

Life & PHI Application Form

A. Applicant

- 1) Mr Mrs Miss Other: _____
- 2) Family Name: _____ 3) First Name: _____
- 4) Date of Birth: _____ 5) Nationality: _____
- 6) Place of Birth: _____ 7) Location of Assignment: _____
- 7) Occupation (please give full description): _____
- 8) Family Status: Married Divorced Single Other: _____
- 9) Vital Facts: Sex: Male Female Height: _____ (cm/ft) Weight: _____ (kg/lb)

B. Contact Details

PRINCIPAL RESIDENCE (where you are living or intend to live)

OTHER RESIDENCE (if applicable)

- | | |
|--|--|
| 1) Address: _____
_____ | 1) Address: _____
_____ |
| City: _____ | City: _____ |
| Postal Code: _____ | Postal Code: _____ |
| Country: _____ | Country: _____ |
| 2) Telephone (include country dialling code) | 2) Telephone (include country dialling code) |
| Home: _____ | Home: _____ |
| Office/Mobile: _____ | Office/Mobile: _____ |
| 3) Fax: _____ | 3) Fax: _____ |
| 4) E-mail: _____ | 4) E-mail: _____ |

C. Cover Opted For

- 1) Choose the Currency you wish your plan to be in: US Dollar (USD\$) Euro (EUR€) Sterling (GBP£)
- 2) Life Insurance: Yes No
Amount Requested (in your denominated currency): _____
- 3) Income Protection: Yes No
Annual Salary (in your denominated currency): _____
Deferred Period: 13 Weeks 26 Weeks 52 Weeks
Benefit Requested (up to maximum 75% of your salary in your denominated currency): _____

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

D. Health Declaration

STATEMENT OF HEALTH BY APPLICANT. ALL QUESTIONS MUST BE COMPLETED. FAILURE TO INCLUDE ALL MATERIAL MEDICAL INFORMATION OR PROVIDING FALSE INFORMATION MAY RESULT IN CANCELLATION OF COVER OR DENIAL OF CLAIM PAYMENT AT TIME OF CLAIM.

Please check (✓) box if any person for whom application is being made has been advised, counseled, tested, diagnosed, treated, hospitalised, or recommended for treatment within the last 10 years for the following: (If you answer YES to any question, please give complete details in Section E).

HEALTH HISTORY

- 1) Seizures or seizure disorder; paralysis; multiple sclerosis; or any disorder of the central nervous system. YES NO
- 2) Mental retardation; any mental, behavioural, emotional, or eating disorder; anxiety, depression, neurosis or psychosis; psychotherapy; psychological, marital or any form of counselling or therapy. YES NO
- 3) High blood pressure; heart attack; stroke; chest pain or palpitations; murmur; varicose veins, blood clot, anaemia or any other blood, heart, or circulatory disorder or condition. YES NO
- 4) Asthma, emphysema; bronchitis; sinusitis; pneumonia; allergies; apnea; or any breathing difficulty; lung or respiratory disease, disorder or condition. YES NO
- 5) Colitis; chronic diarrhoea or intestinal problems; hernia; ulcer of the stomach or duodenum; haemorrhoids or rectal disorder; hepatitis or liver disorder; gallbladder, pancreas, oesophagus, or any other digestive disorder or condition. YES NO
- 6) Cancer, tumour, growth, cyst, enlarged lymph nodes; psoriasis, keratosis, lesions of the skin or mouth, or any other skin disorder. YES NO
- 7) Disease or disorder of the breast; kidney, kidney stones; bladder; prostate; abnormal PSA, or any other urinary disorder or infection. YES NO
- 8) Disease or disorder of the genital or reproductive system; herpes, any sexually transmitted disease; endometriosis, or abnormal pap smear. YES NO
- 9) Been treated for infertility; taken any medication, or advised to seek treatment, diagnostic tests or surgery for infertility. YES NO
- 10) Arthritis; rheumatism; gout; TMJ (temporomandibular joint syndrome); any injury to or disease or disorder of the spine, back, jaw, bones, muscles, or joints; joint replacement; or chiropractic treatment. YES NO
- 11) Pituitary, adrenal, or thyroid disorder; lupus; diabetes. YES NO
- 12) Cataracts; glaucoma; or any eye disorder; hearing loss; or any ear nose, or throat disorder. YES NO
- 13) Alcoholism; alcohol, drug or substance abuse or dependency. YES NO
- 14) Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), HIV Positive, or other immune disorders. YES NO
- 15) Physical defect, infirmity, or congenital illness. YES NO
- 16) During the past 3 years, has any illness or injury prevented you from working? YES NO

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

D. Health Declaration - Continued

- 17) During the past 5 years, have you or any person to be covered or been advised to consult a medical practitioner for any significant physical impairment, deformity, sickness, operation, injury, or hospitalisation other than revealed above? YES NO
- 18) Do you or any person to be covered have or ever had a prosthesis, implant, monitoring device, or internal fixation (i.e. pins, plates or screws)? YES NO
- 19) Have any parents, children, or siblings suffered from cancer, diabetes, hyperlipidemia, chronic mental diseases before 50 years of age? YES NO
- 20) Has any person to be covered used drugs not prescribed by a doctor other than over-the-counter medications within the past 10 years? YES NO
- 21) Has any person to be covered been prescribed or taken any medication due to any disease, disorder, condition, injury or counselling in the past 12 months? YES NO
- 22) Is any person to be covered currently taking drugs or medication? YES NO
- 23) Has any person to be covered gained or lost more than 12 kilos (or 25 pounds) during the last 12 months? YES NO
- 24) Has any person to be covered been advised to have medical treatment, counselling, or surgery which has not been performed? YES NO
- 25) Are you or any person to be covered aware of any symptoms present now which may give rise to a claim? YES NO
- 26) Has any person to be insured smoked cigarettes or used tobacco in any form in the past 12 months? YES NO
- 27) Has any person to be covered ever been declined, postponed, rated, or limited for Life, Health, or Accident Insurance? YES NO
- 28) Has any person to be covered been hospitalised in the past 10 years for any reason? YES NO
- 29) Are you or any person to be covered currently pregnant? YES NO
- 30) Do you engage in any profession, sport, or hobby that could be considered hazardous? YES NO
- 31) Have you or any person to be covered had any major dental treatment in the past five years including dental surgery, periodontal treatment or crowns, bridgework, or dentures? YES NO
- 32) Are you or any person to be covered contemplating any dental treatment? YES NO

Additional information or observations: _____

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G. Representations, Acknowledgments and Authorisations

I apply for ANNUAL coverage as indicated herein, for which I am or may become eligible under the agreement. I acknowledge that should I cancel my plan part way through the policy year, I may still be liable to pay the balance of the premium if I have elected to pay the premium by instalments. I have read all the statements made herein, and represent that they are true and complete to the best of my knowledge and belief. I understand that failure to disclose information in this application may be the basis for cancellation of my HealthCare International membership or claims denial.

I hereby declare that I have read the information leaflet and that I have been informed of the terms and conditions of the insurance plan. I accept these terms and conditions and declare that to the best of my knowledge and belief, the statements made in this Application Form are true and complete.

I agree that there shall be no insurance until this application has been accepted by the Insurer, the first full premium has been paid and received by HealthCare International.

I authorise any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, insurance company, or other person or firm to provide the Insurer or their authorised representative information, including copies of records, concerning advice, care, or treatment provided to me and/or my dependents, including without limitation, information relating to mental illness or use of drugs or alcohol.

I understand that such information will be used by the insurer for the purpose of evaluating my application for health insurance, or by Insurer representatives involved in evaluating, determining, or administering claims for insurance benefits for me or my dependents. I understand that I or any authorised representative will receive a copy of this authorisation upon request.

I understand that upon receipt of a certificate of insurance and associated documents, if I am not entirely satisfied, I can cancel this application and receive a full refund of the premium I have paid (provided that I do not submit any claim), if I return my documents to HealthCare International within 14 days of the start of the policy.

HealthCare International confirm that in accordance with the European Union Data Protection legislation, personal data and information that you give us and that we hold on file for you, will not be given to any hospital and/or medical provider in connection to any claim or services provided by us. You also have the right to consult and rectify any error in the files the insurer holds on your behalf.

I authorise you to charge my card account unspecified amounts in respect of the premium for my annual HealthCare Plan as and when the premiums become due, until this instruction is countermanded by myself in writing. I understand that I will be notified at least 4 weeks in advance of my renewal date of the renewal premium amount.

Date Signed: _____ Signature of Applicant: _____

H. Method of Payment

Please choose how often you would like your premium collected.

1) **By Debit / Credit Card:** AMEX MasterCard VISA Diners Club Other: _____

Period of Payment: Monthly Quarterly Six Monthly Annually

Card Holder's Name: _____ Card Number: _____

Expiry Date: _____ Amount: _____

Billing Address (if different to Principal Residence): _____

2) **By Bank Transfer:** Provisional cover can only commence when the transfer has been completed. **(Annual Payments only)**

Please instruct your bank to make sure that the transfer identifies you as the source beneficiary of the transfer, and the CM/Policy Number.

Account Name: HealthCare International Bank: Barclays Address: 8/9 Hanover Square, London, W1A 4ZW, U.K.

Accounts:	Currency:	Sort Code:	Account:	IBAN:	SWIFT/BIC:
	US Dollar (\$)	203647	74341111	GB33BARC20364774341111	BARCGB22
	Euro (€)	203647	87250188	GB10BARC20364787250188	BARCGB22
	Sterling (£)	203647	20263397	GB88BARC20364720263397	BARCGB22

3) **By Cheque:** Made payable to HealthCare International **(Annual Payments only)**

Please put your name, address and CM/Policy Number on the back of the cheque. Provisional cover cannot commence until the cheque has cleared. Please note that for the time being we can only accept cheques drawn on banks with a UK banking licence – if you are not sure if your bank has a UK banking licence please check with your bank first.