

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):
Country: _____ Number: _____
- 7) Are you eligible from 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: _____ (cms/feet) Weight: _____ (kgs/lbs)
BMI

B. Contact Details

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

1. Address: _____ 1. Address: _____

Postal Code: _____ Postal Code: _____
Country: _____ Country: _____
2. Telephone (include country code): 2. Telephone (include country code):
Home: _____ Home: _____
Office/Mobile: _____ Office/Mobile: _____
3. Fax: _____ 3. Fax: _____
4. E-mail: _____ 4. E-mail: _____
5. Where would you like your policy documents sent? Principal residence (above) Other residence (above)
How would you like your policy documents sent? Airmail (standard) Courier (US\$50 surcharge)

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

C. Medical Cover Required

Choose the area of cover you require:

- World-wide cover excluding USA OR World-wide cover including USA

Choose the plan most suited to your needs:

Plan 1 – HEALTHCARE EXECUTIVE

Excess option

- Zero Deductible
 US\$ 250 Annual Deductible
 US\$ 1,000 Annual Deductible

Plan 2 – HEALTHCARE PREMIUM

Excess option

- Zero Deductible
 US\$ 250 Annual Deductible
 US\$ 1,000 Annual Deductible

Plan 3 – HEALTHCARE PLUS

Excess option

- US\$ 250 Annual Deductible
 US\$ 1,000 Annual Deductible

Plan 4 – HEALTHCARE STANDARD

Excess option

- US\$ 250 Annual Deductible
 US\$ 1,000 Annual Deductible

Plan 5 – HEALTHCARE EMERGENCY PLUS

US\$ 2,000 Deductible per course of treatment and per year

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

Preferred start date: _____

D. Spouse and/or dependent children to be insured

(You can include your spouse and any dependent children under age 19, or under age 25 if unmarried and a full-time student. If you have more than one legal spouse, provide information on a separate sheet).

SPOUSE

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

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

5) Place of Birth: _____

6) Social Security Number (if any):

Country: _____ Number: _____

7) Is your spouse 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: _____ (cms/feet) Weight: _____ (kgs/lbs)

BMI

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|-----------------|
| OFFICE USE ONLY |
|-----------------|

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

DEPENDENT CHILDREN

(For children age 19 and older, please attach proof of schooling)

| Name | Date of Birth | Sex (Male/Female) | Height (cms/feet) | Weight (kgs/lbs) | Full-Time Student (yes/no) |
|----------|---------------|----------------------|----------------------|---------------------|-------------------------------|
| 1. _____ | _____ | _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ | _____ | _____ |

Are any of the dependent children eligible for benefits from any Social Security or government plan or other employer plan or do they have any other medical insurance in force today?

NO YES if Yes, please give details: _____

E. Personal Accident Cover

All applicants over the age of 18 are automatically insured for Personal Accident cover up to US\$25,000. However, you can opt to have this increased in increments of US\$10,000 up to US\$125,000. This option is not available to children under the age of 18.

Please select additional amounts of cover required: Policyholder US\$ _____ Spouse US\$ _____

F. Health Declaration

STATEMENT OF HEALTH BY APPLICANT (to include Spouse and/or Dependent Children listed in Section D. 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 and dependents) 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 circle the condition to which you are referring and give complete details in Section G).

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, behavioral, 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, anemia, 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 diarrhea or intestinal problems; hernia; ulcer of the stomach or duodenum; hemorrhoids or rectal disorder; hepatitis or liver disorder; gallbladder, pancreas, esophagus, or any other digestive disorder or condition
 YES NO
- 6) Cancer, tumor, 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

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

F. Health Declaration – Continued

- 9) Been treated for infertility; taken any medication, or advised to seek treatment, medication, 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
- 17) During the past 5 years, has any person to be covered consulted 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 counseling in the past 12 months?
 YES NO
- 22) Is any person to be covered currently taking any 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, counseling, or surgery which has not yet 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) Have you or your spouse (if to be insured) smoked cigarettes or used tobacco in any form in the past 12 months?
You YES NO If yes, how many? _____
Spouse YES NO If yes, how many? _____
Children YES NO If yes, how many? _____
- 27) Has any person to be covered ever been declined, postponed, rated, or limited for Life, Health, or Accident Insurance?
 YES NO
- 28) Have you or 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 now pregnant?
 YES NO
If yes, list name, anticipated date of delivery, and physician in 'Additional information or observations' below
- 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: _____

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

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 |
|-----------------|-----------------|----------------------|------------------------------------|-------------------------|-----------------------------|---|
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(If more space is needed, attach separate page which must be signed and dated).

H. Additional Health Insurance Information

1) Family Doctors (if any):

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

2) Current Cover

If you, your spouse, and/or your dependent children are insured today, it is in your interest to send us a copy of the 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.

Current Policy and Insurer: _____ Expiration date: _____

3) Expediting your application

We cannot accept your application if this Health Declaration is incomplete. Should we need to contact you rapidly regarding the Health Declaration, please indicate your preferred method:

Telephone Number: _____ Private E-mail: _____
 Other: _____

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

I. Representations, Acknowledgements and Authorizations

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 term, I may still be liable to pay the balance of the premium. 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 policy or claims denial.

The insurance plan shall be governed exclusively by the laws of Ireland, Allianz Worldwide Care Limited underwrite the medical portion of this plan on behalf of HealthCare International.

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 payment has been effectively received by HealthCare International.

I authorize any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, or other person or firm to provide the Insurer or their authorized 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 authorized representative will receive a copy of this authorization 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 30 days of the start of the policy.

HCI 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.

Date Signed: _____ Signature of Applicant: _____

J. Method of Payment

Please choose how often you would like your premium collected – Remember, in order not to penalise those applicants who have chosen to pay their premiums annually, we have levied a small administration charge on these premiums as follows:- Monthly 2%, Quarterly 3% and six monthly 6%.

A) By Debit/Credit Card: AMEX MasterCard VISA Other: _____

Monthly Quarterly Six Monthly Annually

Card Number: _____ Expiry Date: _____ Amount US\$: _____

Card Holder's Name: _____

Billing Address (if different to principal residence): _____

I authorize 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, and that there will be a 3% surcharge for credit card collections.

Signature : _____ Date: _____

B) By Credit Transfer: *Provisional cover can only commence when the transfer has been completed.*

Please instruct your bank to make sure that the transfer identifies you as the source or beneficiary of the transfer.

Bank: Barclays Bank PLC

Address: 8/9 Hanover Square, London, W1A 4ZW UK.

Account Numbers: US\$: 74341111 Euro: 87250188 £: 20263397

Account Name: HealthCare International SA **Sort Code:** 20-36-47

C) By Cheque: Made payable to: HealthCare International SA.

Please put your name and address on the back of the cheque. Provisional cover cannot commence until the cheque has cleared.

K. Additional Information

Please provide any additional information on a separate sheet of paper.

THANK YOU FOR YOUR ASSISTANCE AND SUPPORT