INDIVIDUAL APPLICATION FORM (UNDERWRITTEN)

Please complete this form in block capitals using black ink

GLOBAL HEALTH®
Health Insurance for Expatriates

YOUR BROKER DETAILS

If you were introduced to William Russell through a broker, please state their name and company.

Name of broker: Company name:

YOUR PERSONAL DETAILS

First name: Surname: Mr/Dr/Mrs/Ms/Miss

Address:

Telephone No (for correspondence): Telephone No (other): Fax No:

Email (home): Email (other):

Date of birth: Nationality: ☐ Male ☐ Female

Country of residence: How long have you lived here:

Occupation:

PREVIOUS/CURRENT INSURANCE

Have you previously held a policy, or do you currently hold a policy, with William Russell or Dubai Insurance Company? ☐ **Yes** ☐ **No**

Previous/current policy number: Date of expiry of policy:

Have you previously been insured, or are you currently insured, with another health insurer? ☐ **Yes** ☐ **No**

Name of Insurer:

GLOBAL HEALTH PLAN REQUIRED

Global Health Essential

☐ **Essential Care** ☐ **Essential Care Plus**

Area of cover: Full cover in 184 countries. Out-of-area cover restricted to emergency treatment, covered by your plan, and received during temporary trips of up to 90 days duration to any EU country, Andorra, Australia, Bali, Channel Islands, China, Cyprus, Gibraltar, Greenland, Hong Kong, Iceland, Japan, Liechtenstein, Macau, Monaco, New Zealand, Norway, San Marino, Singapore, Switzerland and Taiwan (up to US$50,000). No cover is provided in respect of treatment (either planned or emergency treatment) received in the United States of America, Canada, the Caribbean, and the London area.

Global Health Elite

☐ **Bronze** ☐ **Silver** ☐ **Gold** ☐ **Platinum**

Area of cover required:

☐ **Area One** provides world-wide cover excluding the USA.

☐ **Area Two** provides world-wide cover, with cover in the USA limited to temporary trips of up to 45 days and subject to a benefit limit of US$100,000.

☐ **Area Three** provides world-wide cover, with cover in the USA limited to temporary trips of up to 90 days and subject to a benefit limit of US$250,000.

☐ **Area Four** provides cover in Africa & the Indian Sub-continent, plus cover for emergency treatment, covered by your plan, and received during temporary trips of up to 90 days duration outside Africa & the Indian Sub-continent (up to US$100,000, €93,750, or £62,500). No cover is provided in respect of treatment (either planned or emergency treatment) received in the United States of America, Canada, the Caribbean, or within the London area.

☐ **Semi-private room discount** Only available to residents of Hong Kong and Singapore with Global Health Elite Area 1 cover.

☐ **Direct billing in Hong Kong and China** Available to residents of Hong Kong with a nil excess. Available to residents of China with a nil or $50 / £30 / €45 excess. A 7.5% premium surcharge will apply in China.

EXCESS REQUIRED

☐ **Nil** Standard excess for Essential Care and Bronze. Available for Essential Care Plus, Silver, Gold and Platinum with a 20% premium loading.

☐ **$50 / £30 / €45** Standard excess for Essential Care Plus, Silver, Gold and Platinum. Not available for Essential Care and Bronze.

☐ **$100 / £60 / €90** Available for Silver, Gold and Platinum with a 5% discount. Not available for Essential plans or Bronze.

☐ **Other, please state:** To view higher excess options, please visit our web site or contact William Russell.

OPTIONAL PLANS REQUIRED

☐ **Maternity Plan** (Only available with a Global Health Platinum or Global Health Elite Gold plan)
Provides cover for routine maternity care, out-patient complications of pregnancy, childbirth, caesarean delivery, and newborns (first 28 days of life), per pregnancy after a 12 month waiting period.

☐ **Global Travel** Who do you require cover for: ☐ **Self** ☐ **Partner** ☐ **Whole family**

☐ **Global Personal Accident**
Please select the benefit limit, and who you require cover for:

$75,000 / £50,000 / €75,000 ☐ **Self** ☐ **Partner**
$150,000 / £100,000 / €150,000 ☐ **Self** ☐ **Partner**
$225,000 / £150,000 / €225,000 ☐ **Self** ☐ **Partner**
$300,000 / £200,000 / €300,000 ☐ **Self** ☐ **Partner**
$375,000 / £250,000 / €375,000 ☐ **Self** ☐ **Partner**

NB: The Global Personal Accident plan does not cover accidents arising out of hazardous occupations and hazardous activities. If your occupation is not 100% office based and/or you participate in hazardous activities of any kind, you must send us a detailed job description and/or details of your hazardous activities. Cover for your hazardous occupations/activities may be subject to a premium loading, and/or special terms.

FAMILY MEMBERS TO BE INCLUDED IN THE PLAN

Please enter the names and details of all dependants for whom cover is required. You may include your partner and children, up to age 18 or up to age 25 if in full-time education – proof will be required. Children aged 18 or over who are not in full-time education must make their own application for cover.

First name(s)	Surname	Date of birth dd/mm/yy	Relationship to applicant	Country of residence	Occupation/ Full-time education
Partner					
Child 1					☐ Yes ☐ No
Child 2					☐ Yes ☐ No
Child 3					☐ Yes ☐ No
Child 4					☐ Yes ☐ No

HEALTH DECLARATION

IMPORTANT
The Global Health plans do not cover the treatment of pre-existing conditions and related conditions. A pre-existing condition means any disease, illness or injury for which you have received medication, advice or treatment, or you have experienced symptoms, whether the condition has been diagnosed or not, at any time before the start of your cover. A related condition is any disease, illness or injury that is caused by a pre-existing condition or results from the same underlying cause as a pre-existing condition.

We rely on the information that you give us in this form when we decide whether or not to accept your application, and whether or not we need to apply special terms. Special terms are exclusions or conditions that we may apply to your cover. If you submit a claim for the treatment of any pre-existing condition or related condition which you omitted to tell us about here or you omit to tell us everything about, we will refuse to pay that claim. We also have the right to declare your Global Health plan void, or we may impose special terms on your plan which will apply retrospectively. Please therefore take the greatest care to ensure that this application form is completed fully and accurately.

If, after completing your application form, any changes occur in the facts contained in the form, such as a change in your state of health or the state of health of any of your dependants, you must tell us in writing about the change, and we reserve the right to decline or accept your application with special terms.

Please give full details about each condition by answering the questions in the following health declaration accurately and in as much detail as possible. Please continue on a separate sheet if necessary. We cannot accept your application if this health declaration is incomplete.

1. Your height (cms): Your weight (kgs): Your partner's height (cms): Your partner's weight (kgs):

2. Have any persons named in this application ever:

A. Undergone a surgical operation (including any cosmetic surgery or any refractive laser eye surgery)? ☐ **Yes** ☐ **No**
B. Been a patient in a hospital clinic or sanatorium? ☐ **Yes** ☐ **No**
C. Been advised to have any medical tests or investigations? ☐ **Yes** ☐ **No**
D. Had any abnormal medical test results? ☐ **Yes** ☐ **No**
E. Been tested HIV and /or Hepatitis C positive? ☐ **Yes** ☐ **No**
F. Had an application for insurance turned down or accepted at special terms? ☐ **Yes** ☐ **No**

3. Are any of the persons named in this application aware of any symptoms or abnormal signs which may give rise to a claim? ☐ **Yes** ☐ **No**

4. Are any persons named in this application currently taking any drugs or medication? ☐ **Yes** ☐ **No**

5. Have any persons named in this application ever suffered from, been diagnosed with, treated or prescribed drugs for:

A. Conditions of the eyes, ears, nose or throat?.............. ☐ **Yes** ☐ **No**
B. Fainting, blackouts or fits?.............. ☐ **Yes** ☐ **No**
C. Any high blood pressure, heart or circulatory conditions?.............. ☐ **Yes** ☐ **No**
D. Diabetes or any other endocrine disorder?.............. ☐ **Yes** ☐ **No**
E. Any rheumatic or arthritic conditions (including gout)?.............. ☐ **Yes** ☐ **No**
F. Any spine, bone, muscle or joint conditions?.............. ☐ **Yes** ☐ **No**
G. Asthma, respiratory, pulmonary or allergic conditions?.............. ☐ **Yes** ☐ **No**
H. Genito-urinary or renal conditions?.............. ☐ **Yes** ☐ **No**
I. Stomach, liver or bowel conditions?.............. ☐ **Yes** ☐ **No**
J. Cysts, tumour or cancer?.............. ☐ **Yes** ☐ **No**
K. Any skin conditions?.............. ☐ **Yes** ☐ **No**
L. Any gynaecological or breast conditions?.............. ☐ **Yes** ☐ **No**
M. Any physical defect, infirmity or congenital illness?.............. ☐ **Yes** ☐ **No**
N. Any nervous, mental or psychiatric condition?.............. ☐ **Yes** ☐ **No**
O. Any alcohol and/or drug dependency problem?.............. ☐ **Yes** ☐ **No**
P. A higher than normal cholesterol level?.............. ☐ **Yes** ☐ **No**
Q. Any neurological conditions, including migraine and/or headaches?.............. ☐ **Yes** ☐ **No**
R. Any other type of disease, injury or medical condition?.............. ☐ **Yes** ☐ **No**

6. Has any person named in this application ever suffered from any pre or post natal complications, complications of childbirth or suffered any miscarriage?.............. ☐ **Yes** ☐ **No**

If you have answered YES to any question, please give full details below. Please continue on a separate sheet if necessary.

Question No: Name of person who suffered the illness/injury:
Date(s) on which the illness/injury occurred:
Diagnosis:
Treatment/tests performed and results:
Date you last suffered symptoms or received treatment relating to this condition:
Name and address of treating physician:
Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: Name of person who suffered the illness/injury:
Date(s) on which the illness/injury occurred:
Diagnosis:
Treatment/tests performed and results:
Date you last suffered symptoms or received treatment relating to this condition:
Name and address of treating physician:
Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: Name of person who suffered the illness/injury:
Date(s) on which the illness/injury occurred:
Diagnosis:
Treatment/tests performed and results:
Date you last suffered symptoms or received treatment relating to this condition:
Name and address of treating physician:
Give details of any foreseeable need for further consultation or treatment for this condition:

DOCTOR'S CONTACT DETAILS

1. When did the persons named in this application last consult a general practitioner, consultant or medical specialist?

	Applicant	Partner	Child 1	Child 2	Child 3	Child 3
Date						

2. Please give details of the doctor who is most familiar with your medical history and the medical history of your family members.

Name: Practice name:

Address:

Telephone No: Fax No: Email:

Length of time you have known this doctor: If less than two years, please complete question 4.

3. If this doctor does not treat all persons named in this application, please supply additional information.

Name: Practice name:

Address:

Telephone No: Fax No: Email:

Who does this doctor treat?

Length of time the patient has known this doctor:

4. If you or your family member(s) have known the doctor(s) above for less than two years, please provide details of the previous doctor(s).

Name: Practice name:

Address:

Telephone No: Fax No: Email:

Who did this doctor treat?

Length of time the patient has known this doctor:

Date of last consultation

CURRENCY, METHOD AND FREQUENCY OF PREMIUM PAYMENT

Please state the currency in which you wish to pay premiums:*

*NB: Essential plans are ONLY available in US Dollars. The currency in which you pay your premium will be the currency in which your plan benefits and excess are denominated.

☐ **US Dollars** ☐ **Sterling** ☐ **Euros**

Method and frequency of payment options available

Please note that semi-annual health, travel and personal accident premiums include a 3% surcharge, and quarterly and monthly health, travel and personal accident premiums include a 5% surcharge.

1. **Cheque or bank draft:** ☐ **Annually** Payable to William Russell Limited and drawn on a UK bank account.
2. **Bank transfer**: ☐ **Annually**
3. **Direct debit:** ☐ **Annually** ☐ **Semi-annually** ☐ **Quarterly** ☐ **Monthly**

   Only available if you pay sterling premiums from a UK bank account. An original completed and signed direct debit mandate will be required before we can commence your cover. A direct debit mandate is available from our web site or by contacting William Russell.
4. **Credit/debit card:** ☐ **Annually** ☐ **Semi-annually** ☐ **Quarterly** ☐ **Monthly**

   A credit/debit card authorisation form is attached.

START DATE

Date on which you wish your Global Health plan to commence:

☐ **On acceptance**

☐ **Other** (Please state)**:**

Please note that we cannot commence your plan until we have accepted your application form and until we have received payment of your first annual, semi-annual, quarterly or monthly premium in accordance with the terms of the Global Health plan agreement. Cover cannot be backdated.

THE INSURER

The insurer of your Global Health plan will be Hauteville Insurance Company Limited.

DECLARATION AND AUTHORISATION

I hereby apply for cover on behalf of all the persons named in this application form for a Global Health plan as specified above. I declare that I have read and understood the plan agreement of the Global Health plan as specified above and that I am aware that cover shall be provided in accordance with the agreement. I have made a full and complete disclosure about the medical history of each person included in this application and I fully understand that pre-existing conditions as defined in the Global Health plan agreement shall not be covered by the insurance plan.

I also understand that I must notify William Russell Ltd of any changes in the facts contained in this application form, such as a change in the state of health of any person named in it. I authorise any doctor who has ever treated or advised any of the persons named in this application to provide William Russell Limited with any information they may require in connection with treatment related to any claim under this plan. I declare that the information given in this application is true and complete.

If I have applied for a travel insurance plan, I declare that at the time of purchasing this insurance or at the time of booking any future trip(s), I am aware of no reason why any journey or trip should be cancelled or curtailed or expense be incurred.

If I have indicated that I wish to pay by credit or debit card, I agree that William Russell Limited may debit my account with the appropriate premiums on or before their due dates, and all subsequent renewal premiums due as invoiced by William Russell Limited until I give written notice that I wish to terminate this agreement. I understand that my cover will terminate in accordance with the terms of the Global Health plan agreement if William Russell Limited are unable to collect my premium – for whatever reason – and I do not provide William Russell Limited with an alternate method of payment immediately.

I hereby give William Russell Limited authorisation to send my insurance documents in pdf format by email to the email address I have stated in this application. If I have applied through an intermediary, I hereby give William Russell Limited authorisation to send my insurance documents in pdf format by email to my intermediary.

Signature of applicant: ______________________ **Date:** __________

Signature of partner: ______________________ **Date:** __________

IMPORTANT:
Please ensure you have given an answer to every question. An incomplete form will delay your application. If after completing, signing and dating your application form any changes occur in the facts you have given us, such as a change in your state of health or in the state of health of any of your dependants, you must tell us in writing about the change, and we reserve the right to decline to accept your application or to accept your application with special terms.

This application form will be valid for 28 days from the date on which it is signed. If cover is not commenced within 28 days, we reserve the right to request that a new application form is completed.

WILLIAM RUSSELL
Peace of mind wherever you are

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CREDIT/DEBIT CARD AUTHORISATION

Please complete this form in block capitals using black ink

APPLICANT/POLICY-HOLDER DETAILS

Full name of applicant/policyholder: ____________________

Policy number: ____________________

CREDIT/DEBIT CARD DETAILS

I would like to pay my plan premium to William Russell Limited by the following credit/debit card:

☐ **Mastercard** ☐ **VISA** ☐ **American Express** ☐ **Switch** ☐ **Visa Delta**

Credit/debit card number: ____________________

Start date: __________ **Expiry date:** __________ **Issue number (Switch):** __________

Name as on card: ____________________

Address to which card is registered: ____________________

____

AUTHORISATION - TO BE SIGNED BY THE APPLICANT/POLICY HOLDER

I hereby authorise that the card account specified above may be debited with the appropriate annual/monthly premium(s) due, and all subsequent renewal premiums due as notified by William Russell Limited, until I give notice in writing that I wish to terminate my plan agreement.

I understand that my premiums may increase at each plan renewal date. I understand that premiums due under the plan must be received by William Russell Limited on or before their due date and, should any attempt by William Russell Limited to debit the above card be declined, I understand that my plan cover will cease from the day before the unpaid premium due date, and that William Russell Limited will not be liable for any lapse in cover.

Signature of applicant/policyholder: ____________________ **Date:** __________

AUTHORISATION - TO BE SIGNED BY THE CARD HOLDER WHEN THE HOLDER OF THE ABOVE CARD IS NOT THE APPLICANT/POLICY HOLDER

I hereby authorise that the card account specified above may be debited with the appropriate annual/monthly premium(s) due, and all subsequent renewal premiums due as notified by William Russell Limited to the applicant/policy holder named above, until I give notice in writing that I wish to terminate this arrangement.

Signature of card holder: ____________________ **Date:** __________

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