HEALTH INSURANCE
PROPOSAL FORM

MUA

THE POLICY HOLDER

FULL NAME: .....

ADDRESS: .....

EMAIL: ..... TEL: .....

THE INSURED PERSON/THE EMPLOYEE/THE BENEFICIARY

SURNAME: .....

FIRST NAME(S): .....

NIC/PASSPORT NO.: .....

ADDRESS: .....

PHONE (W): ..... (H).: ..... (M): .....

EMAIL: ..... DATE OF BIRTH: ..... AGE: .....

GENDER: ..... MARITAL STATUS: .....

PROFESSION: .....

PLAN CHOSEN: Please tick appropriate

- **Individual**

☐ Prestige: A ☐ B ☐ C ☐ Complement prestige: E ☐ F ☐

☐ Essentiel: 1 ☐ 2 ☐ 3 ☐ 4 ☐

☐ Student care: 1 ☐ 2 ☐ Region: .....

☐ CFE: 1 ☐ 2 ☐

- **Corporate**

☐ Basic: In Patient Limit : ..... Out Patient Limit : .....

☐ Other: .....

- **Catastrophe** ☐ Limit: ..... ☐ Excess: .....

Bank name: ..... Branch: .....

Bank account number: .....

DEPENDANTS TO BE INSURED (spouse and/or children)

	SURNAME(S)	*NAME(S)*	*DATE OF BIRTH*	*RELATIONSHIP*	*SEX*	*AGE*
DEPENDANT 1						
DEPENDANT 2						
DEPENDANT 3						
DEPENDANT 4						
DEPENDANT 5						

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A complete answer must be given to each question. Every relevant material fact have to be disclosed, failing which, the contract will either be rendered void or rights under the contract being adversely affected.

DETAILS OF PREVIOUS OR EXISTING MEDICAL INSURANCE

Are you currently under a medical insurance cover? ☐ Yes ☐ No

If you answered "yes", please specify the following information:

Insurance company: .....

Expiry date of the Medical Insurance: .....

Will you maintain your Medical Insurance with the above mentioned Insurance Company? ☐ Yes ☐ No

If "no", please provide a testimonial from the previous Insurer stating the full period of cover, the previous limits and any exclusion or limitation of the previous cover for each beneficiaries who are currently insured.

The waiting period may be reduced depending on the period of the previous medical cover(s), and provided that there is no gap (uninsurable period of insurance) in joining our Healthcare scheme.

If no testimonial is provided, normal waiting period shall be applied.

Has any exclusion been applied on your previous cover or do you have any remaining balance for pre-existing conditions with your previous Insurer. ☐ Yes ☐ No

If you answered "yes", please give details:

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In case of pre-existing condition, an official document stating the amount still available with the previous Insurer remaining balance shall be requested. Moreover, please note that if the said document is not provided, all pre-existing conditions shall be excluded.

MEDICAL HISTORY

Has any one of the persons to be insured received any specific medical treatment or undergone any surgical intervention and/or performed any tests in a hospital/clinic? ☐ Yes ☐ No
If you answered "yes", which one:

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Is any one of the persons to be insured actually suffering from any illness, malformation, physical or mental handicap? ☐ Yes ☐ No
If you answered "yes", which one:

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Is any one of the persons to be insured currently undergoing medical treatment, under medical supervision and/or expecting to undergo medical treatment/surgery within the next 12 months? ☐ Yes ☐ No
If you answered "yes", which one:

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Has any one of the persons to be insured ever suffered or is suffering from any of the following illnesses listed below?

	MAIN MEMBER		DEPENDENT 1		DEPENDENT 2		DEPENDENT 3		DEPENDENT 4		DEPENDENT 5	
Hypertension	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Cholesterol	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Cardio vascular problems	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Liver problems	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Cancer, tumor, cyst or any other pernicious diseases	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Disorder of the respiratory system, lungs or chest	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Prolapsed disc, sciatica or scoliosis	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Any other illnesses	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

If you answered “yes” for any of the above, please give details for each applicable illness below:

NAME (Main Member / Dependent)	**NATURE OF ILLNESS**	**TREATMENT OR CONSULTATION DETAILS** (Date & Place)	**ADDITIONAL TREATMENT REQUIRED**

DECLARATION AND AUTHORISATIONS

UNDERTAKINGS

I hereby declare that all the information communicated is true and correct and that I have not withheld any information which would have influenced the Insurer's decision to accept or decline this application. I acknowledge that any false information will nullify this application and will render my insurance contract null and void.

I hereby authorize The Mauritius Union Assurance Cy. Ltd to seek, from my treating and/or family doctor and/or any medical centers, any information concerning my state of health and/or any treatments received and/or any pre-existing illnesses in relation to the present medical insurance application.

I hereby declare that I have been informed of the Terms and Conditions, waiting period, excess, main/special exclusions, limits regarding the cover, as well as the claims procedure of this medical insurance policy/policies and request to start this medical insurance policy/policies, as from 1st ..... 20..... subject to the above conditions, the present application does not constitute a valid cover note.

INTRODUCTORY AGENT

☐ I/We hereby certify that Mr/Mrs/Miss .....
is acting as my sole introductory agent.

GO GREEN

Authorisation to receive electronic communications

☐ Would you like to receive emails from MUA with information on our products/service, competitions, promotional offers and exclusive client discounts?

☐ I/We would agree that my Renewal Notices, Insurance Policies, Statement of Accounts and any correspondence pertaining to my policy be sent to the email address specified above. Consequently, I will no longer receive hard copies of my insurance documentation.

I/We understand that MUA Ltd including its subsidiaries and associates ("MUA") will use reasonable means to protect the security and confidentiality of information sent and received electronically. I am aware of the risks inherent to the emailing of documents, including but not limited to, documents being intercepted or misdirected to wrong recipients.

I/We undertake to hold MUA and/or any of its agents harmless against claims or demands and/or any consequences arising from the execution of the present instruction. I further undertake not to enter any action against the company and hereby irrevocably renounce to any rights I may have in relation to the present instruction.

With this registration, I am also entitled to send MUA my supporting documents by e-mail. I understand that my original documents will still be necessary for customer due diligence, claims or other specific cases.

I/We will be responsible for updating the designated e-mail address provided, as and when necessary. The present authorisation will remain valid until written revocation by me.

DATA PROTECTION

Data collection, retention & disclosure

The Applicant acknowledges, understands and agrees that MUA Ltd including its subsidiaries and associates (MUA) shall, for the performance of its obligations hereunder, collect and where necessary or required, process and store personal information which the Applicant hereby voluntarily discloses to it (the "Personal Data") for as long as is necessary to fulfil the purposes for which it was collected, including for the purposes of satisfying any legal, accounting or reporting requirements. MUA has a legal obligation to store basic information about its customers for ten year, except for specific loans cases or "les actions réelles" where it is thirty years, after they cease being customers. MUA undertakes to treat the Personal Data confidentially and securely in line with the provisions of the Data Protection Act 2017, (DPA) as amended from time to time.

MUA undertakes not to reveal or otherwise disclose the Personal Data to any external body, unless:

1. it has obtained the express consent of the Applicant(s), or
2. it is under either a legal obligation or any other duty to do so, or
3. the Personal Data is disclosed to any agent, service provider, professional adviser or any other person under a duty of confidentiality towards MUA.

The Applicant expressly acknowledges and agrees that the Personal Data may be shared within MUA solely for providing the Applicant with information about products that may be of interest to him/her.

Your rights

Pursuant to the provisions of the DPA and subject to the prescribed fee (if any) the Applicant acknowledges that he has, in relation to his Personal Data which is in the custody or control of MUA, the right:

1. to access to, to request rectification and erasure;
2. to object to the processing;
3. to withdraw consent at any time, without affecting the lawfulness of processing based on the consent which he had provided prior to his withdrawal.

Transfer to the Insurers Association of Mauritius ("IAM") for General Insurance Business

The Applicant understands and agrees that Personal Data shall be sent to the Insurers' Association of Mauritius and exchanged between relevant insurers through a common exchange portal at the time of a claim solely and exclusively for the purposes of the claims handling and recovery process.Transfer outside Mauritius

I/We expressly acknowledge and agree that the foregoing disclosures may require that the Personal Data be transferred to parties located in countries which do not offer the same level of data protection as the Applicant's home country.

Complaint

Should I/We wish to exercise any of the aforementioned rights or should I/We have any queries relating to the processing of his/her Personal Data, I/We may contact MUA Data Protection Officer at DPO@mua.mu. For more information on how your privacy is protected, please consult our MUA Data Protection Policy.

In case you are not satisfied with the reply provided, you may refer the complaint to the Data Protection Commissioner.

I/We acknowledge that the consent given in this Form applies to all Personal Data provided to MUA as from now on.

Full name of client: .....

Signature: ..... Date: .....

INTERNAL USE

Received by: ..... **Date:** .....

Decision:

- ☐ Approved
- ☐ Standard Conditions
- ☐ No Waiting Period

Remarks: .....

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