DRAFT BILL

Health Insurance Continuity Following Residence Permit Cancellation

Legislative Report | Bill Text | Appendix A

JudgeAI | September 2026

REPORT

JudgeAI Bill

LEGISLATIVE REPORT
To Accompany the Draft Administrative Resolution
Health Insurance Continuity Following Residence Permit Cancellation

Purpose and Summary

The proposed Administrative Resolution continues an eligible private-sector worker's existing health insurance during an otherwise uncovered period of lawful presence following cancellation of a residence permit. It amends Article 26 of Administrative Resolution No. (78) of 2022 through a prospective, employer-financed endorsement. The former insurer remains responsible for the existing package, including newly arising covered conditions, within the remaining policy limits. [1]

The instrument is a proposed resolution of the Director General of the Dubai Health Authority (DHA). It does not establish a federal insurance scheme or alter immigration status. References to the "Act" in this report mean the proposed Administrative Resolution.

Background and Need for Legislation

Article 26(a)(3) of the existing implementing bylaw provides continued coverage for 30 days after visa cancellation or until earlier departure. GDRFA guidance identifies a 60-day period of permitted stay after cancellation. These periods can leave an uncovered interval; they do not establish that every worker experiences one. The actual policy, individual immigration category, departure date, replacement insurance and available assistance determine the position. [1][3]

An interruption may affect established treatment or a new medical need arising during that interval. Existing emergency protections, replacement-policy safeguards, charitable assistance and affordable individual insurance form part of the baseline. A pending assistance application, however, does not establish timely access to equivalent protection. The proposal addresses the residual gap after those protections have been assessed.

Decision Logic Underlying the Selected Regulatory Architecture

The comparative assessment examined how each arrangement affects the ability of patients and those financing coverage to maintain essential activities. Continuing the previous package was preferred in the assessed circumstances because it protects both established treatment and newly arising covered needs. A narrower treatment arrangement reduced the concentration of financing costs but left greater exposure for a patient with a new condition.

The choice depends on the circumstances. When residual medical exposure was small and the former employer's financial position was sufficiently weak, the narrower arrangement became

preferable. The same occurred when existing arrangements actually supplied timely access to new care. These findings support case-specific eligibility and monitoring of financial burdens.

The draft specifies advance payment and allocation of employer credit losses to the insurer. These details change the timing and distribution of costs. They implement the selected approach but have not undergone a separate completed comparative assessment. The methodological appendix distinguishes that drafting refinement from the arrangement already assessed.

Reasons for Choosing an Integrated Package of Tools

An extension date alone would leave uncertainty about payment, proof of entitlement and claim handling. The proposal therefore combines automatic inclusion in future policies, advance employer payment, individual records, reasoned decisions, direct billing and complaints procedures. Employer nonpayment cannot terminate coverage under an issued policy; the insurer retains its recovery claim against the employer.

Eligibility considers practical access to replacement protection. A worker's declaration provides initial evidence, while the insurer may rebut it with specific verifiable information. This avoids requiring the worker to disprove every product or assistance programme. Existing limits, exclusions and lawful co-payments remain, preventing the endorsement from becoming an unpriced new annual package.

Alternatives Considered

Retaining current arrangements preserves existing protections but leaves the verified residual gap unresolved. Continuing only established necessary treatment through a financing pool reduces the burden concentrated on a former employer, but the assessed version excludes newly arising non-emergency needs. Continuing the previous package was selected on the existing assessment.

A broader pooled arrangement covering care that cannot safely wait, regardless of diagnosis date, was identified for further study. It was not included in the completed comparison. Neither that arrangement nor provisional payment before eligibility is established is silently added to this draft.

Section-by-Section Analysis

Section 1-Short title and application. Identifies the Resolution and limits its application to the specified private-sector insurance relationship and transition.

Section 2-Contents. Provides the operative section index for the Resolution.

Section 3-Definitions. Identifies the principal policy, former insurer, responsible employer, endorsement and relevant periods and authorities.

Section 4-Relation to existing law. Supplements Article 26 while preserving existing continuation, replacement and emergency protections and superior legal requirements.

Section 5-Eligibility. Requires a qualifying policy, cancelled residence permit, lawful presence and an actual residual coverage gap; a new diagnosis is not disqualifying.

Section 6-Replacement assessment. Requires actual, timely and affordable equivalent protection. A declaration is rebuttable by specific evidence; a pending charitable application is insufficient.

Section 7-Duration. Starts continuation after existing coverage ends and terminates it at the earliest specified event, including day 60 after cancellation. Annual policy expiry cannot defeat an attached obligation.

Section 8-Scope and limits. Preserves the previous package, remaining limits and applicable co-payments. It prevents restarted waiting periods and requires disclosure of remaining benefits.

Section 9-Mandatory endorsement and employer duties. Incorporates the endorsement into covered new and renewed policies and prohibits recovery of its cost from wages or final entitlements.

Section 10-Premium pricing and payment. Requires approved actuarial pricing and advance employer payment for the conditional obligation, with no health-based repricing upon activation.

Section 11-Return and accounting. Distinguishes earned charges from refundable unearned premium and requires calculation and timely return without impairing attached coverage.

Section 12-Notices and confirmation. Requires clear policy information, prompt cancellation notices and a next-working-day eligibility decision after sufficient information is received. Employer silence does not defeat entitlement.

Section 13-Direct billing and claims. Keeps responsibility with the insurer, preserves contractual direct billing and coordinates overlapping payments without transferring liability to charity.

Section 14-Default and solvency. Allocates employer credit losses under issued coverage to the insurer, preserves federal prudential rules and includes attached obligations in lawful portfolio transfers.

Section 15-Reasoned decisions and complaints. Requires specific reasons, free complaints and a two-working-day decision on coverage-confirmation complaints, subject to shorter mandatory deadlines and existing remedies.

Section 16-Data and records. Limits collection and disclosure to necessary information. Payment obligations do not entitle employers to diagnoses or unrestricted medical records.

Section 17-Reporting and review. Establishes quarterly aggregate reporting and a review after 12 months of mandatory application, including access failures and burdens on employers.

Section 18-Administration, rulemaking and accountability. Assigns implementation to existing authorities, sets preparatory deadlines and prevents subordinate measures from narrowing the Resolution's protections.

Section 19-Transition. Applies automatically to future issuance and renewal; permits separately approved, employer-paid additions to existing policies without retroactive repricing or reduced rights.

Section 20-Severability and commencement. Provides publication, staged commencement and preservation of provisions capable of lawful independent operation.

Budgetary and Federalism Considerations

The employer funds the endorsement. Its approved price must reflect claims, administration, reserves, reinsurance and accepted credit risk. No new public fund, compulsory inter-insurer pool, levy or State payment guarantee is created. Premiums are insurance consideration, not personal deposits; absence of a claim does not make the entire payment refundable.

DHA and DHIC incur implementation and oversight work. Existing approved resources are the initial basis; any additional expenditure requires a separate budget decision. Programme costs remain unquantified because transition volumes, duration, utilisation, remaining limits and administration costs have not been established.

The legal basis rests on the insurance functions and obligations in Law No. (11) of 2013 and the implementing framework. Federal insurer supervision remains applicable. The proposal does not alter residence permission, creditor priority or federal capital requirements. Employer prepayment does not eliminate insurer insolvency risk. [1][2][5]

Oversight, Reporting, and Evaluation

Quarterly reports distinguish active and activated endorsements, confirmation times, denials, complaints, premiums, refunds, claims, arrears and credit losses. They separately identify interrupted care, exhausted limits and unavailable replacement protection. No claim payment is not evidence of no medical need.

The 12-month review examines access and financial sustainability, particularly financially vulnerable employers. It also identifies remaining gaps: exhausted limits, unresolved eligibility and unavailable clinicians or medicines. Changes for future periods follow the competent approval process and cannot retroactively remove attached rights. Enforcement uses existing powers and applicable offences; the Resolution creates no new fine. Existing complaint rules

remain relevant alongside the proposed special deadline. [4]

Comparative Analysis of Current Law and the Act

Current law supplies post-cancellation continuation and replacement safeguards. The proposal adds a conditional period after existing protection ends, without extending lawful stay or exceeding its own 60-day outer limit. Existing policies retain their agreed prices until renewal; new and renewed policies include the endorsement automatically. An issued endorsement continues despite employer payment disputes. The worker receives a defined evidential procedure and access to reasoned decisions.

The 90-day preparation requirement, 120-day insurer submission deadline, 180-day mandatory commencement and two-working-day special complaint deadline are proposed provisions, not descriptions of current law. The final formal instrument requires the competent adoption procedure and official Arabic text.

Primary legal sources reviewed for this drafting file:

[1] Administrative Resolution No. (78) of 2022, particularly Articles 24 and 26.

Official source

[2] Law No. (11) of 2013 Concerning Health Insurance in the Emirate of Dubai.

Official source

[3] GDRFA, Cancellation of all types of residence permits.

Official source

[4] DHA Policy Directive PD-04-2025, Insurance Complaints Management.

Official source

[5] Central Bank of the UAE, current legislative framework for insurance supervision.

Official source

JUDGEAI BILL

UNITED ARAB EMIRATES

EMIRATE OF DUBAI

DUBAI HEALTH AUTHORITY

DRAFT ADMINISTRATIVE RESOLUTION

SEPTEMBER 20, 2026

A BILL

To amend Administrative Resolution No. (78) of 2022; to provide for the continuation of existing health insurance during a qualifying period following cancellation of a worker's residence permit; and to prescribe the financing, administration and enforcement of that continuation.

Be it enacted by the Director General of the Dubai Health Authority, by Administrative Resolution under Law No. (11) of 2013 Concerning Health Insurance in the Emirate of Dubai and Law No. (6) of 2018 Concerning the Dubai Health Authority, as amended, as follows:

TITLE I--PRELIMINARY PROVISIONS

SECTION 1. SHORT TITLE AND APPLICATION.

(a) Short title. This Resolution may be cited as the "Health Insurance Continuity Following Residence Permit Cancellation Resolution".

(b) Application. This Resolution applies to health insurance policies covering private-sector workers in the Emirate of Dubai that are issued or renewed on or after the mandatory application date, and to separate endorsements included in existing policies under section 19. Incorporation and financing of the endorsement shall precede a qualifying cancellation event. Continuation coverage shall be activated only upon satisfaction of sections 5 through 7.

(c) Responsible insurer. A duty to continue insurance under this Resolution shall be performed by the insurer responsible for the primary policy, subject to a transfer of insurance obligations authorised under applicable law. The cancellation of a residence permit shall not, of itself, transfer that duty to a different insurer or to a public body.

(d) Territorial and personal limits. Coverage under this Resolution shall remain subject to the territorial conditions of the primary policy and the requirement that the worker remain lawfully present in the United Arab Emirates. This Resolution shall not grant, renew or extend permission to reside, remain or work in the United Arab Emirates.

(e) Existing entitlements. The continuation required by this Resolution shall supplement the coverage otherwise available under the primary policy and applicable law. A person exercising an existing right shall not be required to exchange that right for a less favourable right under this Resolution.

(f) Administration. The Dubai Health Insurance Corporation shall administer this Resolution within its lawful functions and subject to the oversight of the Dubai Health Authority. A reference to an administrative function under this Resolution shall not transfer a function assigned by federal law to another authority.

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Resolution is as follows:

SEC. 3. DEFINITIONS.

(a) Defined terms. In this Resolution:

(1) AUTHORITY. The term "Authority" means the Dubai Health Authority.

(2) CORPORATION. The term "Corporation" means the Dubai Health Insurance Corporation exercising its functions within the Dubai Health Authority.

(3) EMPLOYER. The term "employer" means the person required to finance the worker's health insurance under the relevant primary policy. In relation to obligations attached to cancellation of a residence permit, it means the person bearing that responsibility immediately before cancellation. A subsequent change in employment shall not release that person from an obligation already incurred under this Resolution.

(4) WORKER. The term "worker" means an individual insured as a private-sector worker in the Emirate of Dubai under a policy governed by this Resolution. The use of that term after termination of employment shall not establish that an employment relationship continues.

(5) PRIMARY POLICY. The term "primary policy" means the health insurance policy covering the worker, together with its applicable terms, benefits and mandatory extensions. For determining continuation following a particular cancellation event, it means the policy under which the worker was insured immediately before that cancellation.

(6) PRIOR INSURER. The term "prior insurer" means the insurer responsible for the primary policy, or a lawful transferee of its obligations. The term includes an insurer that has closed the primary policy in its administrative system while an obligation under this Resolution remains outstanding.

(7) ENDORSEMENT. The term "endorsement" means the approved insurance condition requiring the prior insurer to provide continuation coverage upon satisfaction of this Resolution. The condition shall form part of a policy under section 9 irrespective of whether the insurer has issued a separate paper or electronic instrument evidencing it.

(8) CONTINUATION COVERAGE. The term "continuation coverage" means the coverage required by sections 5 through 8 after the end of the coverage otherwise available under the primary policy. It shall not constitute a new annual policy or restore an exhausted benefit limit.

(9) CANCELLATION DATE. The term "cancellation date" means the effective date on which the competent immigration authority cancels the worker's residence permit, as shown by that authority's record. It shall not mean the date of dismissal, notice of dismissal or closure of an insurance record unless those dates coincide.

(10) LAWFUL STAY END DATE. The term "lawful stay end date" means the final date on which the worker is individually authorised to remain in the United Arab Emirates following cancellation, as established by the competent immigration authority. A general description of a grace period shall not override the individual's applicable date.

(11) EQUIVALENT REPLACEMENT. The term "equivalent replacement" means insurance or another legally secured arrangement that is actually available to the worker within the required time and provides the protected services without reducing the protection required under section 8. A discretionary application for assistance shall not constitute a legally secured arrangement.

(12) AFFORDABLE PURCHASE. The term "affordable purchase" means acquisition of a replacement policy at a price that the worker can meet without foregoing expenditure

necessary for housing, food or necessary medical care for the worker and persons supported by the worker. The existence of a quoted price shall not establish affordability.

(13) REMAINING LIMIT. The term "remaining limit" means the unused amount or service entitlement available under the applicable limit of the last primary insurance period, after accounting for covered services chargeable to that limit and any correction of an erroneous entry.

(14) PROVIDER. The term "provider" means a person or facility lawfully providing the covered health service. Membership of an insurer's network and authorisation of a particular service shall remain governed by the primary policy and applicable law, subject to this Resolution.

(15) WORKING DAY. The term "working day" means a day counted as a working day for the relevant insurance procedure under applicable rules of the Authority or Corporation. A shorter mandatory period applicable to urgent care shall not be extended by this definition.

(16) MANDATORY APPLICATION DATE. The term "mandatory application date" means the date determined by section 20(b)(2).

(b) Other terms. A term not defined in subsection (a) shall have the meaning assigned to it by Law No. (11) of 2013 or Administrative Resolution No. (78) of 2022, as applicable. The Corporation shall use those definitions when preparing the standard endorsement and shall not enlarge eligibility by an inconsistent administrative definition.

(c) References. A reference to the primary policy shall include a more favourable enforceable condition relevant to the benefit in question. A reference to applicable law shall include binding federal requirements and instruments issued within the competence of the Authority and Corporation.

SEC. 4. AMENDMENT AND RELATION TO EXISTING LAW.

(a) Amendment. Article 26 of Administrative Resolution No. (78) of 2022 is amended by adding paragraph (e) as follows:

"(e) Following the end of coverage retained under paragraph (a)(3), or under a more favourable policy term, health insurance for a qualifying private-sector worker shall continue for the verified remaining period prescribed by the Health Insurance Continuity Following Residence Permit Cancellation Resolution. Continuation shall be provided by the responsible insurer and financed in accordance with that Resolution. This paragraph shall not reduce existing coverage, the mandatory period for its retention, protection on replacement of a policy, or rights to emergency care."

(b) Existing continuation. The prior insurer shall first determine the coverage that remains available under existing law and the primary policy. It shall not treat the additional coverage under this Resolution as satisfying an earlier period that the insurer was already required to cover.

(c) Replacement protections. The requirements applicable to replacement policies, continuity of insurance and authorised transfer of obligations under Article 26(c) of Administrative Resolution No. (78) of 2022 shall remain effective. A replacement shall not be recorded as operative solely because an application has been submitted or a future commencement date has been proposed.

(d) Price of a policy already in force. Nothing in this Resolution shall authorise an increase in the price of a policy already in force contrary to Article 24(d)(3) of Administrative Resolution No. (78) of 2022. Prospective application and separate voluntary endorsements shall be governed by section 19.

(e) Other jurisdictions and authorities. This Resolution shall not amend federal immigration, employment, insurance supervision, insolvency or public-finance law. A requirement for approval by the Central Bank of the United Arab Emirates or another competent authority shall remain applicable to an insurance product or transaction subject to that requirement.

(f) Existing liabilities. A person shall remain liable for a breach of an existing duty to arrange, finance or provide insurance notwithstanding that the conditions for continuation coverage under this Resolution are not satisfied. Failure to qualify for additional coverage shall not determine the merits of a claim arising under another legal provision.

(g) Rule of construction. An implementing form, system requirement or agreement shall not reduce a right established by this Resolution. Where a lawful policy term grants greater protection, the insurer shall apply that term to the extent of the greater protection without charging twice for the same insured service.

TITLE II--ENTITLEMENT AND COVERAGE

SEC. 5. CONDITIONS OF ENTITLEMENT.

(a) Conditions. A worker shall be entitled to continuation coverage where all of the following conditions are satisfied:

(1) The endorsement was in force on the cancellation date, whether incorporated by operation of section 9 or separately obtained under section 19.

(2) The worker was insured under the primary policy immediately before the cancellation date.

(3) Coverage under the primary policy, including mandatory continuation and any more favourable contractual period, has ended or will end before the worker's lawful stay end date.

(4) The worker remains lawfully present in the United Arab Emirates during the period for which continuation coverage is required.

(5) No equivalent replacement is available for the relevant period within the meaning of section 6.

(6) The period falls within the limit established by section 7.

(b) Individual determination. The prior insurer shall determine the conditions in subsection (a) by reference to the worker's actual policy, cancellation record, lawful stay and available replacement. It shall not infer that a worker is covered or uncovered solely from membership of an occupational group or from the date on which employment ended.

(c) Medical history. Entitlement shall not be restricted to a worker with a chronic condition, a previous diagnosis or a treatment prescribed before the cancellation date. A new medical need falling within the benefits of the primary policy shall be considered under section 8 on the same basis as another covered need.

(d) Administrative omission. Where an endorsement is incorporated by operation of section 9, absence of a separate endorsement, premium entry or confirmation document shall not prevent entitlement. The prior insurer shall correct the omission in its records without requiring the worker to secure a replacement contract from the employer.

(e) Absence of an insurance relationship. This Resolution shall not designate an insurer that was not party to the relevant insurance relationship as debtor for an uninsured worker. Existing duties and liabilities of the employer and any other responsible person shall remain enforceable under the applicable law.

(f) Determination before expiry. The prior insurer may determine prospective entitlement before primary coverage ends, using the information then available. It shall state the proposed commencement date and the conditions requiring correction if the worker obtains replacement coverage, leaves the United Arab Emirates or ceases to be lawfully present before that date.

(g) No duplicate premium at activation. Satisfaction of this section shall activate the obligation financed under sections 9 through 11. The insurer shall not require payment of an additional continuation premium by the worker as a condition of recognising the right or issuing the confirmation required by section 12.

SEC. 6. ASSESSMENT OF EQUIVALENT REPLACEMENT.

(a) Relevant arrangements. In assessing replacement, the prior insurer shall consider existing insurance, enforceable assistance and a qualifying opportunity to purchase replacement insurance. It shall identify the arrangement relied upon, its commencement date, eligibility conditions, protected services and any financial obligation imposed on the worker.

(b) Actual availability. A replacement arrangement shall be treated as available only where the worker can lawfully obtain and use it in the worker's current immigration and employment position, within the time required for continuity and without an uncovered interval. A product unavailable to a person with a cancelled residence permit shall not satisfy this requirement.

(c) Purchase opportunity. A proposed purchase shall qualify only if there is an actual offer to the worker, ascertainable terms, a commencement date that prevents the relevant gap, and an affordable purchase price. A general advertisement, illustrative quotation or statement that insurance products exist shall not establish a qualifying offer.

(d) Affordability. Where an insurer relies upon self-purchase, it shall identify the premium, payment date and other compulsory charges material to acquiring the policy. The worker may identify expenditure described in section 3(a)(12) that prevents purchase. The insurer shall consider that information and shall not equate gross salary previously earned with money presently available to make the payment.

(e) Initial evidence. The worker's statement that no equivalent replacement is available shall be sufficient initial evidence of that fact. The insurer may rebut the statement only by identifying specific, verifiable information showing a qualifying replacement and disclosing the material information to the worker in the decision under section 15.

(f) Limits on demands for proof. The worker shall not be required to prove the absence of every product or assistance programme in the market, obtain refusals from every insurer or charitable organisation, or apply for discretionary assistance as a precondition to consideration of entitlement. A request for further information shall identify the specific

disputed condition.

(g) Partial or discretionary assistance. An application awaiting determination, a possibility of charitable aid, or a discretionary promise shall not replace the protected package. Assistance legally secured for a particular service shall be accounted for under section 13 to prevent duplicate payment for that service, without being treated as a replacement of unrelated benefits.

(h) Subsequent replacement. After continuation coverage has commenced, termination on account of replacement shall occur when equivalent replacement actually begins under section 7(b)(1). A new advertisement or unaccepted offer shall not be treated as an insurance commencement event or retrospectively invalidate services already covered.

SEC. 7. COMMENCEMENT, DURATION AND TERMINATION OF CONTINUATION COVERAGE.

(a) Commencement. Continuation coverage shall commence on the day immediately following the actual end of primary coverage, including its mandatory continuation and any more favourable contractual period, if the conditions in section 5 are then satisfied. An administrative closing date shall not shorten a period of primary coverage that remains legally effective.

(b) Termination. Continuation coverage shall end upon the earliest of the following events:

(1) The commencement of an effective equivalent replacement.

(2) The worker's actual departure from the United Arab Emirates.

(3) The end of the worker's individually applicable lawful period of stay.

(4) The end of the sixtieth calendar day following the cancellation date.

(5) The death of the insured worker.

(c) Individual lawful period. Where the lawful stay end date precedes the date in subsection (b)(4), the earlier date shall govern. Permission to remain for longer than sixty days shall not, solely by reason of that permission, extend the coverage created by this Resolution beyond subsection (b)(4).

(d) Survival of obligation. If the residence permit is cancelled while the endorsement is in force, the prior insurer's conditional obligation shall survive subsequent annual expiry of the primary policy, technical closure of that policy or termination of the employment relationship. This subsection applies where the additional coverage begins only after annual expiry of the primary policy.

(e) No restart on re-entry. Departure ending continuation coverage shall not be disregarded because the worker later re-enters the United Arab Emirates. Re-entry shall not restart the sixty-day period or revive an ended entitlement under the same cancellation event.

(f) Record of dates. The insurer's confirmation shall identify the cancellation date, the end of primary coverage, the continuation commencement date and the latest possible termination date. Where the lawful stay end date is earlier, or replacement or departure occurs, the insurer shall record the actual termination event and date.

(g) Services before termination. A claim for a service properly received while coverage was in force shall be processed within the applicable claims period even if submitted or determined after coverage ends. Termination shall not release an accrued payment obligation, erase the service record or permit an earlier covered service to be reclassified as uninsured.

(h) Separate events. The insurer and employer shall maintain a distinction between employment termination, residence permit cancellation, primary policy expiry, departure and replacement commencement. An instruction referring only to one event shall not be used to substitute its date for another event relevant to entitlement.

SEC. 8. BENEFITS, LIMITS AND ACCESS TO COVERED SERVICES.

(a) Preserved package. Continuation coverage shall preserve the benefits, applicable provider network, territorial conditions, agreed co-payments and contractual exclusions of the primary policy, subject to any greater protection required by law or an enforceable policy term. The insurer shall not substitute a package limited to pre-existing treatment.

(b) New conditions. A newly arising disease, injury or other medical need shall be covered where the service falls within the preserved package and satisfies its applicable conditions. The insurer may apply a lawful exclusion or limit but shall not refuse the service merely because diagnosis, referral or first presentation occurred after cancellation of the residence permit.

(c) Remaining limits. Continuation coverage shall use the remaining limits of the last primary insurance period. It shall not create a new full annual limit. Where the policy contains different limits for different benefits, the insurer shall identify the applicable remaining limit for the benefit claimed and shall not substitute a different exhausted limit.

(d) Calculation of limits. The insurer shall record the opening remaining balance and covered amounts charged against it. A balance shall not be declared exhausted without a calculation identifying the relevant limit and charges. Correction of an erroneous charge shall be reflected in the balance and in the consideration of any affected claim.

(e) No duplicate deductions. A service paid under primary coverage and a service paid during continuation shall each be charged once to the applicable limit. Reopening, transferring or correcting a claim shall not result in a second deduction for the same service. A pending claim shall be distinguished from a finally settled amount in the statement of the balance.

(f) Waiting periods. No new waiting period shall be imposed solely because continuation coverage begins or an endorsement is activated. A waiting period already completed under the primary policy shall not be restarted. This subsection shall not enlarge a benefit otherwise excluded by a lawful term of that policy.

(g) Access and network changes. A network change shall comply with the rules otherwise applicable to the policy. The insurer shall inform the worker of the available route for obtaining a covered service under the applicable network and authorisation arrangements. Possession of an insurance card shall not, by itself, constitute performance of the insurer's payment and service-access obligations.

(h) Emergency care. Existing legal requirements relating to emergency care shall remain effective. A pending administrative determination under this Resolution shall not suspend those requirements or extend a mandatory clinical or claims deadline applicable to an emergency service.

TITLE III--ENDORSEMENT AND FINANCING

SEC. 9. MANDATORY ENDORSEMENT AND DUTIES OF THE EMPLOYER.

(a) Incorporation. Every health insurance policy issued or renewed on or after the mandatory application date and covering a private-sector worker in the Emirate of Dubai shall include the standard endorsement approved under section 18 for each such worker. Incorporation shall occur by operation of this Resolution and shall not depend upon a separate signature, form, invoice line or entry in an insurer's system.

(b) Employer payment. The employer shall pay the approved premium for the endorsement for each worker included in the primary policy. The premium shall be due before commencement of the endorsement. The employer shall make the payment to the insurer through the payment arrangements specified in the approved insurance documents.

(c) Effect of issuance. An insurer that issues or renews a policy subject to subsection (a) shall undertake the continuation obligation whether or not it has collected the separately attributable premium. The insurer may accept the employer's credit risk; the consequences of non-payment shall be governed by section 14 and shall not be transferred to the worker.

(d) Individual record. Under a group policy, the employer and insurer shall identify the workers included and the effective period of each endorsement. A group invoice shall not prevent the insurer from confirming an individual worker's coverage, determining the applicable balance or identifying the premium attributable to that worker.

(e) No recovery from worker. The employer shall not deduct the premium, security for its payment or debt collection costs from the worker's wages, compensation or final settlement. It shall not condition delivery of a required employment or insurance document upon the worker reimbursing such an amount.

(f) Notice to worker. The employer shall inform the worker whether the mandatory endorsement applies and when it takes effect. The notice shall distinguish an endorsement already effective from a future endorsement or an offer concerning an existing policy. A future arrangement shall not be represented as present insurance protection.

(g) Cooperation after termination. Termination of employment shall not release the employer from an obligation to pay a premium already due, transmit cancellation information under section 12 or supply an existing record necessary to identify the worker's insurance. The employer shall not require a new employment relationship as a condition of that cooperation.

(h) No duplicate charge. Where an endorsement already provides the protection required by this Resolution for the relevant worker and period, the insurer shall not impose a second charge for the same risk period merely because the endorsement is reissued in the standard form.

Any adjustment shall identify the additional obligation and comply with approved pricing and existing-law protections.

SEC. 10. PREMIUM APPROVAL AND PAYMENT.

(a) Prior submission. Before offering an endorsement, the insurer shall submit its terms and proposed premium to the Corporation for approval, together with the actuarial justification and operational arrangements required under section 18. Approval by the Corporation shall not dispense with a separate approval required under federal law.

(b) Contents of justification. The submission shall identify the insurance obligation priced and the assumptions material to expected claims, administration, reserves, reinsurance and employer credit risk. It shall distinguish costs of accepting the conditional obligation during the primary policy from costs associated with the period after that obligation is activated.

(c) Approved basis. The insurer shall apply only the approved premium and pricing method. It shall disclose the charge, the period and persons covered, the payment deadline, and the method for determining any refundable amount in the policy documents provided to the employer. An undisclosed charge shall not be collected from the worker upon activation.

(d) Medical condition at activation. The insurer shall not increase the price of an endorsement already in force because of a diagnosis established, a treatment requested or a claim submitted when continuation coverage is activated. Acceptance of the insured risk shall be determined under the endorsement effective on the cancellation date.

(e) Payment obligation and insured obligation. The deadline for the employer's payment shall not be construed as a condition defeating the worker's right under a policy already issued or renewed within section 9(a). A dispute over collection, invoicing or allocation shall be resolved between the insurer and the person liable to pay.

(f) Evidence of payment. The insurer shall maintain a record of the amount received, the payer, the workers and periods to which it is allocated, and any amount outstanding. A payment record shall be capable of correction where a payment was assigned to the wrong worker or period without requiring payment a second time for an obligation already discharged.

(g) No statutory monetary rate. This Resolution shall not establish a fixed premium in dirhams or authorise a rate that has not received the required approval. The Corporation shall not treat the maximum duration of coverage as a monetary tariff or as dispensing with the actuarial justification required by subsection (b).

(h) Prospective changes. A new rate shall apply only to the policies or endorsements and periods for which the change is lawfully approved. It shall not retrospectively increase an employer's agreed price or reduce an obligation already accepted by the insurer. Changes to an existing policy shall remain subject to section 4(d).

SEC. 11. ACCOUNTING AND RETURN OF PREMIUM.

(a) Separate disclosure. The insurance documents shall disclose the charge for the obligation and its administration and the method for determining the unearned part, if any, eligible for return. The insurer shall not describe the entire premium as an individual cash deposit held for the worker unless such an arrangement is separately established by applicable law.

(b) No claim and unearned premium. Absence of a claim, failure of a qualifying event to occur, or a worker's decision not to obtain care shall not, by itself, establish that the whole premium is unearned. The insurer shall apply the approved method to the obligation accepted and the period during which it was borne.

(c) Calculation. Recalculation shall take place under the disclosed, approved method after the relevant risk and coverage obligations have been finally determined. The statement shall identify the premium received, the earned amount, any remaining obligation affecting the calculation, the proposed refundable amount and the person entitled to receive it.

(d) Return. The insurer shall pay an amount determined to be refundable to the employer or other person legally entitled to its return not later than thirty calendar days after the amount is established. A refusal to return an amount claimed shall be accompanied by the calculation and the applicable ground for retaining that amount.

(e) Accrued obligations. Cancellation of the residence permit or closure of the primary policy shall not authorise return of a sum necessary to discharge an obligation that has already arisen. A return, charge reversal or accounting correction shall not terminate or diminish coverage owed to the worker under this Resolution.

(f) Policy rules. A more favourable applicable policy rule governing return of premium shall remain effective to the extent consistent with accrued coverage and the prevention of duplicate return. A return already made shall be recorded before a further return is calculated for the same person, period and payment.

(g) Disputed allocation. A dispute between an employer and insurer over the allocation of a payment or refundable amount shall not be treated as a medical exclusion or passed to a provider as evidence that an otherwise covered worker has no insurance. Undisputed coverage and claims shall continue to be administered under sections 12 and 13.

(h) Audit trail. The insurer shall preserve the connection between the original premium record, each adjustment, a return and the surviving insurance obligation. The record shall distinguish an accounting transaction from a lawful change in the dates or extent of coverage and shall be available to the competent supervisor under applicable law.

SEC. 12. NOTICE AND CONFIRMATION OF ENTITLEMENT.

(a) Initial confirmation. On issuing or renewing a primary policy incorporating the mandatory endorsement, or separately issuing an endorsement under section 19, the insurer shall provide the employer and worker with confirmation of its effective period, activation conditions, maximum duration, means of contact and complaint procedure.

(b) Employer notification. The employer shall notify the prior insurer of cancellation of the residence permit not later than the next working day after receiving confirmation of cancellation. The notification shall identify the worker and provide the cancellation record or information necessary for lawful verification of that record.

(c) Worker notification. The worker or the worker's authorised representative may notify the insurer directly. Failure or delay by the employer in notifying cancellation shall not extinguish entitlement where the objective conditions in section 5 are satisfied. The insurer shall not require the employer's separate consent to consider a direct notification.

(d) Relevant records. The insurer shall first use the policy, endorsement and payment information in its possession. For immigration status, it may use the cancellation document, evidence of the individual's lawful stay period and the prior insurance identifier. It shall not require a new active residence visa to establish a right arising specifically after cancellation of the previous permit.

(e) Missing information. If information necessary to determine a specific eligibility condition is missing, the insurer shall request it without delay and identify the complete outstanding requirement and its relevance. Information already held by the insurer shall not be requested again from the worker. The insurer shall record receipt and subsequent correction of the relevant information.

(f) Decision. Not later than the next working day after receipt of sufficient information, the insurer shall confirm entitlement or provide a reasoned refusal under section 15. A confirmation shall identify the protected package, applicable remaining limits, coverage dates, insurance identifier and route for obtaining covered care.

(g) Administrative delay. Where entitlement has arisen, delay in issuing a card or certificate or entering a record in a system shall not change the commencement date or release the insurer from payment for covered services. The insurer shall correct the record and process the service by reference to the period in which it was received.

(h) Unestablished entitlement. This Resolution shall not create a separate provisional payment entitlement before eligibility is established. This subsection shall not authorise withholding an undisputed existing benefit, denying the effect of subsection (g), or suspending duties relating to emergency care under applicable law.

SEC. 13. DIRECT BILLING AND SETTLEMENT OF CLAIMS.

(a) Insurer responsibility. The prior insurer shall remain responsible to the insured worker for performance of the continuation obligation and shall pay covered services through the applicable claims and settlement arrangements. Appointment of a third-party administrator shall not release the insurer from that responsibility.

(b) Direct settlement. Where the primary policy provides for direct settlement with a provider, the worker shall not be required to prepay the full covered charge in place of the insurer solely because continuation coverage is in force. Applicable co-payments and other lawful obligations of the insured person shall remain payable under the preserved policy terms.

(c) Verification. The insurer shall make the information necessary to verify continuation coverage available through its applicable verification arrangements. A provider's inability to read an updated card shall not, by itself, establish that a properly entitled worker is uninsured or that a covered service falls outside the continuation period.

(d) Claims rules. Authorisation, submission, determination and payment shall follow the deadlines and procedures applicable to the primary policy and the relevant service. The insurer shall not restart a completed waiting period or impose a new claims condition solely because the same policy obligation is administered as continuation coverage.

(e) Coordination. Where more than one legally effective arrangement covers the same service, the insurer shall coordinate settlement to prevent duplicate payment. The record shall identify the service, liable payer and amount already paid or payable. Coordination shall not be used to deny unrelated benefits or treat service-specific aid as replacement of the entire package.

(f) Charitable assistance. An expected charitable decision shall not displace an insurance obligation that has arisen. This Resolution shall not require a charitable organisation to reimburse an insurer, finance a worker's premium, guarantee a claim or accept liability for an employer's default. Any actual assistance shall be considered only within its lawful scope.

(g) Payment after expiry. An insurer shall not reject an otherwise valid claim solely because the continuation period ended before the claim was submitted or paid. Applicable submission limits shall remain effective, and the date of the covered service shall determine whether it falls within the insured period.

(h) Disputed and undisputed portions. In communicating a coverage dispute, the insurer shall identify the specific benefit, amount or period in dispute. An employer payment dispute shall not be included as a clinical ground for refusing authorisation, and an undisputed part of effective coverage shall not be suspended merely because a complaint concerning another part is pending.

SEC. 14. PAYMENT DEFAULT, SOLVENCY AND TRANSFER OF OBLIGATIONS.

(a) Employer default. After the insurer's obligation under an effective endorsement has arisen, refusal by the employer to pay, a pricing dispute or the employer's insolvency shall not terminate continuation coverage. The insurer shall retain its lawful right to recover the debt from the employer.

(b) Credit loss. An insurer that issues a primary policy with a mandatory endorsement, or separately issues an effective endorsement without collecting the corresponding premium, shall bear any unrecovered credit loss. The same rule shall apply if a payment is later reversed or otherwise not received. The insurer shall account for the risk in its price, capital and reserves as required by applicable law.

(c) Persons not liable. A loss described in subsection (b) shall not be collected from the worker, the worker's family, a charitable programme or a public budget by virtue of this Resolution. A recovery action against the employer shall not make the worker responsible for collection costs or require surrender of an accrued insurance right.

(d) Prudential requirements. Premiums, reserves, investments, capital and reinsurance shall remain subject to applicable federal law and competent insurance supervision. Approval of an endorsement by the Corporation shall not certify solvency or exempt an insurer from a prudential requirement.

(e) No special estate or priority. This Resolution shall not establish a separate personal deposit for the worker, a statutory trust over insurance assets or a special priority among creditors in an insurer's insolvency. A record identifying an individual premium or obligation shall not, of itself, create such an arrangement or priority.

(f) Portfolio transfer. A permitted transfer of the relevant insurance portfolio shall include both accrued and conditional obligations under the endorsements and the information required to perform them. Transfer shall be subject to the approvals and protection of insured persons required by applicable law.

(g) Continuity of records. In a transfer under subsection (f), the transferor shall identify the workers covered, cancellation events already notified, applicable remaining limits, pending claims and the periods for which conditional obligations survive annual expiry. Administrative transfer shall not restart a waiting period or reduce a surviving obligation.

(h) Insurer insolvency. In the event of the insurer's insolvency, the powers and procedures of the competent insurance supervisor and other competent authorities shall apply. This Resolution shall not create a new State guarantee of payment, impose an unapproved contribution on another insurer or designate a public fund as substitute payer.

TITLE IV--ADMINISTRATION AND REMEDIES

SEC. 15. REASONED DECISIONS AND COMPLAINTS.

(a) Reasons. A refusal, partial refusal or decision that coverage has ended shall identify the applicable eligibility condition or policy term, the relevant facts, the period or service affected, the calculation of a limit where relied upon, and the available complaint procedure. A statement that the system shows no active card shall not replace determination of the underlying right.

(b) Evidence of replacement. Where refusal rests on equivalent replacement, the decision shall identify the arrangement and the evidence of availability, timing, scope and affordability required by section 6. The insurer shall disclose material information sufficient for the worker to contest that ground, subject to lawful protection of other persons' information.

(c) Access to complaint. The insurer shall receive a complaint without charging the worker a fee for its submission or consideration. A complaint may be made by the worker or an authorised representative through the insurer's applicable complaint channels. The insurer shall identify the decision or omission complained of and record the date received.

(d) Entitlement complaint deadline. A complaint concerning confirmation of continuation entitlement shall be determined within two working days after receipt. Where a shorter mandatory deadline applies, the shorter deadline shall govern. The determination shall address the disputed condition and communicate the result and reasons to the complainant.

(e) Clinical and emergency matters. A complaint concerning medical authorisation or emergency care shall remain subject to the special rules and deadlines applicable to that matter. The general entitlement deadline in subsection (d) shall not authorise deferral of an urgent clinical decision or replacement of an existing emergency procedure.

(f) Corporation channel. The worker may submit a complaint to the Corporation through its existing insurance complaint channel without awaiting an answer from the insurer, subject to the applicable admissibility requirements. The insurer's notice shall identify that channel. Existing language, time-limit and procedural requirements for that channel shall remain effective.

(g) Undisputed rights. Submission or consideration of a complaint shall not suspend an undisputed part of coverage already in force. An employer's refusal to cooperate, pay a debt or support a complaint shall not determine whether the worker has an accrued right under the issued policy.

(h) Other remedies. Existing administrative review and judicial remedies shall remain available. This Resolution shall not amend the periods for challenging a decision of the Authority,

confer judicial powers on an insurer or condition a statutory remedy upon surrender of a separate contractual or legal claim.

SEC. 16. INFORMATION, CONFIDENTIALITY AND RECORDS.

(a) Necessary information. A person administering this Resolution shall process only information necessary to establish insurance, cancellation, lawful stay, coverage dates, availability of replacement, payment of covered services or lawful supervision. A general request for unrelated employment, immigration or medical records shall not be justified by participation in this arrangement alone.

(b) Medical information. Access to a worker's diagnosis and treatment information shall be limited to persons requiring it for lawful performance of insurance, care or supervisory functions. The employer shall receive the information necessary to pay and account for its obligation; that responsibility shall not create an entitlement to the worker's clinical history.

(c) Financial information. Information about the worker's financial position shall be sought only to the extent necessary to determine a disputed claim that an affordable replacement is available. The insurer shall identify the specific affordability issue and shall not demand broader financial information merely because the worker applies for continuation coverage.

(d) Government verification. Exchange with immigration authorities or other public bodies shall require the legal basis and arrangements applicable to that exchange. This Resolution shall not constitute independent permission for unrestricted access to a government information system or for reuse of its contents for an unrelated purpose.

(e) Decision record. The insurer shall retain a record connecting the policy and endorsement with the notification, documents considered, coverage decision, applicable limits, claims, payment history, material corrections and complaints. Record retention, access, security and disposal shall comply with the requirements applicable to that information and function.

(f) Corrections. Where a material error in an insurance, date or claims record is established, the responsible person shall correct the record and its use in the affected determination. A correction shall identify the superseded entry and preserve the information required for lawful audit. It shall not erase evidence of an accrued payment or reporting obligation.

(g) Supervision and disclosure. Records shall be supplied to a competent supervisor on a lawful request within the applicable procedure. Reporting to the Corporation under section 17 shall use aggregated information; publication shall not disclose identifiable patient information, protected clinical records or confidential information beyond what applicable law permits.

(h) Service providers. Use of an administrator, information processor or other service provider shall not enlarge the purposes for which information may be used. The insurer shall remain responsible for the insurance obligations allocated to it and shall ensure that the records

needed to perform them remain available through lawful arrangements.

SEC. 17. REPORTING AND REVIEW.

(a) Quarterly reports. Insurers shall report to the Corporation quarterly in the standard form established under section 18. The form shall identify the reporting period, the population and policies included, the definitions used and corrections to a previous submission.

(b) Required information. Reports shall include aggregate information on:

(1) Effective and activated endorsements, covered periods, entitlement confirmations, refusals and stated grounds.

(2) Time taken to confirm entitlement, complaints and their outcomes, and administrative delays affecting an established right.

(3) Premiums, returns, claims, payments, unpaid employer amounts and unrecovered credit losses.

(4) Reported interruptions of care, exhaustion of limits and absence of equivalent replacement.

(c) Distinct events. A report shall distinguish an absence of a claim from an absence of medical need; a request refused from a request withdrawn; and an accrued obligation from a payment already made. The Corporation shall not prescribe a form that automatically classifies every worker with no paid claim as having had no need for care.

(d) Quality of information. Where an insurer corrects a material reporting error, it shall identify the affected period, field and corrected value. The Corporation shall maintain comparable reporting definitions and shall require the basis of a submitted aggregate to be ascertainable from the insurer's lawful records.

(e) Review. Twelve months after the mandatory application date, the Corporation shall submit to the Authority a review of access to covered care, approved premiums, refusals, employer financial burdens, payment default and adequacy of insurance provision. The review shall identify the data periods and any material limitations affecting its conclusions.

(f) Proposed changes. Where the review identifies a material threat to insurance availability or performance of obligations, the Corporation shall propose changes to the competent authority. A proposal shall identify the legal instrument required, the persons and future periods affected, and arrangements for preserving obligations already incurred.

(g) Protection pending review. Reporting, a pending review or a recommendation for change shall not authorise retrospective reduction of accrued coverage. A tariff or condition for a

future period shall be changed only through the applicable approval and publication procedure.

(h) Data protection. The Corporation shall publish or disclose aggregate information only within its lawful powers and with the protection required by section 16. Publication of a report shall not create a right to obtain an individual worker's medical record or employer payment history.

SEC. 18. IMPLEMENTING INSTRUMENTS, SUPERVISION AND ACCOUNTABILITY.

(a) Standard instruments. Not later than ninety days after publication of this Resolution, the Corporation shall approve the standard endorsement, requirements for actuarial justification, premium accounting and return, notifications, entitlement confirmation and reporting forms necessary for its administration.

(b) Insurer submissions. Insurers shall submit their products, proposed premiums and implementation arrangements not later than one hundred and twenty days after publication. The Corporation shall organise their consideration before the mandatory application date. A federal approval required for a product or transaction shall be obtained through the applicable federal procedure.

(c) Minimum contents. The standard endorsement shall identify the insured obligation, eligible workers, commencement and termination events, preserved package and limits, employer payment obligation, consequences of default, confirmation procedure and complaint channels. It shall incorporate sections 5 through 15 without conditioning the worker's right on a further employer authorisation.

(d) Limits on implementation. An implementing instrument shall not shorten coverage established by this Resolution, create an additional ground of refusal, transfer the employer's premium obligation to the worker, restore an exhausted annual limit or establish a new State guarantee. The Corporation shall refer a proposed change requiring a different legal authority to the competent authority.

(e) Publication. Instruments required for implementation shall be published in accordance with the applicable requirements for instruments of the Authority and Corporation. The applicable period between publication and binding operation shall be observed. A form not yet effective shall not be used to reduce rights under the policy or this Resolution.

(f) Supervision. The Authority and Corporation shall supervise compliance within their existing powers. In exercising those powers they may require the records and explanations lawfully necessary to determine compliance, direct correction where authorised and use the procedures otherwise applicable to insurance obligations and complaints.

(g) Liability. A sanction shall be imposed only where the conduct falls within an offence or contravention established by applicable law and through the prescribed procedure. This Resolution shall not establish a new fine, public fee, penalty tariff or source of revenue from enforcement. A breach shall not be assigned a monetary penalty by analogy to a different offence.

(h) Administration and public resources. Administrative functions shall be performed within lawfully approved resources. This Resolution shall not appropriate public money, establish an inter-insurer fund or authorise expenditure without the approval required by applicable public-finance law. An additional public resource requirement shall be referred for the necessary budget decision.

TITLE V--TRANSITION AND COMMENCEMENT

SEC. 19. TRANSITIONAL ARRANGEMENTS.

(a) New and renewed policies. Mandatory incorporation under section 9 shall apply to policies issued or renewed on or after the mandatory application date. For a worker included in such a policy, the insurer shall not rely on the absence of a separately executed endorsement to exclude the obligation established by this Resolution.

(b) Existing policy price and benefits. A policy already in force before that date shall retain its agreed price and protection until a lawful renewal or separate arrangement under subsection (c). This Resolution shall not require retrospective payment of a premium for an earlier uninsured risk period or retrospectively substitute new policy conditions for existing ones.

(c) Voluntary early inclusion. The insurer and employer may separately agree to include an endorsement approved by the Corporation in an existing policy. The employer shall pay the corresponding approved premium before the new obligation commences, subject to the insurer's responsibility for an effective endorsement that it issues. Inclusion shall not reduce the rights under the primary policy.

(d) Worker rights. An agreement under subsection (c) shall not require the worker to consent to deterioration of the existing package or surrender an accrued claim. Any greater protection retained under the primary policy shall continue to be administered together with the endorsement according to section 4(g).

(e) Cancellation before commencement. Where the residence permit was cancelled before the endorsement took effect, this Resolution shall not create a new right retrospectively in respect of that cancellation. Existing insurance rights, employer obligations and applicable assistance arrangements shall remain unaffected.

(f) Accurate notice. The employer and insurer shall distinguish present coverage from future coverage in notices, invoices, certificates and information supplied to the worker. An approved product awaiting commencement, a pending renewal or a proposed voluntary endorsement shall not be represented as an effective right to continuation coverage.

(g) Preparation. Approval of forms, submission of products, training and system preparation may be undertaken during the preparatory period established by section 20. Those activities shall not authorise early collection of an unapproved charge, premature termination of existing protection or refusal to perform a duty already imposed by law.

(h) Obligations after renewal or expiry. A change of insurer on a later renewal shall not release the prior insurer from continuation obligations already attached to a cancellation event during the effective period of its endorsement. Performance or lawful transfer of those

obligations shall be governed by sections 7 and 14.

SEC. 20. SEVERABILITY, PUBLICATION AND EFFECTIVE DATES.

(a) Publication. This Resolution shall be published in the Official Gazette. The Authority shall make the implementing information available through its applicable publication channels so that employers, insurers and insured workers can ascertain the operative requirements and dates.

(b) Effective dates.

(1) Section 18(a) through (e) shall take effect thirty days after the date of publication for the preparation, approval and publication of implementing instruments and products.

(2) The remaining provisions, including mandatory incorporation of the endorsement, shall take effect one hundred and eighty days after the date of publication.

(3) The ninety-day and one-hundred-and-twenty-day periods in section 18 shall be measured from publication of this Resolution and shall not restart when preparatory powers take effect.

(c) Severability. If a competent court or authority holds a provision of this Resolution, or its application to a person or circumstance, invalid, the remaining provisions and their valid applications shall remain effective to the extent that they can lawfully operate independently. This subsection shall not confer a power withheld by superior law or authorise a body to disregard a binding decision.

(d) Accrued rights and superior law. Severability shall not be construed to cancel an accrued insurance claim, validate an unlawful premium or alter a remedy governed by superior law. The competent authority shall give effect to a binding determination through the procedures available under applicable law.

(e) Implementing documents. The endorsement, forms and product approvals shall state the applicable commencement dates consistently with this section. An insurer or employer shall not substitute the date of a private administrative instruction for the statutory mandatory application date.

END OF BILL

APPENDIX A

Basis for Selecting the Regulatory Architecture

The completed assessment of 20 September 2026 examined a residual interruption of health coverage in Dubai after cancellation of a residence permit. It used the project's existing ontology, normative kernel, semantic and empirical compilation, consequence transformation, tensor/Domino propagation, Riemannian field and TI-minimax comparison. The normative premise was preservation of each person's capacity to act; it was not a monetary cost-benefit total.

The assessment contained ten factual actors, thirteen primary outcomes and three within-actor causal transitions. Proposed inter-actor transitions were not separately calibrated. The resulting field contained 1,246 roles and 1,425,424 cells per alternative, with propagation converging after fourteen waves. Roles are computational positions, not 1,246 observed people. These counts do not establish population representativeness.

Defined Terms Used in This Explanation

Normative Universe denotes the ontology and normative apparatus used to represent affected actors, conditions of agency and relevant consequences.

TI denotes the calculated threat index used by the existing comparison procedure. The scalar values below show the greatest modeled threat for each alternative; the selection procedure uses the full normative vector. TI is not a probability of illness, a premium rate or a measured percentage improvement in population welfare.

Relative calibration denotes comparative empirical judgments mapped to the existing scale. It does not require every input to be an exactly published probability. The conditional tests preserved the original reliability assessments.

Link-classes describes the legally consequential relationships through which coverage, payment, access and interruption affect represented outcomes. The term does not imply that every relationship mentioned in the final draft was separately calibrated.

Scenario Set and the Legal Choice Rule

Alternative A retains current policies, replacement safeguards, emergency protections, available assistance and affordable individual purchase. Alternative B continues the previous package during a verified uncovered lawful interval, financed by the former employer or subscribing sponsor. Alternative C finances established necessary treatment through a pool; its assessed scope excludes newly arising non-emergency needs.

The existing TI-minimax rule compares legally plausible alternatives from the represented actors' perspectives. The selected alternative minimizes the greatest modeled threat through the kernel's full-vector procedure. This supplies a normative choice within the represented situation; it does not enact a legal instrument or establish a universal ranking for all residents.

Eligibility matters to the scenario boundary. A person with an effective equivalent replacement is not assumed to experience the residual gap. Existing charitable assistance was included in the baseline; a pending application alone was not treated as receipt of care.

Statutory Mechanisms That Change Link-Classes

Sections 5-8 translate the selected coverage relationship into eligibility, actual replacement assessment, duration and benefit scope. Continuing the previous package protects new covered needs as well as established therapy. Remaining limits and existing exclusions constrain that protection.

Sections 9-14 specify the financing and performance relationships: automatic endorsement, employer prepayment, insurer responsibility, individual accounting, direct claims and allocation of employer credit loss. Sections 12 and 15-18 provide confirmation, complaints, limited data use and oversight intended to make the obligation operational.

This detailed financing version is designated B1 in the research file. Advance payment changes the timing of employer resource loss; insurer liability for employer default changes risk incidence. Those refinements were drafted after selection of B and have not received a separate completed semantic and numerical assessment. No independent outcome improvement is attributed to them here.

Computed TI Results Used for Selection

The completed original run reported:

- Alternative A, existing arrangements: greatest modeled TI 0.02777426; not selected.
- Alternative B, continuation of the previous package: greatest modeled TI 0.01039279; selected.
- Alternative C, pooled established treatment: greatest modeled TI 0.01323933; not selected.

The receipt identifier is e2_calc_8f1ee8a2c1c565f2245e948ebbdb4f0e. Three exact local replays reproduced the original input, winner and numerical results. Fourteen additional conditional variants tested joint medical and financial conditions, practical access and a selection boundary. They produced no new empirical observations or model API calls; the 559 protected source and data files remained unchanged.

B won eight of nine joint-grid cases. C won where residual medical exposure was low and the former employer was financially fragile. With the pool contributor's relative financial-threat intensity fixed at 0.20 in that low-residual profile, B remained selected at employer intensity 0.35 and C at 0.50. These adjacent scale levels are not premium percentages, currency amounts or a calibrated continuous threshold.

C also won the separate condition in which existing pathways supplied new-care access. B remained selected when that access worsened and when implementation of established treatment under C deteriorated. Reversal identifies a circumstance relevant to choice; it is not evidence of a calculation defect.

Selection Finding

The completed comparison selects B for the accepted situation. It supports a draft continuing the previous package and monitoring access and payer burdens. This appendix reports run-level comparative results, not an actuarial tariff or undisclosed coefficients.

The finding does not certify every detail of B1, establish insurer solvency, restore exhausted policy limits or fund care before eligibility is established. Final-text drafting checks are separate from normative recomputation. The preserved calculation supports the original architecture and the reported conditional findings only.