Evolution Health Plan (Asia Pacific)

FMU

morganprice international

Application form

Part A

Please complete all parts of 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 | Forename(s) | Surname

Date of birth | Gender | Height | Weight

Overseas address | Post/Zip code

Phone | Mob | Email

Home address | Post/Zip code

Occupation | Nationality

Country of residence | Home country *(for which you have a passport)*

How long have you been resident in your country of residence *(years/months)*?

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

Choose your area of cover
- ◯ Worldwide excluding USA, China, Singapore & Hong Kong
- ◯ Worldwide excluding USA
- ◯ Worldwide

Choose your level of cover
- ◯ Standard
- ◯ Standard Plus
- ◯ Comprehensive
- ◯ Premium
- ◯ Elite

Please select the annual excess you wish to apply to your policy
- ◯ Nil
- ◯ 100
- ◯ 250
- ◯ 500
- ◯ 1000
- ◯ 2500
- ◯ 5000

Home country evacuation module (120 adult/75 child) ☐

Please specify the currency in which you wish to pay premiums and receive benefits
- ◯ US Dollar $

2 Cover required — continued

Do you or any of the persons to be included in this proposal, have existing health insurance? Yes ◯ No ◯

If yes, which provider?

3 Dependants to be included

	Full name of dependants	Relationship to proposer	D.O.B	Nationality	Gender	Height	Weight	Occupation
Spouse								
Dep. 1								
Dep. 2								

4 Payment method

Please specify how you would like to pay

- Annually by credit/debit card ◯
- Semi annual by credit/debit card ◯
- Quarterly by credit/debit card ◯
- Monthly by credit/debit card ◯
- Annually by bank transfer *- details supplied on request* ◯

Additional surcharges - credit/debit card & SEPA Direct Debits

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.

American Express will incur a further 3.5% charge:

i. If paying by credit/debit card please complete attached payment form

Additional surcharges - bank transfer

Annual bank transfer	$30

The bank transfer fee does not need to be included as long as the payee selects to pay all charges.

5 Data Protection & General Data Protection Regulations

The data protection law in the UK changed on 25 May 2018. This paragraph sets out how we process your data and your rights under the new laws, although you should refer to the Morgan Price Privacy Notice at [www.morgan-price.com/privacy-policy/] for further details.

Morgan Price International Healthcare Ltd together with its insurance partners are the joint controller and processor of your personal data (the insurance partner of your policy will be advised to you when you purchase the cover). We will collect your personal data including but not limited to special categories of Personal Data about you (this includes details about your sex, ethnicity, age, and information about your health and medical conditions). We respect your privacy and we are committed to protecting your personal data.

This notice aims to give you information on how we collect and process your personal data when using our insurance services, including any data you may provide when you purchase our insurance products or services. Personal data, or personal information, means any information about an individual from which that person can be identified. It does not include data where the identity has been removed (anonymous data). Where we need to collect personal data by law, or under the terms of an (insurance) contract we have with you and you fail to provide that data when requested, we may not be able to perform the contract we have or are trying to enter into with you or provide the insurance services to you (for example, to provide you with medical claims insurance services). In this case, we may have to cancel the insurance product or insurance service you have with us but we will notify you if this is the case at the time. We will only use your personal data when the law allows us to. Most commonly, we will use your personal data in the following circumstances:

- Where we need to perform the insurance contract we are about to enter into or have entered into with you;
- Where we need to assess any medical conditions, claims and Health data to perform our obligations under the insurance contract;
- Where it is necessary for our legitimate interests (or those of a third party) and your interests and fundamental rights do not override those interests; and;
- Where we need to comply with a legal or regulatory obligation.

We will only use your personal data for the purposes of providing insurance products and services unless otherwise indicated to you. We may have to share your personal data with our insurance partners, which may include reinsurers, insurance intermediaries, third party medical claims administrators and other related parties to satisfy our contractual and legal obligations under the insurance contract (policy terms).
Many of our external third parties are based outside the European Economic Area (EEA) so their processing of your personal data will involve a transfer of data outside the EEA. Whenever we transfer your personal data out of the EEA, we ensure a similar degree of protection is afforded to it by ensuring that we use specific contracts approved by the European Commission. We have put in place appropriate security measures to prevent your personal data from being accidentally lost, used or accessed in an unauthorised way, altered or disclosed. In addition, we limit access to your personal data to those employees, agents, contractors and other third parties who have a business need to know. They will only process your personal data on our instructions and they are subject to a duty of confidentiality.
We will only retain your personal data for as long as necessary to fulfil the purposes we collected it for, including for the purposes of satisfying any legal, accounting, or reporting requirements.
Under certain circumstances, you have rights under data protection laws in relation to your personal data. More details of these rights can be found within our Privacy Notice and at [www.morgan-price.com/privacy-policy/]. These rights include: Request access to your personal data; Request correction of your personal data; Request erasure of your personal data; Object to processing of your personal data; Request restriction of processing your personal data; Request transfer of your personal data and Right to withdraw consent.

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 section 5 of this proposal.
c. I am consenting for my insurance broker to act on my behalf for the purposes of transferring sensitive data.
d. 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 answered all questions about this policy honestly and fully. I/We also understand that I/we must tell the insurer straight away if anything that I/we have already told the insurer changes. I/we understand that nondisclosure or misrepresentation of any facts may entitle the insurer to void the insurance. This proposal and the information provided 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.
e. I/We understand that the signing of this proposal does not bind me/us to complete, or insurers to accept this insurance.
f. 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 _____

Policy No. _____

Surname: _____

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Part B

Confidential medical declaration

Important: You and the persons applying for cover under this policy must declare to us any and all known pre-existing medical conditions. If you do not tell us, your policy may be cancelled and any claim you make may not be paid.

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

6. 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 note that if you answer yes to any of these questions, you MUST provide further details in the addditional information section.

6.1.	AIDS/ARC/HIV	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.2.	Alcohol dependency or drug/substance abuse	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.3.	Anaemia or any blood disorder	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.4.	Arthritis, or any disorder of any muscles or joints	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.5.	Asthma, bronchitis or any other respiratory disorder	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯

		Policyholder	Spouse	Dep. 1	Dep. 2
6.6.	Back/spine/neck	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.7.	Blood pressure/hypertension *If yes, please complete our hypertension questionnaire*	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.8.	Blood vessels/clots/circulatory system	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.9.	Bones (including fractures)	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.10.	Brain/head	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.11.	Cancer, tumour, growth or cyst	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.12.	Carpal tunnel syndrome	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.13.	Cerebrovascular disease/disorder or stroke	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.14.	Chest pains, palpitations, heart murmur, angina, heart attack or any other heart disorder	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.15.	Cystic fibrosis	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.16.	Dental/gum disease	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.17.	Diabetes	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.18.	Ears, eyes, nose or throat	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.19.	Epilepsy, convulsions, seizures, fits	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.20.	Gastrointestinal disorder (stomach/intestines)	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.21.	Gout	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.22.	Hernia	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.23.	Immune system disorder	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.24.	Injury, operation, physical defect or deformity	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.25.	Kidney/bladder/urinary tract	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.26.	Liver, gall-bladder, pancreas or spleen	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.27.	Lungs/breathing	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.28.	Mental/nervous disorder	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.29.	Neurological/nervous system	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.30.	Paralysis	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.31.	Prostate	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯

		Policyholder	Spouse	Dep. 1	Dep. 2
6.32.	Rheumatic fever	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.33.	Reproductive disorder or infertility	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.34.	Skin	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.35.	Sleep disorder	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.36.	Stroke	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.37.	Surgical operation	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.38.	Ulcer	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.39.	Urinary abnormality	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.40.	Other medical condition not listed	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.41.	Do you wear spectacles/glasses or contact lenses?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.42.	Are you currently undergoing or been advised to undergo any dental treatment?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.43.	Do you currently have any crowns, inlays, fillings, bridges or missing teeth?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.44.	Have you smoked, used tobacco or nicotine replacements in the last 12 months? If so, how many per day?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.45.	Do you have any known allergies, including food allergies?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.46.	Have you suffered any symptoms for which you have not sought medical advice?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.47.	Do you have any known check-ups or doctor appointments pending now or in the future?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.48.	Are you currently under the care of any specialist? (e.g. a cardiologist or oncologist)	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.49.	Are you currently pregnant?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯

Please provide us with the name and address of your regular personal or family doctor/physician. If you do not have a regular doctor, please give the last doctor you visited and and approximate date. - *If there is a different doctor for each applicant, please provide all detais and indicate which physician applies to each applicant.*

Additional information

Please use this space to provide details if you answered "Yes" to any of the questions in the rest of Section 5. If you require additional space, please continue on a separate sheet.

	Question no.	Name of illness/medical condition*	Dates (to and from)	What medical treatment was provided?	Current medication name and daily dose	Have you had any hospital stay in relation to this condition?	What is the current status of the condition?**
Policyholder							
Spouse							
Dep. 1							
Dep. 2							

*Where applicable, please state the area of the body affected (e.g. left or right arm)
**Please enter either Complete Recovery, Ongoing or Recurrent (or likely to recur)

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

Release of Medical Information Form (ROMIF)

morganprice international

Please complete and sign the following authority for release of medical information.

Part C

AUTHORISATION

Your policy is underwritten by various insurers and administered by Morgan Price International Healthcare Limited.

I declare that all the information I have given on this form is correct to the best of my knowledge.
To support the application for my health insurance policy, I give my consent for any doctor, medical practitioner, medical facility, or any other person who has attended or examined me, to furnish Morgan Price or their authorised representatives with any/all information relating to my sickness, illness or injury, medical history, consultations, prescriptions, treatment and medical records.

This information is required by Morgan Price and their Insurers/Reinsurers in order to confirm coverage for my medical condition(s).

A photocopy of this authorisation shall be considered as effective and valid as the original.

Insured/Policyholder (Please Print)

Date of Birth | Policy Number

I wish to see any report from the medical practitioner before it is sent to you ○ Yes ○ No

I wish for another person/organisation(s) to help with the this application and I agree, for that reason, that Morgan Price or any policy administrator and the person/organisations(s) named below may discuss this application to the extent necessary to each other my relevant health and medical details. ○ Yes ○ No

If you answered yes please give the name of the person or organisation(s) here:
(e.g. Insurance broker or Intermediary)

(If you give the name of an organisation, this will mean that we can communicate with any employee of that organisation, which will help us if the person you usually deal with is unavailable).

Signature Name (Please Print)

Date

If there are dependants on this application form, please confirm by ticking this box that you have the authorisation of all of them to proceed with this application. ☐