

Worldwide Medical Expenses Protection Plan Application Form



Please complete this form and return it to us by POST.

If you wish to speed up the process, please, initially forward the form to us by fax to +44 (0) 20 8207 2878 or by email to info@iphinsurance.com

**INTERNATIONAL PRIVATE
HEALTHCARE LIMITED**
IPH HOUSE STIRLING WAY
BOREHAMWOOD
HERTFORDSHIRE WD6 2BT
UNITED KINGDOM
TELEPHONE: 44 (020) 8905 2888
FACSIMILE: 44 (020) 8207 2878
E-MAIL: info@iphinsurance.com

For Official Use Only

APPLICANT DETAILS			
Title:	Family Name:	First Name:	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth:	Height in cm:	
Weight in kg:	Nationality:	Country of Residence:	
Occupation:	Telephone:	Fax:	
Full Address:			
Postcode:	Email:		

DEPENDANTS DETAILS								
This includes your spouse and children who are aged not less than 15 days and not more than 18 years at the date of enrolment, or under 24 years if in full-time education – evidence will be required. The nationality of dependants will be deemed to be the same as main applicant.								
	Family Name	First Name	Gender M/F	Date of Birth	Height in cm	Weight in kg	Occupation	Relationship with Applicant
1								
2								
3								
4								

PLAN OPTIONS	
Plan Currency: \$ US Dollar	Type of Plan: Executive <input type="checkbox"/> Executive Plus <input type="checkbox"/> Elite <input type="checkbox"/>
Area: Area 1 (worldwide excluding USA, Canada & Caribbean) <input type="checkbox"/>	Area 2 (worldwide including USA, Canada & Caribbean) <input type="checkbox"/>
Optional Benefits: Personal Accident Option <input type="checkbox"/>	

MEDICAL HISTORY AND GENERAL QUESTIONS		
A	Are there any medical conditions, disabilities or health problems (other than common colds, flu and the like), be they intermittent or recurring illnesses or otherwise, which apply to you, or to any other person mentioned in this application, whether a doctor or specialist have been consulted or not? If YES, please give full details in medical history details section. If space is insufficient, please continue on a separate sheet of paper.	Yes <input type="checkbox"/> No <input type="checkbox"/>
B	Have you or any person mentioned in this application visited a doctor in the last 12 months for any reason? If YES, please give full details in medical history details section. If space is insufficient, please continue on a separate sheet of paper.	Yes <input type="checkbox"/> No <input type="checkbox"/>
C	Have you or any person mentioned in this application had a surgical operation for any reason? If YES, please give full details in medical history details section. If space is insufficient, please continue on a separate sheet of paper.	Yes <input type="checkbox"/> No <input type="checkbox"/>
D	Are there any other additional facts affecting the proposed insurance which should be disclosed to the Insurers? If YES, please give full details in general question details section. If space is insufficient, please continue on a separate sheet of paper.	Yes <input type="checkbox"/> No <input type="checkbox"/>
E	Have you or anyone else included in the proposal for cover ever been refused cover by an Insurance Company or been accepted with special terms? If YES, please give full details in general question details section. If space is insufficient, please continue on a separate sheet of paper.	Yes <input type="checkbox"/> No <input type="checkbox"/>
F	Please give the name and address of your usual medical attendant.	

MEDICAL HISTORY DETAILS					
Please specify which corresponding question in medical history you are responding to.					
	Name	Nature of illness / disability and treatment	Date	Duration	Present state of health

GENERAL QUESTIONS

Please specify which question you are responding to.

PAYMENT DETAILS

How would you like to pay your annual premium: By Credit Card By Debit Card By Cheque (Cheque should be made payable to IPH Limited)

If you are paying by credit card, please complete the following credit card details. You may also choose to pay the annual premium by:

One full payment or Four quarterly payments

Card Number

Cardholder Name

Expiry Date

Security Code

Issue No.

(Debit card only)

I authorise you, until further notice in writing, to charge to my MasterCard/Amex/Visa/Debit Card account unspecified amounts in respect of my IPH Ltd Healthcare Plan subscription, as and when these become due, until this instruction is countermanded by giving notice in writing to IPH Ltd at the address shown. Note: 3% Credit card surcharge applies

Cardholder Signature:

Date:

IMPORTANT NOTES

Underwriters shall not be liable for expenses incurred for any medical condition which originated prior to the date of acceptance of your membership or which was foreseeable at the time of application unless such medical conditions have been declared to and accepted by the Insurers. This proposal form should be completed to the best of your knowledge and belief and any material facts (see below *) must be disclosed. Failure to do so may nullify cover under any policy issued.

* A material fact is one that is likely to influence the Insurers acceptance or assessment of the proposal. You should consult your Insurance advisor if you are in doubt as to what constitutes a material fact.

If you consider that the answer to any question in the proposal form requires expert knowledge which you do not have, you should indicate this in your answer.

IPH RESERVE THE RIGHT TO DECLINE ANY APPLICATION

This insurance is not available to permanent residents of the United States of America, or Canada, of whatever nationality. Purchase of this insurance by permanent residents of the United States or Canada will render the policy void.

Your application can be processed when the full premium and the completed application form is registered with International Private Healthcare Limited.

DATA PROTECTION DECLARATION

We will collect certain information about you in the course of considering your application and, if we issue a policy to you, conducting our relationship with you. This information will be processed for the purposes of underwriting your insurance coverage, managing any policy issued and administering claims. We may pass your information to underwriters, medical practitioners, medical assistance companies and claims administrators for these purposes. This may involve the transfer of your information to countries that do not have data protection laws. You may have a right of access to, and correction of, information that we hold about you. Please contact International Private Healthcare if you would like to exercise either of these rights. Some of the information we collect about you may be classified as 'sensitive' - that is, information about racial or ethnic origin, and physical or mental health. Data protection laws impose specific conditions in relation to sensitive information, including in some circumstances the need to obtain your explicit consent before we process the information. By signing this proposal form you consent to the processing and transfer of information including sensitive information described in this notice. Without this consent we would not be able to consider your application.

EXCLUSIONS

No benefit or reimbursement shall be paid by the insurers in respect of claims arising from:-

- any medical, physical or mental condition (including chronic or recurring conditions), not disclosed on your Application Form for cover, in respect of which you had suffered or sought treatment or advice at any time prior to your original inception date or, if later, the date you joined your plan,
- any medical, physical or mental condition or treatment or service which is specifically excluded on your Certificate of Insurance. After 12 months any excluded medical or related condition may be eligible for cover provided the condition(s) has not recurred, you have not received or needed treatment or medication or sought advice for such condition(s), your original inception date or, if later, the date you joined your plan,
- suicide or self-inflicted injury,
- alcohol or drug abuse,
- illness or injury whilst performing duties as a serving member of a military or police force or unit,
- routine medical examination (including vaccinations, the issue of medical certificates and attestations, and examinations as to suitability for employment or travel) and routine eye and ear examinations (including the cost of spectacles, contact lenses and hearing aids),
- treatment relating to birth defects and congenital illnesses. Birth defects are deemed to include hereditary conditions,
- all dental treatment which is not emergency dental treatment as described herein,
- tests and treatment relating to infertility and in vitro fertilisation,
- any abortion (and its consequences) unless it has been confirmed by a physician to be medically or surgically necessary,
- prosthesis, corrective devices and medical appliances which are not required intra-operatively,
- cryo preservation or introduction or re-introduction of living cells,
- treatment of mental illness, stress, psychiatric or psychological disorders,
- elective and/or cosmetic surgery,
- any sexually transmitted diseases,
- Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex Syndrome (ARCS) and all diseases caused by and/or related to the virus HIV positive,
- the performance of professional and/or hazardous sports and all kind of racing other than on foot,
- treatment by a family member and any autotherapy including prescription of drugs or any treatment that is not scientifically recognised,
- the acquisition and implantation of artificial heart and mono or bi-ventricular devices,
- flying other than as a passenger on a scheduled regular carrier (this applies only to permanent total disability cover under the Elite Plan and the optional Personal Accident Benefits),
- any criminal act,
- war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, act of terrorism,
- any losses directly or indirectly arising out of contamination due to an act of terrorism, regardless of any contributory causes (If the insurer alleges that by reason of this exclusion any loss is not covered by this insurance the burden of proving the contrary shall be upon the insured),
- ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
- travelling specifically to obtain medical treatment unless agreed by underwriters.

DEDUCTIBLE: You will be responsible for the first \$100 of each and every ailment/diagnosed medical condition for which a claim, in respect of Out-patient services, is made within any one policy year.

DECLARATION

I/we declare that the above statements are true and complete and that, apart from the matters declared above, I/we are in good health and ordinarily enjoy good health. I agree to the Insurers obtaining medical information from any doctor who has attended me and authorise such doctor to release this information. The refusal to submit medical information by any person mentioned in the schedule or doctor, clinic, hospital or institution shall be construed as a waiver of benefits by such person and/or supplier of services and the Insurers shall have no further obligation towards such person or entity. I/we agree that this proposal shall form the basis of the contract should the insurance be effected and that the acceptance of my/our application shall be based on these statements.

Signature of Applicant:

Date: