Individual Application Form

A. Applicant

1) Family Name: _____ 2) First Name: _____

3) Date of Birth: _____ 4) Nationality: _____

5) Place of Birth: _____

6) Social Security Number (if any): Number: _____ Country: _____

7) Are you eligible for any Social Security or government plan or do you have any other medical insurance in force today?

☐ NO ☐ YES if YES, please give details: _____

8) Occupation (please give full description): _____

9) Family Status: ☐ Married ☐ Divorced ☐ Single ☐ Other: _____

10) Vital Facts: Sex: ☐ Male ☐ Female Height: _____ (cm/ft) Weight: _____ (kg/lb)

11) Broker (if any): _____

12) Referral (how did you hear about us): _____

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B. Contact Details

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

1) Address: _____

_____

_____

Postal Code: _____

Country: _____

2) Telephone (include country dialling code)

Home: _____

Office/Mobile: _____

3) Fax: _____

4) E-mail: _____

OTHER RESIDENCE ***(if applicable)***

1) Address: _____

_____

_____

Postal Code: _____

Country: _____

2) Telephone (include country dialling code)

Home: _____

Office/Mobile: _____

3) Fax: _____

4) E-mail: _____

5) Where would you like your policy documents to be sent? ☐ Principal Residence ☐ Other Residence

How would you like your policy sent? ☐ Airmail (standard) ☐ Courier (US$/EUR€ 75 or GBP£ 40 surcharge)

6) Where are you currently located should we need to contact you for more information? ☐ Principal Residence ☐ Other Residence

C. Spouse or Partner and/or Dependent Children To Be Insured

SPOUSE or PARTNER ***(Include your spouse or partner and any dependent children under age 21, or under age 25 if unmarried and a full-time student.)***

1) Family Name: _____ 2) First Name: _____

3) Date of Birth: _____ 4) Nationality: _____

5) Place of Birth: _____

6) Social Security Number (if any): Number: _____ Country: _____

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C. Spouse or Partner and/or Dependent Children To Be Insured continued ...

7) Is your spouse or partner eligible for benefits from any Social Security or government plan or employer plan or does she/he have any other medical insurance in force today? ☐ NO ☐ YES if YES, please give details: _____

8) Occupation (please give full description): _____

9) Vital Facts: Sex: ☐ Male ☐ Female

Height: _____ (cm/ft) Weight: _____ (kg/lb)

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DEPENDENT CHILDREN ***(For children age 21 or older, please attach proof of schooling)***

	Name	Date of Birth	Sex (M/F)	Height (cm/ft)	Weight (kg/lb)	Full-Time Student (Y/N)
1)						
2)						
3)						
4)						
5)						

Are any of the dependent children eligible for benefits from any Social Security or government plan or does she/he have any other medical insurance in force today? ☐ NO ☐ YES if YES, please give details: _____

D. Medical Cover Required

1) **Choose the area of cover you require:** ☐ World-wide cover Excluding USA ☐ World-wide cover Including USA

All plans automatically include full cover for medical evacuation, assistance, accident and emergency, whilst travelling anywhere in the world (including USA).

2) **Choose the Currency you wish your plan to be in:** ☐ US Dollar (USD$) ☐ Euro (EUR€) ☐ Sterling (GBP£)

3) **Choose the plan most suited to your needs:**

☐ **Plan 1 - HEALTHCARE EXECUTIVE**
☐ **Plan 2 - HEALTHCARE PREMIUM**
☐ **Plan 3 - HEALTHCARE PLUS**
☐ **Plan 4 - HEALTHCARE STANDARD**
☐ **Plan 5 - HEALTHCARE EMERGENCY PLUS**

Choose the Excess Option you wish to include:

*The Deductible for the **Emergency Plus Plan** is set at US$/EUR€ 2,000 or GBP£ 1,400.*

☐ Zero Deductible (only applicable to Premium and Executive Plans)
☐ US$/EUR€ 250 or GBP£ 175 Deductible
☐ US$/EUR€ 1,000 or GBP£ 700 Deductible

Choose your Co-Pay: ***This is limited to the first USD$/EUR€ 20,000 or GBP£ 16,500 of covered expenses.*** ☐ Nil ☐ 10% ☐ 20% ☐ 30%

Preferred start date: _____

E. Optional Cover

1) **PERSONAL ACCIDENT COVER**

All applicants over the age of 18 are automatically insured for Personal Accident cover up to USD$/EUR€ 25,000 or GBP£ 15,000. However, you can opt to have this increased in increments of USD$/EUR€/GBP£ 10,000 up to USD$/EUR€ 125,000 or GBP£ 115,000. (This option is not available to children under the age of 18). This amount must be in the same currency as your Plan above.

Please select additional amounts of cover required: Policyholder: _____ Spouse/Partner: _____

2) **DENTAL COVER**

Please select the members that require Dental Cover:

☐ Policyholder ☐ Spouse/Partner ☐ Child1 ☐ Child2 ☐ Child3 ☐ Child4

3) **TRAVEL OPTION**

Please select the members that require Travel Cover:

☐ Policyholder ☐ Spouse/Partner ☐ Child1 ☐ Child2 ☐ Child3 ☐ Child4

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

F. Health Declaration

STATEMENT OF HEALTH BY APPLICANT (to include Spouse or Partner and/or Dependent Children listed in Section C). 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 (including yourself, spouse or partner and dependents) has been advised, counseled, tested, diagnosed, treated, hospitalised, or recommended for treatment within the last 5 years for the following: (If you answer YES to any question, please circle the condition to which you are referring and give complete details in Section G).

HEALTH HISTORY

1) Do you or any of your dependents named in this application have any physical defect or infirmity? ☐ YES ☐ NO
2) Have you or any of your dependents suffered from any recurring illness or injury or taking prescribed drugs on a regular basis, whether or not medical attention was sought? ☐ YES ☐ NO
3) Have you or any of your dependents undergone a surgical operation or do you have reason to believe that a surgical operation will be required in the future? ☐ YES ☐ NO
4) Have you or any of your dependents consulted with a medical practitioner in the last two years or will need to do so in the foreseeable future? ☐ YES ☐ NO
5) Are you or any of your dependants involved in hazardous or dangerous activities or sport? If YES, please state activities and sports below. ☐ YES ☐ NO

(Eligible claims for Hernia and Kidney Stones will be subject to a 50% copay if claimed within the first 30 days. Any treatment or diagnosis of cancer within the first 30 days of the policy inception date will not be covered.)

Additional information or observations: _____

_____

G. Details to Health History

GIVE DETAILS ON EACH ITEM CHECKED (√) "YES" IN SECTION F.

Question Number	Person Affected	Condition / Diagnosis	Treatment (Surgeries / Medications)	Treatment Dates (From / To)	Ongoing or Date of Recovery	Name, Location or Telephone Number of Physician, Hospital / Institution
(If more space is needed, attach a separate page which must be signed and dated)						

H. Additional Health Insurance Information

1) Family Doctors *(if any)*

Name: _____
Address: _____
Telephone: _____
Fax: _____
E-Mail: _____

Additional Family Doctors *(if any)*

Name: _____
Address: _____
Telephone: _____
Fax: _____
E-Mail: _____

2) Current Cover

If you, your spouse or partner, and/or your dependent children are insured today, it is in your interest to send us a copy of your current policy, because the HealthCare International waiting periods may be removed if there is a "continuity" of cover between your current policy and the HealthCare International policy. If we remove the waiting period, we will confirm this to you in writing.

Current Policy and Insurer: _____ Expiration Date: _____

3) Additional Information ***Please provide any additional information on a separate sheet of paper.***

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

I. 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 HealthCare International 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 all medical and mental illness or use of drugs or alcohol.

I understand that such information will be used by Us 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 or use the policy in any way (e.g. visa application). I also acknowledge that the documents must be returned to HealthCare International within 14 days of the date of issue.

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: _____

J. 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: HSBC Address: 20 Eastcheap London EC3M 1ED, UK

Accounts:

Currency:	Sort Code:	Account:	IBAN:	SWIFT/BIC:
US Dollar ($)	400515	59763170	GB79MIDL40051559763170	MIDLGB22
Euro (€)	400515	59763197	GB29MIDL40051559763197	MIDLGB22
Sterling (£)	400231	81392816	GB47MIDL40023181392816	MIDLGB2106G

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.

Please Send Application Form To The HealthCare International UK Administration Office

HealthCare International
UK Administration Office
Tel: +44 (0)20 7590 8800 Fax: +44 (0)20 7590 8815
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enquiries@healthcareinternational.com www.healthcareinternational.com
United Kingdom