company KSC on their products and services. I understand that you will disclose my relevant contact information to them for that purpose.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Such communications should be sent to me by the following methods:

Email	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-app notifications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 13 Payment details

Please don't make any payments until you receive your policy number.

Your premium will need to be paid in US Dollars by bank transfer.

### Payment frequency

Payments are subject to the following administration surcharges: 0% for annual payment, 3% for half-yearly payments and 4% for quarterly payments.

Please tick to indicate your preferred payment frequency:

	Annual	Half-yearly	Quarterly
Bank transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Please return your fully completed form by:

@ Email: [underwriting@e.allianz.com](mailto:underwriting@e.allianz.com)

🏠 Post: Allianz Care  
15 Joyce Way  
Park West Business Campus  
Nangor Road  
Dublin 12, Ireland

If you have any questions regarding this Application Form or the application process, please contact our Helpline on: + 965 1868 700 (calling from Kuwait) or +353 1 630 1301 (calling from outside Kuwait).

The insurer is Warba Insurance and Reinsurance Company KSCP, Commercial Registration No. (24982) Insurance Registration No. (4), WARBA Tower, Ahmad Al Jaber St., Sharq, P.O. Box 24282 Safat, 13103 Kuwait.

This policy is supported by AWP Health & Life SA, a limited company governed by the French Insurance Code and acting through its Irish Branch. Part of the Allianz Group, AWP Health & Life SA is registered in France: No. 401 154 679 RCS Bobigny. Irish Branch is registered in the Irish Companies Registration Office, registered No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. AWP Health & Life SA provides administration services and technical support for the policy. Allianz Care and Allianz Partners are registered business names of AWP Health & Life SA.

Policies are administered in Kuwait by Wapmed TPA Services Company, PO Box 26739 Safat 13128 Kuwait.