Insured by:

الأهلية للتأمين
Al Ahlia Insurance

Administered by:

Bupa

WORLDWIDE HEALTH OPTIONS APPLICATION FORM

IMPORTANT INFORMATION

This product is insured by Al Ahlia Insurance Company (Al Ahlia)

Please write clearly in black ink and BLOCK CAPITALS. Return this form to medical@alahlia.com or fax us on +973 1722 4870 or post to
Al Ahlia Insurance Company, PO Box 5282, Manama, Kingdom of Bahrain.
If you have any questions when completing this form, please contact your broker or call us on +973 1720 4467

We look forward to welcoming you as a member.
For full details of terms and conditions, please see a copy of our membership guide available on request.

Checklist - *please make sure*:

- ➥ you have read, signed and dated the declaration in section 12 ◯
- ➥ the information you have given in sections 1-11 is correct and complete ◯

We will not be able to process your application if this form is incomplete.

Please be sure to check the entire form.

1 MAIN MEMBER: YOUR PERSONAL DETAILS

The date you want your cover to start: D D M M Y Y *Your cover cannot start before the date we receive your completed application form.*

Title | First name

Other initials | Family name

Male / Female | Nationality | 1st Language

Occupation | Date of birth D D M M Y Y

Do you have current health cover with any other insurer, including Al Ahlia or Bupa? Yes ◯ No ◯
If Yes, please give details of your cover:

Name of other health insurer

How long have you been with this insurer D D D D

Name of plan / cover | Membership number

2 MAIN MEMBER: YOUR ADDRESS DETAILS *(please let us know straightaway about any change of address)*

Residency address *(your permanent or usual address in the country where you are resident. This should be the country in which you are living on the first day of your current membership year.)*	**Correspondence address** *(where membership documents cannot easily be sent to you at your residency address, please supply an alternative address to which they may be sent)*
Building name / number	Building name / number
Street	Street
Town/City	Town/City
Postal / zip / area code	Postal / zip / area code
Region	Region
Country	Country

If you have been living in the UK for 90 days or more out of the last 120 days at the start of your current membership year, then you are deemed resident in the UK. Does this apply to you? Yes ◯ No ◯ Do you have a residence in the USA? Yes ◯ No ◯

3 MAIN MEMBER: YOUR OTHER CONTACT DETAILS

Main contact (home)				Secondary contact (work)			
	Country code	Area code	Number		Country code	Area code	Number
Telephone				Telephone			
Fax				Fax			
Mobile				Mobile			
Email				Email			

4 ADDITIONAL PERSONS TO BE COVERED WITH YOU

1st additional person (1)

Title | First name

Other initials | Family name

Male / Female | Nationality | 1st Language

Occupation | Date of birth D D M M Y Y

Relationship to you

2nd additional person (2)

Title | First name

Other initials | Family name

Male / Female | Nationality | 1st Language

Occupation | Date of birth D D M M Y Y

Relationship to you

3rd additional person (3)

Title | First name

Other initials | Family name

Male / Female | Nationality | 1st Language

Occupation | Date of birth D D M M Y Y

Relationship to you

4th additional person (4)

Title | First name

Other initials | Family name

Male / Female | Nationality | 1st Language

Occupation | Date of birth D D M M Y Y

Relationship to you

If any of these additional persons have different home or correspondence addresses to yours, please write their name and addresses on a separate sheet and confirm you have done so by ticking here: ◯

5 DOCUMENTATION

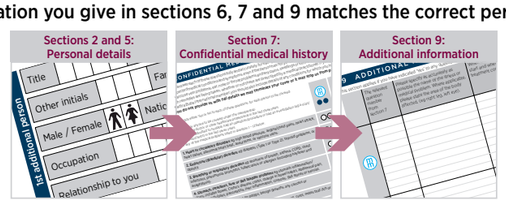
If you would like to view your membership documents online via MembersWorld instead of receiving them in the post, please tell us which email address you would like us to send the link to. Please choose one of the following options:

Main contact *(home)* ◯ Secondary contact *(work)* ◯ Other *(below)* ◯

Email

IMPORTANT INFORMATION

It is important that the information you give in sections 6, 7 and 9 matches the correct persons from sections 1 and 4.



Follow these icons when referring to yourself and additional persons

(mm) = Main member (1) = First additional person (2) = Second additional person (3) = Third additional person (4) = Fourth additional person

6 CONFIDENTIAL MEDICAL HISTORY

This section asks for health and medical details, past and present about yourself and each person named in Section 4. Please tick Yes or No to every question for every person. If you tick Yes to a question, please give full details in Section 7 on the next page. Please ensure you tell us about any known or suspected conditions and symptoms even if professional advice has not yet been sought.
If you are applying to increase cover and you are already a member of a Bupa International administered plan, you should also include details of any conditions for which you have made claims within the last seven years. This information will be passed to our underwriting team who will assess the terms of your plan.
If you do not provide us with full details we may terminate your cover or it may stop us from paying your claims.

Have you or anyone to be covered under the membership: ● seen a doctor or other healthcare professional in the last three years ● been admitted to hospital, had an operation/procedure or had an investigation (eg a scan/blood tests) in the last seven years for any of the medical problems listed in question 1 – 12 below:	mm Y N	1 Y N	2 Y N	3 Y N	4 Y N
1. Heart or circulatory disorders eg high blood pressure, angina/chest pains, heart attack, heart failure, abnormal heart beat, aneurysms, or varicose veins.	Y N	Y N	Y N	Y N	Y N
2. Endocrine (glandular) disorders eg diabetes (Type 1 or Type 2), thyroid problems, or obesity.	Y N	Y N	Y N	Y N	Y N
3. Breathing or respiratory disorders eg shortness of breath, asthma, COPD, chest infections, pneumonia, bronchitis, tuberculosis or allergies (including hayfever and anaphylaxis).	Y N	Y N	Y N	Y N	Y N
4. Stomach, intestines, liver or gall bladder problems eg stomach inflammation/ ulcers, irritable bowel, Crohn's disease, colitis, change in bowel habits, abdominal pain, haemorrhoids/piles, pancreatitis, liver inflammation, cirrhosis, gall stones or hernias.	Y N	Y N	Y N	Y N	Y N
5. Cancer, tumours or growths eg polyps, benign growths, any cancers or pre-cancerous condition.	Y N	Y N	Y N	Y N	Y N
6. Skin problems eg eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed, or allergic conditions.	Y N	Y N	Y N	Y N	Y N
7. Brain or nervous system disorders eg stroke, dementia, migraine, repeated headaches, multiple sclerosis, epilepsy/fits, nerve pain (including sciatica and shingles) or meningitis.	Y N	Y N	Y N	Y N	Y N
8. Muscle or skeletal problems eg arthritis, back pain, neck/shoulder problems, cartilage and ligament problems, joint replacements, fractures, osteoporosis, gout or inflammatory conditions.	Y N	Y N	Y N	Y N	Y N
9. Urinary or reproductive system problems eg kidney or bladder problems (including kidney failure), recurrent urinary infections, incontinence; pregnancy/childbirth problems (including caesarean sections), heavy or irregular periods, fibroids, endometriosis, infertility, abnormal smears, polycystic ovaries, testicular or prostate disorders.	Y N	Y N	Y N	Y N	Y N
10. Blood/infective/immune disorders eg abnormal blood tests, high cholesterol, anaemia; hepatitis, HIV, malaria; or any autoimmune disorder.	Y N	Y N	Y N	Y N	Y N
11. Eye, ear, nose, throat and dental problems eg cataracts, glaucoma, visual impairment; deafness, ear infections, tonsillitis; dental infections, wisdom teeth problems or gingivitis.	Y N	Y N	Y N	Y N	Y N
12. Psychiatric/psychological disorders eg schizophrenia, compulsive or eating disorders; depression, stress, anxiety or drug/alcohol dependency.	Y N	Y N	Y N	Y N	Y N
Please also answer the following questions:					
13. Is anyone to be covered taking any medication, prescribed or otherwise?	Y N	Y N	Y N	Y N	Y N
14. Is anyone to be covered receiving any treatment of any kind, or require or expect to require any review, investigations or treatment for any current or past medical problem not already mentioned in this application?	Y N	Y N	Y N	Y N	Y N
15. Has anyone to be covered experienced any signs or symptoms of any medical problem in the last six months, regardless of whether a health care professional has been consulted?	Y N	Y N	Y N	Y N	Y N
Further details (for over 16s only):					
How tall are you? feet/inches ◯ metres/centimetres ◯					
How much do you weigh? stones/pounds ◯ kilogrammes ◯					
Have you used tobacco products within the last seven years?	Y N	Y N	Y N	Y N	Y N

7 ADDITIONAL INFORMATION

This section applies if you have indicated 'Yes' to any questions in section 6. If you are unsure whether any details are relevant, you must include them.

	The relevant question number from section 6	Please specify as accurately as possible the name of the illness or medical problem. Where applicable, please state the area of the body affected, (eg right leg, left eye).	When did the symptoms start and when was treatment completed?	What treatment did you receive and when (please include dates, names and details of medications)?	What was the outcome of the treatment (eg ongoing, complete recovery, recurrent or likely to recur)?
mm					
1					
2					
3					
4					

N.B. Please tell us immediately if you or any additional persons to be covered under the membership experience any symptoms before you receive your membership documents. Failure to do so may affect your claims.

If there is insufficient space, please use a separate sheet and indicate that you have done so by ticking here: ◯

8 IF YOU HAVE A DOCTOR, PLEASE FILL IN THE DETAILS BELOW

Doctor's name	
Full postal address	

Your consent to your doctor to disclose medical information.
On behalf of myself and each person named on this form, I authorise this doctor to provide Al Ahlia and Bupa International with any information they ask for in connection with my membership application and any claims (past, present and future). Please tick here to give your consent: ◯

If any family members included in your application have a different doctor, please give the name and / or address details on a separate sheet - and confirm you have done so by ticking here: ◯

9 CHOOSE YOUR COVER OPTIONS

	mm	1	2	3	4
Worldwide Medical Insurance For treatment received whilst staying in hospital, either overnight or as a day-case, plus related benefits. Worldwide Medical Insurance gives you the reassurance of covering essential hospital treatment you may need, whether in an emergency or a planned visit. Surgery, cancer treatment and advanced imaging, whether received whilst staying in hospital or as a visiting patient, are also included.	**Each member to be included on this plan automatically receives cover for Worldwide Medical Insurance, our core cover. Please tick the options you wish to add for you and any additional people.**				
Worldwide Medical Plus: For specialist treatment where you do not need to stay in hospital. Worldwide Medical Plus covers you for consultations with a doctor or specialist and medical treatments that do not require a hospital stay. These may include osteopathy or complementary therapies, for example. Some of these treatments or consultations may take place before or after a hospital stay, but many will be totally independent.	◯	◯	◯	◯	◯
Worldwide Medicines and Equipment: For prescribed medicines and medical equipment. Often, treatment does not end when you leave the hospital or clinic or after you have seen a specialist. This option covers you for prescription medicines and the rental of medical appliances, such as oxygen supplies or wheelchairs. Our unique benefit for long-term prescriptions will also pay for any medicine required to manage chronic conditions such as asthma.	◯	◯	◯	◯	◯
Worldwide Wellbeing: For a range of health screenings, vaccinations, dental and optical treatment. Our Wellbeing option is designed to help you protect and maintain your health. It covers medical screenings that can provide valuable early detection of conditions such as cancer. It covers dental and optical treatments, which can play an important role in keeping you healthy by identifying underlying problems such as mouth cancer or diabetes.	◯	◯	◯	◯	◯
Worldwide Evacuation: For when you can't get the treatment you need in a local hospital. The Worldwide Evacuation option covers you for reasonable transport costs to the nearest suitable medical centre, when the treatment you need is not available nearby. Repatriation, which is also included, gives you the added option of returning to your home country or specified country of nationality, to be treated in familiar surroundings.	◯	◯	◯	◯	◯
Cover for pre-existing conditions: If you have a pre-existing medical condition, this option could provide you with the opportunity to be covered for it. If you would like to find out if we can cover you and to obtain a quote, please tick here. If your plan includes cover for pre-existing conditions, this cover does not apply in the USA.	◯	◯	◯	◯	◯
USA cover: If you spend most of your time in the USA, then you will need to buy USA cover on an annual basis. If you spend most of your time outside the USA, you can choose to add USA cover to your plan by ticking in this section. Please note, we do not cover permanent USA residents. This cover will increase your premium. If your plan includes cover for pre-existing conditions, this cover does not apply in the USA.	◯	◯	◯	◯	◯

Please refer to the membership guide for full details.

10 YOUR PAYMENT DETAILS *(DIRECT DEBIT, CREDIT CARD OR CHEQUE/BANKERS DRAFT)*

Your currency for your cover and subscription payments is USD($)

How will you make your subscription payments *(please tick one only):* Monthly ◯ Quarterly ◯ Yearly ◯

By credit card *(please complete the below Card Payment Authority):*

By cheque or bankers draft in the currency you have indicated above: ◯

Please fill in the name of the person paying the subscription in the box provided below when choosing to pay via cheque or bankers draft.

Name

11 CREDIT CARD

Card payment authority

To Bupa International on behalf of Al Ahlia, I authorise you, until further notice in writing, to charge to my card account, subscriptions and other unspecified amounts, as and when payments become due. I will advise you immediately if the card becomes lost, stolen or if I wish to close my card account or cancel the authority.

(please tick) MasterCard ◯ Visa ◯ American Express ◯

Please note that we do not accept Maestro payments.
You will be given 14 days notice of other unspecified amounts to be collected.

Cardholder's name as it appears on the card:

Card number: - - -

Valid from date: /

Expires/end date: /

Cardholder's signature

Date

12 YOUR MEMBERSHIP DECLARATION

This product is insured by Al Ahlia Insurance Company.

In view of the declaration below, it is essential that complete information is supplied.

Benefits may not be payable if you do not fully disclose any material facts which could influence our assessment and acceptance of this application and, if you are in any doubt as to whether any facts are material, you should disclose them. You are advised to keep a record of all information you supply to us in connection with this application, including letters. If you would like a copy of this application form, please ask us.

It is our intention to provide a first class service to members at all times.

However, if you have any comments or complaints, you can call the Customer Services helpline on +44 (0) 1273 323 563, 24 hours a day, 365 days a year. Alternatively you can email via www.bupa-intl.com/membersworld, or write to us at: Bupa International, Victory House, Trafalgar Place, Brighton, East Sussex, BN1 4FY , UK. If we have not been able to resolve the problem and you wish to take your complaint further, please write to our head of Customer Relations at: Al Ahlia Insurance Company, PO Box 5282, Manama, Kingdom of Bahrain.

For hearing or speech impaired members with a textphone, please call +44 (0) 1273 866 557. We also offer a choice of Braille, large print audio for our letters and literature. Please let us know which you would prefer.

I hereby apply to be enrolled as a Member with the Dependants listed above included in my membership. I declare that to the best of my knowledge and belief the information given in this Application is true and complete. I agree that the Rules of the Al Ahlia scheme will be binding on me and all eligible Dependants included in my membership. I agree that any cover which I may purchase for the USA shall terminate upon informing Al Ahlia or Bupa International that I have become a resident of the USA.

I confirm that I give explicit consent on behalf of myself and any family members specified in this form for Al Ahlia and Bupa International to process our personal information with respect to our membership and I confirm that I have brought the Data Protection Notice to the attention of these family members.

Data Protection Notice

Purpose: Personal data collected on you, and where appropriate, your family, will be used by Al Ahlia and Bupa International to process your claims, administer your policy and may be used to detect and prevent fraud or improper claims.

Confidentiality: The confidentiality of patient and member information is of paramount concern to Al Ahlia and Bupa International. To this end, Al Ahlia and Bupa International fully comply with Data Protection Legislation and Medical Confidentiality Guidelines. Al Ahlia and Bupa sometimes use third parties to process data on their behalf. Such processing, which may be undertaken outside the European Economic Area, is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by the Data Protection Act.

Medical Information: Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care, including your General Practitioner/Primary Health Physician, or to their agents, and, if applicable, to any person or organisation who may be responsible for meeting your treatment expenses, or their agents. Claims information may also be shared with appointed third parties involved in the management and handling of your claim. Claims information may be discussed with the Al Ahlia or Bupa International Agent/Adviser where you have requested the Agent / Adviser to assist you.

Member details: All membership documents and confirmation of how we have dealt with any claim you may make will be sent to the main member.

Telephone calls: In the interest of continuously improving our service to members, your call will be recorded and may be monitored.

Research: Anonymised or aggregated data may be used by Al Ahlia and Bupa International, or disclosed to others, for research or statistical purposes.

Fraud: Information may be disclosed to others with a view to preventing fraudulent or improper claims.

Names and Addresses: Al Ahlia and Bupa International do not make the names and addresses of members or patients available to other organisations.

Keeping you informed: Al Ahlia and Bupa International would, on occasion, like to keep you informed of Bupa International products and services which they consider may be of interest to you.

Contact Address: If you do not wish to receive information about Bupa International's products and services, or have any other Data Protection queries please write to the administrator's Head of Information Governance, at Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA or at DataProtection@Bupa.com.

For office use only	Identification stamp / broker name and ID number

IMPORTANT INFORMATION - YOUR MEMBERSHIP DECLARATION

Please be aware that this form must be received by Al Ahlia no more than six weeks after the declaration date.
It is advisable that you fill in your form with complete up-to-date medical history before you sign and date this form.
If we receive this form after six weeks from this declaration date, or with incomplete information, we will be unable to register your details and enrol you on the plan.

I also give consent to Al Ahlia to obtain my personal and medical information and that of my dependants (if any) from my previous insurer, if applicable. I confirm that I have brought this declaration and Data Protection Notice to the attention of such dependants.

Please use the checklist on the front of the form to ensure you have filled everything in completely.

Signature	Date