

EXPATHEALTH PLAN – PROPOSAL FORM

FMU Application

Please complete this form and return it to your agent / insurance broker.

It is important that you complete this form fully. Failure to do so may result in the form being returned to you for completion.

All proposals are reviewed prior to acceptance and therefore no cover shall be granted until confirmation is provided.

1. Your personal details

Title (Mr/Mrs/Ms/Miss/Other):

Forenames:

Surname:

Date of Birth: (DD/MM/YY)

Overseas Residential Address:

Post/Zip Code:

Telephone no:

Mobile no:

Fax no:

Email Address:

Home Address:

Post/Zip Code:

Nationality:

Occupation:

Occupation of spouse:

Country of residence:

Home Country (country for which you have a passport):

How long have you been resident in your country of residence (Years/Months)?:

Have you or any of the people to be included in this proposal, ever been refused cover by an insurance company or been accepted on special terms ? (If yes provide details on a separate sheet.)

Yes

No

2. Cover Required

Date upon which annual cover to commence, or the date on which your proposal is accepted by insurers, whichever is the later: (DD/MM/YY)

Choose your area of cover:

Please Tick

Area 1 - Worldwide excluding the USA and Canada

Area 2 - Worldwide excluding the USA and Canada but with 90 days accident and emergency cover in the USA and Canada

Area 3 - Worldwide

Choose your level of cover:

Please Tick

Bronze

Silver

Gold

If you would like to increase the standard excess please enter here (Details of the excess options available are shown on the benefits table): (£/€/S)

Please specify the currency in which you wish to pay premiums and receive benefits:

Please Tick

US Dollar \$

Sterling £

Euro €

3. Dependants to be included

Full name of dependants	Relationship to proposer	Date of birth (DD/MM/YY)	Sex (M/F)	Nationality	Occupation

Do you or anyone included in this proposal, participate in any occupation, sport, pastime or activity which is likely to involve extra risk in connection with this plan? (eg, Mountaineering, Hang Gliding or other sports):

Yes No

If Yes, please give details:

4. Confidential Medical Declaration (please answer the following questions for all applicants listed on Page1 & 2)

Important : All material facts must be disclosed. Failure to do so could result in the rejection of a claim and/or termination of your cover. Material facts are those which can be reasonably regarded as likely to influence the assessment and acceptance of this application. If there is any doubt about whether certain facts are material facts these should be disclosed.

	Yes	No
1. Are any medical/surgical/dental consultations and/or procedures (including x-ray lab or other testing) recommended, scheduled or contemplated for applicant?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has any applicant ever been refused medical or dental insurance, or ever had a policy postponed, rated or accepted on special terms?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has any applicant been examined by, consulted with, or received medical treatment from a physician in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has any applicant been examined by, consulted with, or received medical treatment from a medical specialist or consultant in the last 4 years?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has any applicant been confined (stayed overnight) in a hospital, clinic, sanatorium, or other treatment facility in the last 4 years?	<input type="checkbox"/>	<input type="checkbox"/>

Has any applicant listed had any disease or impairment of or suffered any symptoms or required any medication, treatment or hospital consultation(s) for the following (please answer all questions):

	Please Tick	
	Yes	No
1. AIDS / ARC/ HIV	<input type="checkbox"/>	<input type="checkbox"/>
2. Alcohol dependency or drug/substance abuse	<input type="checkbox"/>	<input type="checkbox"/>
3. Anaemia or any blood disorder	<input type="checkbox"/>	<input type="checkbox"/>
4. Arthritis, or any disorder of any muscles or joints	<input type="checkbox"/>	<input type="checkbox"/>
5. Asthma, bronchitis or any other respiratory disorder	<input type="checkbox"/>	<input type="checkbox"/>
6. Back / spine / neck	<input type="checkbox"/>	<input type="checkbox"/>
7. Blood pressure / hypertension	<input type="checkbox"/>	<input type="checkbox"/>
8. Blood vessels / Clots / Circulatory system	<input type="checkbox"/>	<input type="checkbox"/>
9. Bones (including fractures)	<input type="checkbox"/>	<input type="checkbox"/>
10. Brain / Head	<input type="checkbox"/>	<input type="checkbox"/>

Continued

	Please Tick	
	Yes	No
11. Cancer, tumour, growth or cyst	<input type="checkbox"/>	<input type="checkbox"/>
12. Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
13. Cerebrovascular Disease / Disorder or Stroke	<input type="checkbox"/>	<input type="checkbox"/>
14. Chest pains, palpitations, heart murmur, angina, heart attack or any other heart disorder	<input type="checkbox"/>	<input type="checkbox"/>
15. Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>
16. Dental / Gum Disease	<input type="checkbox"/>	<input type="checkbox"/>
17. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
18. Ears, eyes, nose or throat	<input type="checkbox"/>	<input type="checkbox"/>
19. Epilepsy, convulsions, seizures, fits	<input type="checkbox"/>	<input type="checkbox"/>
20. Gastrointestinal disorder (stomach / intestines)	<input type="checkbox"/>	<input type="checkbox"/>
21. Gout	<input type="checkbox"/>	<input type="checkbox"/>
22. Hernia	<input type="checkbox"/>	<input type="checkbox"/>
23. Immune System Disorder	<input type="checkbox"/>	<input type="checkbox"/>
24. Injury, operation, physical defect or deformity	<input type="checkbox"/>	<input type="checkbox"/>
25. Kidney / Bladder / Urinary tract	<input type="checkbox"/>	<input type="checkbox"/>
26. Liver, gall-bladder, pancreas or spleen	<input type="checkbox"/>	<input type="checkbox"/>
27. Lungs / Breathing	<input type="checkbox"/>	<input type="checkbox"/>
28. Mental / nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>
29. Neurological / Nervous system	<input type="checkbox"/>	<input type="checkbox"/>
30. Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
31. Prostate	<input type="checkbox"/>	<input type="checkbox"/>
32. Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
33. Reproductive Disorder or Infertility	<input type="checkbox"/>	<input type="checkbox"/>
34. Skin	<input type="checkbox"/>	<input type="checkbox"/>
35. Sleep Disorder	<input type="checkbox"/>	<input type="checkbox"/>
36. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
37. Surgical Operation	<input type="checkbox"/>	<input type="checkbox"/>
38. Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
39. Urinary Abnormality	<input type="checkbox"/>	<input type="checkbox"/>
40. Other medical condition not listed	<input type="checkbox"/>	<input type="checkbox"/>

Please give the name and address of your personal / family physician(s) including zip/postcode:

(If there is a different family physician for each applicant, please provide all details and indicate which physician applies to each applicant):

Confidential Medical Declaration – additional information – please use this space to provide details if you answered “Yes” to any of the questions in Section 4. If you require additional space, please continue on a separate sheet.

Question No.	Applicant Name	Details	Dates (DD/MM/YY)	Diagnosis	Treatment / Current Status

Consent Authorisation

To all physicians and medical practitioners, hospitals and other medical facility: my signature below provides my authorisation for you to provide Morgan Price International Healthcare Limited and their Insurers with any information requested in connection with my application for me or any of the family members named on this application.

Signature of Primary Applicant _____

Date _____

5. Data Protection Act 1998

Morgan Price International Healthcare Ltd is registered under the data protection act 1998. We will collect information in the course of your dealings with us regarding your personal details (including but not limited to your sex, age, ethnic origin and state of health). Any information we do collect will only be used for the purpose of conducting our relationship with you and will be used for the purposes of underwriting your insurance cover, managing the policy we issue for you, and administering any claims you may make. We may need to transfer some or all of this information to our insurance underwriters, their claims handlers, medical assistance companies or other medical practitioners. You have the right to access any details that we hold about you and to amend or delete anything that you may believe is inaccurate or out of date. By signing this declaration you are consenting to us using the information we hold about you in the ways described above. Without this consent we are unable to offer you any insurance cover.

Declaration

- a. I / We have read the policy wording and I / We understand it to be part of the contract of insurance. In particular I/We have read, understand, and accept the definitions, benefits and exclusions of the policy.
- b. I / We have read, understand and accept sections 5 of this Proposal.
- c. To the best of my / our knowledge and belief the information given in connection with this proposal, whether in my hand or not, is true and I / We have not withheld any material facts. I / We understand that non-disclosure or misrepresentation of any material fact may entitle the insurer to void the insurance. A material fact is one which is likely to influence acceptance or assessment of this proposal by the insurer. If you are in any doubt as to whether a fact is material or not you must disclose it, on a separate sheet if necessary. This proposal and the information provided in connection therewith contains statements upon which the insurers will rely in deciding whether to accept this insurance and in determining the terms and conditions of such acceptance.
- d. I / We understand that the signing of this proposal does not bind me / us to complete, or insurers to accept this insurance.
- e. If I/We have elected to pay our premium by instalments using credit or debit cards and Morgan Price have agreed to this, I/we authorise Morgan Price to continue to deduct such instalments as and when they become due unless I/we cancel this credit card authorisation by giving at least 14 days notice in writing. I /we understand that if I/we have made a claim, no refund will be due and I/we will have to pay any outstanding instalments due in the current period of cover.

Signature of Primary Applicant _____

Date _____

8. Premium Payment

A. Payment method

- Annually by credit/debit card
- Annually by cheque
- Annually by Bank transfer (details supplied on request)
- Semi annually by credit/debit card
- Quarterly by credit/debit card
- Monthly by credit/debit card

Additional surcharges (Credit/Debit Cards Only):

Annual payment	0%
Semi annual payments	+4%
Quarterly payments	+5%
Monthly payments	+8%

For Amex payments add an additional 3.5% to the surcharges above.

Annual bank transfer £10/€15/\$18

(i) If paying by credit/debit card please complete the instruction below.

(ii) If paying by cheque, please remember to attach a cheque for the full annual premium to this form when you return it.

B. Credit/Debit Card Authorisation Form

Please only complete if you are paying by Credit/Debit Card

I authorise you, until further notice in writing, to charge my Credit/Debit Card Account unspecified amounts in respect of premiums for my GlobalHealth Plans subscription, as and when these become due, until this instruction is countermanded by my giving notice in writing. I understand I will be given at least one months notice of any subscription increase.

(i) If you have chosen to pay by instalment, the credit/debit card details provided must be in date for the entirety of the policy.

Name on card :

Visa / Mastercard / American Express / Other :

Credit Card Number:

CVC Code: Issue No: _____ Start Date (MM/YY): _____ Expiry Date (MM/YY): _____

Payment frequency: _____

Card Billing Address if different from Residential Address: _____

Signature of Cardholder: _____

Date: _____

(ii) You must keep your credit/debit card details confidential and secure. For security reasons please do not email credit/debit card details to us. If you do so, it is entirely at your own risk.

Agent Stamp