

Please complete this form in block capitals using black ink. For all sections please ensure you give an answer to every question. An incomplete form will delay the processing of your application.

SECTION 1. Your Personal and Cover Details

Please complete for all family members applying for cover.

A. Applicant	1.1 Details About You			
	First Name(s): Title: Mr / Mrs / Miss / Ms / Dr		Surname: (Family Name)	
	Date of Birth: DD/MM/YY	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height: <input type="checkbox"/> cm <input type="checkbox"/> in	Weight: <input type="checkbox"/> kg <input type="checkbox"/> lb
	Occupation:			
	Nationality on Passport:		Passport Number:	

B. Spouse	1.2 Details About Members of Your Family Applying for Cover			
	First Name(s): Title: Mr / Mrs / Miss / Ms / Dr		Surname: (Family Name):	
	Date of Birth: DD/MM/YY	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height: <input type="checkbox"/> cm <input type="checkbox"/> in	Weight: <input type="checkbox"/> kg <input type="checkbox"/> lb
	Occupation:			
	Nationality on Passport:		Passport Number:	

C. First Child (Below Age 19)	First Name(s):		Surname (Family Name):	
	Date of Birth: DD/MM/YY	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height: <input type="checkbox"/> cm <input type="checkbox"/> in	Weight: <input type="checkbox"/> kg <input type="checkbox"/> lb
	Nationality on Passport:		Passport Number:	

D. Second Child (Below Age 19)	First Name(s):		Surname (Family Name):	
	Date of Birth: DD/MM/YY	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height: <input type="checkbox"/> cm <input type="checkbox"/> in	Weight: <input type="checkbox"/> kg <input type="checkbox"/> lb
	Nationality on Passport:		Passport Number:	

E. Third Child (Below Age 19)	First Name(s):		Surname (Family Name):	
	Date of Birth: DD/MM/YY	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height: <input type="checkbox"/> cm <input type="checkbox"/> in	Weight: <input type="checkbox"/> kg <input type="checkbox"/> lb
	Nationality on Passport:		Passport Number:	

Tick if you have any further dependents and please provide details on a separate sheet.

1.3 Residential Address			
Street Address:			
Town/City:	State/County:	Postal Code:	Country:

1.4 Mail Forwarding Address - If different from address in Section 1.3			
Street Address:			
Town/City:	State/County:	Postal Code:	Country:

1.5 Contact Details	
Primary Telephone: + Country (Area) Number	Other Telephone: + Country (Area) Number
Fax: + Country (Area) Number	Email:

1.6 Select the Geographic Area of Cover You Would Like (Tick One)

<input type="checkbox"/> Area 1 - Europe	<input type="checkbox"/> Area 2 - Worldwide excluding the USA and Canada	<input type="checkbox"/> Area 3 - Worldwide*
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1.7 Select the Currency You Would Like (Tick One) - The plan currency also decides your premium currency

<input type="checkbox"/> GB Pounds (£)	<input type="checkbox"/> US Dollars (\$)	<input type="checkbox"/> EU Euros (€)
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***Important Note: USA Citizens & Persons Applying for Cover in the USA**

Effective Dates:

USA Citizens - If you or any family member applying for cover are located in the USA on the date of this application, the effective date of this insurance, if issued, will be the later of: **a)** The effective date requested on the application; or **b)** The date the insured person departs the USA; or **c)** The date the application is accepted and required payment is received and the GlobalSelect International Healthcare Cover, including a certificate of insurance, is issued.

Special Eligibility:

USA Citizens -

Is your expected length of stay outside the USA at least 6 of the next 12 months? Yes No (If your answer is NO, you are ineligible for this product.)
 Date you did (or will) Depart from the USA: ___/___/___ (DD/MM/YY)

Non USA Citizens applying for cover in the USA or located in the USA at time of application -

i) Are you or any family member present in the USA on the Effective Date of the Policy? Yes No

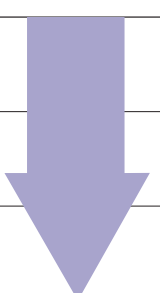
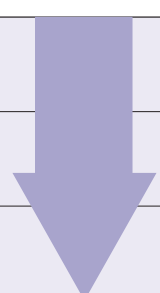

- If No, then no Affidavit of Eligibility is required, please proceed to Section 1.8
- If Yes, please answer question **ii** below

ii) Do you plan to be in the USA more than 6 of the next 12 months? Yes No

- If No, then no Affidavit of Eligibility is required, please proceed to Section 1.8

If You have answered Yes to the above two questions, an Affidavit of Eligibility (available from Us or Your Broker upon request) must be completed and submitted with Your Application. **Note:** If you are still located in the USA at Your Renewal Date and Your expected stay thereafter in the USA will be at least 6 of the following 12 months, You will need to complete an Affidavit of Eligibility at Your Renewal Date.

1.8 Select Which Sub-Plan You Would Like (Tick One Only) - The Voluntary Medical Excesses and premium discounts or increases apply only to the GlobalSelect International Healthcare Cover and not to optional add-on plans or to non-medical sections of cover.

HeadStart	Basic	Standard	Executive
<input type="checkbox"/> £100/\$180/€150 Standard Medical Excess	<input type="checkbox"/> £100/\$180/€150 Standard Medical Excess	<input type="checkbox"/> £50/\$90/€75 Standard Medical Excess	<input type="checkbox"/> £25/\$45/€38 Standard Medical Excess
VOLUNTARY MEDICAL EXCESSES			
		<input type="checkbox"/> Nil Excess 10% Premium Increase	<input type="checkbox"/> Nil Excess 10% Premium Increase
			<input type="checkbox"/> £50/\$90/€75 Excess 5% Premium Discount
		<input type="checkbox"/> £100/\$180/€150 Excess 10% Premium Discount	<input type="checkbox"/> £100/\$180/€150 Excess 10% Premium Discount
<input type="checkbox"/> £250/\$450/€375 Excess 20% Premium Discount	<input type="checkbox"/> £250/\$450/€375 Excess 20% Premium Discount	<input type="checkbox"/> £250/\$450/€375 Excess 20% Premium Discount	<input type="checkbox"/> £250/\$450/€375 Excess 20% Premium Discount
<input type="checkbox"/> £500/\$900/€750 Excess 25% Premium Discount	<input type="checkbox"/> £500/\$900/€750 Excess 25% Premium Discount	<input type="checkbox"/> £500/\$900/€750 Excess 25% Premium Discount	<input type="checkbox"/> £500/\$900/€750 Excess 25% Premium Discount
<input type="checkbox"/> £1,000/\$1,800/€1,500 Excess 30% Premium Discount	<input type="checkbox"/> £1,000/\$1,800/€1,500 Excess 30% Premium Discount	<input type="checkbox"/> £1,000/\$1,800/€1,500 Excess 30% Premium Discount	<input type="checkbox"/> £1,000/\$1,800/€1,500 Excess 30% Premium Discount
<input type="checkbox"/> £2,500/\$4,500/€3,750 Excess 35% Premium Discount	<input type="checkbox"/> £2,500/\$4,500/€3,750 Excess 35% Premium Discount	<input type="checkbox"/> £2,500/\$4,500/€3,750 Excess 35% Premium Discount	<input type="checkbox"/> £2,500/\$4,500/€3,750 Excess 35% Premium Discount
<input type="checkbox"/> £5,000/\$9,000/€7,500 Excess 40% Premium Discount	<input type="checkbox"/> £5,000/\$9,000/€7,500 Excess 40% Premium Discount	<input type="checkbox"/> £5,000/\$9,000/€7,500 Excess 40% Premium Discount	<input type="checkbox"/> £5,000/\$9,000/€7,500 Excess 40% Premium Discount
<input type="checkbox"/> £10,000/\$18,000/€15,000 Excess 45% Premium Discount	<input type="checkbox"/> £10,000/\$18,000/€15,000 Excess 45% Premium Discount	<input type="checkbox"/> £10,000/\$18,000/€15,000 Excess 45% Premium Discount	<input type="checkbox"/> £10,000/\$18,000/€15,000 Excess 45% Premium Discount

SECTION 2. Health Declaration

Please answer all questions for each applicant applying for cover.		If YES, show FAMILY MEMBER Using Letters from Section 1.
1. Are you or any other applicant currently disabled or unable to perform normal activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Are you or any other applicant presently hospitalised, or scheduled for or in need of hospitalisation or surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Have you or any other applicant ever had, been recommended to have, or are you currently on a waiting list for any organ transplant (other than corneal)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Do you or any other applicant participate in professional sports?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If any applicant answered YES to any of the above five questions, he or she does not qualify for this insurance. Thank you for your interest.		
6. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past 5 years? If yes, please complete Section 3.2.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. If a non-USA citizen, have you or any other applicant resided continuously in the U.S. for the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Are you or any other applicant currently pregnant? If yes, please provide due date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If any applicant answered YES to any of the above three questions, he or she may not qualify for this insurance.		

Questions 9 - 30 below must be answered for the applicant and every other member of your family applying for cover. For any question answered "YES," please identify the family member to whom the answer applies (use the letter that corresponds to the family member from Section 1), and provide complete details of the medical condition at issue in the space provided in Section 3.2 of this application, including the name, address and telephone number of all attending physician(s), diagnoses, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. IMG reserves the right to request additional medical information.

Health Declaration - Continued		If YES, show FAMILY MEMBER Using Letters from Section 1.
9. During the last 12 months, have you or any other applicant experienced manifestation or symptoms of, been diagnosed with, or received any consultation, examination, testing or treatment (including medications) for, any medical, health, mental, physical or nervous condition? If yes, please complete Section 3.2.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Have you or any other applicant ever had an application for health, life or disability insurance or reinstatement rejected, cancelled, rated, declined or modified? If yes, please explain in Section 3.2.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you or any other applicant ever experienced manifestation or symptoms of, suffered from, sought consultation, examination, testing or been treated for, or been diagnosed with, any disease, condition, illness, medical problem, disorder, sickness or other problem arising from, involving, or relating to any of the following:		
11. Heart, cardiac, cardiovascular and/or circulatory, including, but not limited to: congestive heart failure, heart attack, angina, chest pain, arteriosclerosis, atherosclerosis, elevated blood pressure, hypertension, swelling of feet/ankles, thrombosis, phlebitis, rheumatic fever, or heart murmur? If yes, in addition to Section 3.2, please complete the following: a. Date of most recent BP reading? _____ b. Result: _____ c. Medications taken (Types & Dosage) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Blood, blood vessels, spleen, arteries, veins or disorders of the blood, including, but not limited to: anaemia, haemophilia, leukemia, hepatitis, lymph glands, or high cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Diabetes, hyperglycemia or hypoglycemia? If yes to diabetes, in addition to Section 3.2, please complete the following: a) Diabetic Type: I ___ or II ___ b) Date diagnosed: _____ c) Controlled by diet only? Yes__ No__ d) Medications (Types and Dosage) _____ e) Date of most recent HbA1c Test? _____ f) Results of HbA1c Test (1 - 10) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Health Declaration - Continued	If YES, show FAMILY MEMBER Using Letters from Section 1.	
14. Asthma or allergies? If yes, in addition to Section 3.2, please specify which one and complete the following: a) Date diagnosed: _____ b) Has hospitalisation or emergency room treatment been required? If yes, describe and list date(s): _____ c) Please list known triggers: _____ d) Medications (Types and Dosage): _____ e) Frequency of attacks: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump, calcification or growth of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid or metabolic disorders, or obesity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
17. Kidney, urinary tract functions, kidney or bladder stones or infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
18. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy or pneumonia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
19. Mental and nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, chemical or drug abuse or dependency, alcoholism, psychiatric counseling and/or support groups, depression, anxiety, chronic fatigue, or eating or sleeping disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
20. Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebral ischemic attacks?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
21. Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease or disorder, vertebrae, degeneration or any other back or neck condition, rheumatism, arthritis, gout, tendonitis, osteoporosis or inflammation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
22. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice, diagnosis or treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
23. Congenital, genetic or hereditary or other birth condition or defect including, but not limited to: mental retardation, Down Syndrome, or other chromosome disorder, physical disorder, deformity or defect?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
24. Digestive system, stomach, or intestines, including, but not limited to: esophageal regurgitation, gastritis, ulcers, colon, or rectum disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Reproductive systems, including but not limited to: prostate or elevated PSA level, vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
26. Eyes, ears, nose, mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation, chronic sinusitis, or TMJ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
27. Any other disease, medical problem, illness, injury or condition of any kind not listed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
28. Do you or any other applicant currently use or during the past 5 years have you or any other applicant used tobacco in any form?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
29. Have you or any other applicant ever applied for or purchased insurance through IMG? If yes, please provide certificate number and details. Certificate Number: _____ Policy Undertaken: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
30. Are you applying for 'switch terms' to transfer from your existing medical insurance policy to a GlobalSelect plan? If yes, you need to complete and submit a GlobalSelect 'Switch Terms Application Form' with this Application Form.	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 3. Confidential Medical Information	
3.1 Medical Practitioner's Details - The name and address of my usual family doctor is as follows:	
Doctor's Name:	Telephone: + Country (Area) Number
Address:	
Country:	Postal/Zip Code:
Date Last Seen:	Reason:
<input type="checkbox"/> If the above details are different for any other applicant, please give details on a separate sheet and indicate that you have done so by ticking this box.	

3.2 Further Medical Information / Prior Insurance

For any question answered "YES" in Section 2, please identify each applicant for whom the answer applies (using the corresponding letter(s) from Section 1), and provide complete details of the medical condition at issue, including the name, address and telephone number of the attending physician(s), hospital(s), clinic(s) and all other health care providers involved, diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. **Please attach additional pages as necessary.**

Question Number From Section 2	Family Member (USE LETTERS FROM SECTION 1)	Condition(s)/Diagnosis, Prognosis, Past and Present Course of Treatment(s)	Physician/Hospital/Clinic/Health Care Provider Name(s), Address & Telephone	Date(s) of Treatment
		<input type="checkbox"/> (Tick if you have attached additional pages as necessary)		

If any applicant applying for cover has ever had an application for health, life, or disability insurance or reinstatement rejected, cancelled, rated, declined or modified (see Section 2, Question 10), please explain below.

(attach additional pages as necessary)

Declaration for GlobalSelect International Healthcare Cover:

AGREEMENT

I (we) understand and hereby agree that:

- (i) I (we) apply for insurance under GlobalSelect International Healthcare Cover.
- (ii) Cover will be provided in accordance with the Policy Wording; and I (we) will read it upon receipt and be bound by it unless I (we) cancel the plan within 30 days after receiving the Policy Wording.
- (iii) This Application will be the basis for and form a part of any insurance issued.
- (iv) I (we) have read all statements, questions and responses contained in this Application or they have been read to me (us) and I (we) understand them.
- (v) My (our) responses to the statements and questions contained in this Application are true, accurate complete and correctly recorded in all respects, and I (we) will supplement such responses prior to the requested effective date in the event of any change or addition thereto.
- (vi) The agent/broker assigned to or assisting with this Application is the representative of me (us) and is not an agent/broker of the Insurer, IMG or IMG Europe Ltd.
- (vii) No agent/broker has the authority to modify or waive any statement, question or response in this Application or to modify or waive any term of the plan, or to waive any of the rights or requirements of the Insurer, IMG or IMG Europe Ltd.
- (viii) No cover will be effective unless and until this Application has been duly accepted in writing by the Insurer, and there has been no change since the date of this Application Form in the insurability of all persons proposed for cover or in any responses to the statements and questions in this Application.
- (ix) The subjects, risks and benefits of insurance for which I (we) apply for cover under the plan are not intended or considered by me (us) to be resident, located or performed in any state of the USA or any particular country.

- (x) Premiums will be applied from the effective date forward and there will be no cover for any claim that begins prior to the effective date.
- (xi) Any misstatement, misrepresentation or omission contained in this Application will void the insurance applied for, and any and all claims and benefits under the plan will be forfeited and waived.
- (xii) The Insurer, IMG and IMG Europe Ltd., their employees, representatives, agents and any other persons or organisations performing services for them or on their behalf, may use, disclose or transfer to any organisation any information about me (us) obtained or collected in connection with this Application, (whether contained in this Application or otherwise) for the purpose of: (1) assessing this Application and providing on-going insurance and customer service; (2) processing and giving effect to credit/debit card payments; (3) providing marketing material in respect of insurance related services of IMG or its associated companies; and (4) processing claims or analysing the insurance.

AUTHORISATION

For purposes of determining my (our) insurability, I (we) authorise any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, pharmacy, medical records service, prescription history clearinghouse, other insurer, government agency, employer, social worker or family member to provide information about me (us), including my (our) entire medical record, to Sirius International Insurance Corporation (publ), International Medical Group, Inc. and IMG Europe Ltd., their employees, representatives, agents and any other persons or organizations performing insurance services for them or on their behalf. By my (our) signature below, I (we) acknowledge that any prior agreement I (we) have made to restrict or limit the disclosure of information about my (our) health does not apply to this authorisation.

This authorisation is valid from the date of my (our) signature shown below. A copy, image or facsimile of this authorisation is as valid as the original.

Signature of Applicant or Guardian: **X**

Date :

Signature of Spouse: **X**

Date :



**Global Personal Accident Plan /
Global Daily IndemnitySM - Hospital Income Plan**
Optional Additional Covers Application Form

IMG Europe Ltd
36-38 Church Road, Burgess Hill
West Sussex, RH15 9AE
United Kingdom
Tel: +44 (0) 1444 46 55 55
Fax: +44 (0) 1444 46 55 50
e-mail: info@imgeurope.co.uk

Underwritten by Sirius International Insurance Corporation (publ) (the "Insurer"). Administered, as agent for and on behalf of the Insurer, by International Medical Group, Inc. ("IMG"). Coordinated, as agent for and on behalf of the Insurer for the purposes of receiving premiums, receiving and holding claims money, and receiving and holding premium refunds by IMG Europe Ltd.

Global Personal Accident Plan and Global Daily Indemnity are only available at the time of application for, and with the purchase of, GlobalSelect International Healthcare Cover. To apply, simply complete Section 4 of this Application.

SECTION 4. Application For Global Personal Accident Plan and/or Global Daily Indemnity Insurance

Please indicate the name of each family member applying for Global Personal Accident Plan and/or Global Daily Indemnity.

	Name	Personal Accident First Unit of Cover	Personal Accident Second Supplemental Unit of Cover	Daily Indemnity Cover
A. Applicant		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Spouse		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. First Child		<input type="checkbox"/> Yes <input type="checkbox"/> No	NOT AVAILABLE	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Second Child		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
E. Third Child		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

	For each individual applying for Global Personal Accident Plan in respect of Accidental Death, please indicate:		% of Death Benefit
Applicant A	Primary Beneficiary Name	Relationship	%
	Address of Beneficiary	Phone No. + ()	
Applicant B	Contingent Beneficiary Name	Relationship	%
	Address of Beneficiary	Phone No. + ()	
Applicant C	Primary Beneficiary Name	Relationship	%
	Address of Beneficiary	Phone No. + ()	
Applicant D	Contingent Beneficiary Name	Relationship	%
	Address of Beneficiary	Phone No. + ()	
Applicant E	Primary Beneficiary Name	Relationship	%
	Address of Beneficiary	Phone No. + ()	
Applicant F	Contingent Beneficiary Name	Relationship	%
	Address of Beneficiary	Phone No. + ()	

Declaration for Global Personal Accident Plan and/or Global Daily Indemnity (If Applicable)

If accepted for the GlobalSelect International Healthcare Cover, I (we) understand that I (we) may qualify for Global Personal Accident Plan and/or Global Daily Indemnity underwritten by Insurer. I (we) hereby incorporate herein the certifications, representations, understandings, agreements, acknowledgements, authorisations, and warranties from the foregoing Application for the GlobalSelect International Healthcare Cover, and understand and agree that the terms, conditions, restrictions and penalties thereof shall likewise apply hereto. If a U.S. citizen, I (we) understand coverage for Global Personal Accident Plan will not be effective prior to the date of my (our) departure from the U.S. If I (we) have also applied for the

optional Global Daily Indemnity plan, I (we) understand that only overnight hospital stays eligible under my (our) GlobalSelect International Healthcare Cover, excluding pregnancies, are covered. I (we) also understand: (i) there is an additional premium for Global Daily Indemnity, (ii) that in the event this Application is not accepted, the premium will be returned to me (us) and neither party will have any obligation, right or liability under the plan, (iii) that the death benefit will be determined by my (our) age at the time of my (our) death, and (iv) that the Global Personal Accident Plan and Global Daily Indemnity are issued in England and are governed by the Laws of England.

Signature of Applicant or Guardian: X	Date :	Signature of Spouse: X	Date :
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SECTION 5. Method and Frequency of Payment - Please choose your method and frequency of payment. The currency you have selected for your plan will also be the currency in which your premium is to be paid.

<input type="checkbox"/>	A. Credit Card			
	Frequency of Payment <small>(Please Tick One Only)</small>	<input type="checkbox"/> Annually	<input type="checkbox"/> Semi-Annually	<input type="checkbox"/> Quarterly

Note: Choosing the semi-annual payment option results in total payments of 110% of the annual premium, choosing the quarterly payment option results in total payments of 112% of the annual premium, and choosing the monthly payment option results in total payments of 120% of the annual premium.

Your Credit/Debit Card Details

Credit Card Type: Visa MasterCard American Express Switch Solo Domestic Maestro

Full Card Number:

Start Date:	Expiry Date:	Issue No.: _____	Security Number: <small>(last 3 digits on signature strip or 4 printed on front of AMEX)</small>
		Issue Date: <small>(if applicable)</small>	

Name as on card:

Address to which card is registered:
(if different from the mailing address given)

Daytime Telephone: +(Country) (Area) Number

If paying by credit/debit card, I authorise IMG Europe Ltd. to debit my credit/debit card account above for the total amount due (including any insurance premium taxes if applicable). In the event that I have chosen a semi-annual, quarterly, or monthly payment frequency, I hereby elect to pre-authorise future credit card payment installments for the balance of the annual period of cover (12 months from the Effective Date), and hereby request and authorise IMG Europe Ltd. to charge my credit card periodically as payment installments become due for premiums. This authorisation will remain in effect for 12 months, unless earlier revoked by me in writing and IMG Europe Ltd. actually receives notice of revocation, whereupon continuing cover may be impacted. At all subsequent renewals, I authorise IMG Europe Ltd. to collect the renewal premiums due at that time, on the same payment frequency basis as the previous year until I give written notice that I wish to terminate this agreement. Cover purchased by credit card is subject to validation and acceptance by a credit card company. I understand that I will be given advance notice of the renewal premiums and that they may vary each year.

Cardholder's Authorisation Signature	X	Date:	DD/MM/YY
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If paying by bank transfer or cheque: To avoid delays, we recommend you check your premium calculation and any taxes (if applicable) with us or your agent.

<input type="checkbox"/>	B. Bank Transfer (Annual Premium Payments Only)	
	Once your Application has been processed, the necessary bank transfer information will be forwarded to you and your payment is required within 10 days. [Please ensure that the name of the Applicant (as declared in Section 1 of this form), is clearly stated on any transfer.] Liability for any bank transfer which does not clearly identify the proposer will not be accepted by the Insurer, IMG or IMG Europe Ltd.	

<input type="checkbox"/>	C. Bank Cheque / Bankers Draft / Money Order** (Annual Premium Payments Only)	
	Please make payable to: IMG Europe Ltd.	Please ensure that the name of the Applicant (as declared in Section 1 of this form), is clearly stated on the reverse of the cheque. ** UK£ Cheque for sterling contract, US\$ cheque for dollar contract or Euro cheque for Euro€ contract

INTERNAL USE ONLY

_____ X	_____ =	_____ +	_____ +	_____
<small>Total Medical Premium</small>	<small>Excess Rate factor</small>	<small>Optional Cover Premium</small>	<small>Insurance Premium Taxes/Levies</small>	
= _____				
<small>Total Premium Due</small>				

SECTION 6. Requested Start Date

Date on which you wish your GlobalSelect International Healthcare Cover to commence:	<input type="checkbox"/> On Acceptance	<input type="checkbox"/> Other / /	<i>(Must be within 30 days after signature. Cover will in no event be effective until approved.) Please note we cannot commence your plan until we have accepted your Application and received your first or annual premium payment)</i>
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SECTION 7. Renewal Contact Information - Please specify the best way to contact you when it comes to renewing your cover:

Mail - Please provide address:

Fax - Please provide fax number: + (Country) (Area) Number

Email - Please provide email address:

Express Mail Despatch Option

Tick here if you would like your Certificate of Insurance express mailed to you. Please note there will be an additional fee of £15/\$25/€25 to be paid in addition to the premium to have your Certificate of Insurance express mailed to you after approval.

Please select the address where you would like your Certificate express mailed (as indicated in Section 1):

<input type="checkbox"/> Residence address	<input type="checkbox"/> Mail Forwarding address	<input type="checkbox"/> Other (no P.O. Boxes please):
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SECTION 8. Insurance Advisor / Broker Use Only

IMG Producer Number: 387648	Phone: +(Country) (Area) Number +62 21 750 2814
Company Name: CTI Insurance Broker	Fax: +(Country) (Area) Number
Contact Name or Stamp:	Email: info@ctibroker.com
GA # (If Applicable):	Website: http://www.ctibroker.com

Please mail or fax this application to:

Address change information or additional contact information should also be directed to this contact information.

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