

Based on the above declarations, the insurer reserves the right to request additional medical reports/documents to complete the assessment of medical conditions.

Non-Disclosure and Misrepresentation: I understand that non-disclosure or misrepresentation of any material facts (including but not limited to the medical history declaration) may invalidate the quoted terms / the health insurance Policy and/or coverage of the undeclared medical conditions. I also agree that no indemnity will be paid under the insurance policy for Pre-existing Conditions which were not disclosed to the insurer at the date of this application. I understand and acknowledge that the coverage of pregnancy not declared in this application will be at the sole discretion of the insurer. The insurer has the right to not cover any maternity claims related 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.

I understand that “Pre-existing Condition means any Disease, Illness or injury for which treatment is received or experience symptoms, incurs expense, receives diagnosis from a physician (even if no treatment is provided) or was aware of at any time prior to applying for insurance” and acknowledge that non-disclosure, misrepresentation shall result in non-coverage of the condition and/or invalidate the policy.

I hereby agree with this in respect to both, myself and my Dependents that I am aware of the general terms of this insurance, and I accept them for myself and on behalf of my dependents. I, the undersigned, declare that all the above information as well as all declarations on the additional questionnaire (personal information) are true and complete. This information shall be considered as an integral part of the insurance policy.

Consent for Release of Medical Information: I hereby provide my Insurer and associated Third party administrator with full authorization to review my medical records across all hospitals and/or medical centers which I have ever visited whether before or after my insurance inception date. This includes all kinds of medical records whether related to services done on a cash basis or under other insurance coverage. I Acknowledge that the coverage under the policy shall be based on Medical Declarations in this application form and based on the information retrieved from my past medical history at the discretion of Salama and/or the authorized TPA.

Anti-Money Laundering: With reference to article (39) of Cabinet Decision No. (10) of 2019 Anti Money Laundering and CFT regulations, SALAMA is adherent to providing all requirements enforced by the regulator and authorities at domestic and international standards through supplementing essential requirements for the organization records and documentation purpose. By accepting the above statement, it includes your consent in permitting SALAMA – Islamic Arab Insurance Company to share such information with relevant authorities upon request. I hereby acknowledge that SALAMA is required to comply with regulatory provisions of Sanctions, Anti-Money Laundering and Combating Financing of Terrorism laws of United Arab Emirates (UAE) including those issued by UAE Central Bank, and I agree to provide all relevant details/records to SALAMA promptly upon SALAMA'S request.