

APPLICATION FORM (INDIVIDUAL)

Are you a current policy holder? YES

Existing policy No. | | | | | | | | | |

YOUR PERSONAL DETAILS

First names

Surname Mr / Dr / Mrs / Ms / Miss

Postal address

Email address (home)

Email address (work)

Telephone No. (home)

Telephone No. (mobile/cell)

Telephone No. (work)

Fax No.

Date of birth

Sex Male Female

Occupation

Nationality

Country of residence

REQUIRED PLAN Essential Care Essential Care Plus**REQUIRED AREA OF COVER** **Area 1 - Far East:** Brunei, Cambodia, French Polynesia, Indonesia, Korea South, Laos, Malaysia, Mongolia, Philippines, Thailand and Vietnam. **Area 2 - Middle East:** Bahrain, Jordan, Kuwait, Oman, Qatar, Saudi Arabia, Syria and U.A.E. **Area 3 - Africa:** Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Djibouti, Egypt, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Ivory Coast, Kenya, Lesotho, Liberia, Libya, Madagascar, Malawi, Mali, Morocco, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Somalia, South Africa, St Helena, Swaziland, Tanzania, Togo, Tunisia, Uganda, Zaire, Zambia and Zimbabwe.**IMPORTANT.**

IF YOU TRAVEL OUTSIDE YOUR AREA OF COVER, WE WILL COVER YOU FOR ACCIDENT AND EMERGENCY TREATMENT ONLY, AND COVER WILL BE LIMITED TO US \$50,000 PER ANNUM. NO COVER WILL BE PROVIDED IN THE UNITED STATES OF AMERICA.

REQUIRED EXCESS Nil (Standard for Essential Care, n/a for Essential Care Plus) \$50 (Standard for Essential Care Plus, n/a for Essential Care) \$1,000 \$2,500 \$5,000**OPTIONAL GLOBAL TRAVEL PLAN REQUIREMENTS** Self only Partner only Self & Partner Whole family**OPTIONAL GLOBAL ACCIDENT PLAN REQUIREMENTS** Self only Partner only Self & Partner \$75,000, or Self only Partner only Self & Partner \$150,000, or Self only Partner only Self & Partner \$225,000, or Self only Partner only Self & Partner \$300,000, or Self only Partner only Self & Partner \$375,000

The Global Accident Plan excludes accidents arising from hazardous and/or manual occupations, private flying, motor-cycle riding and hazardous sports. If you, or your partner's, occupation is not 100% office based and/or you, or your partner, participate in any of the above activities or any hazardous sports, please give details here and we will advise the premium loading necessary to cover the increased risk.

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, and including age 17 or up to, and including age 24 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					<input type="checkbox"/> YES <input type="checkbox"/> NO
Child					<input type="checkbox"/> YES <input type="checkbox"/> NO
Child					<input type="checkbox"/> YES <input type="checkbox"/> NO
Child					<input type="checkbox"/> YES <input type="checkbox"/> NO
Child					<input type="checkbox"/> YES <input type="checkbox"/> NO

HEALTH DECLARATION

IMPORTANT. PLEASE READ THESE IMPORTANT NOTES PRIOR TO COMPLETING THE HEALTH DECLARATION.

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.

Please give full details about each condition by answering the questions in the health declaration 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? YES NO
- B. Been a patient in a hospital clinic or sanitorium? YES NO
- C. Been advised to have any medical tests or investigations? YES NO
- D. Been tested HIV positive? YES NO
- E. 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 present now 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? YES NO
- E. Any rheumatic or arthritic conditions? YES NO
- F. Any spine, bone, muscle or joint conditions? YES NO
- G. Asthma, respiratory 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 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 other type of disease, injury or medical condition? YES NO

If you have answered YES to any question, please give full details on page 3.

IMPORTANT

IF WE NEED TO CONTACT YOU FOR FURTHER INFORMATION, PLEASE GIVE US A PERSONAL CONTACT NUMBER WE CAN USE:

Telephone:

Fax:

Email:

HEALTH DECLARATION

Question No.	
Name of person who suffered the illness/injury	
State the diagnosis of the illness, or, if an injury, give details	
Name and address of the treating physician	
Date(s) on which the illness/injury occurred	
Full details of the treatment/ tests performed and the results	
When did you last suffer from symptoms or receive treatment relating to this condition?	
Is there any foreseeable need for further consultation or treatment for this condition? If yes, please give full details.	



