

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 for 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: _____ (cm/ft) Weight: _____ (kg/lb)
- BMI

B. Contact Details

PRINCIPAL RESIDENCE (where you are living or intend to live)

- 1) Address: _____

Postal Code: _____
Country: _____
- 2) Telephone (include country dialling code)
Home: _____
Office/Mobile: _____
- 3) Fax: _____
- 4) E-mail: _____

OTHER RESIDENCE (if applicable)

- 1) Address: _____

Postal Code: _____
Country: _____
- 2) Telephone (include country dialling code)
Home: _____
Office/Mobile: _____
- 3) Fax: _____
- 4) E-mail: _____

- 5) Where would you like your policy documents to be sent? Principal Residence (above) Other Residence (above)
- How would you like your policy sent? Airmail (standard) Courier (US\$/EUR€ 75 or GBP£ 40 surcharge)

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

C. Spouse and/or Dependent Children To Be Insured

SPOUSE (You can include your spouse and any dependent children under age 21, or under age 25 if unmarried and a full-time student.)

- 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: _____ (cm/ft) Weight: _____ (kg/lb) BMI _____

OFFICE USE ONLY

DEPENDENT CHILDREN (For children age 21 or older, please attach proof of schooling)

	Name	Date of Birth	Sex (M/F)	Height (cm/ft)	Weight (kg/lb)	Full-Time Student (Y/N)
1)	_____	_____	_____	_____	_____	_____
2)	_____	_____	_____	_____	_____	_____
3)	_____	_____	_____	_____	_____	_____
4)	_____	_____	_____	_____	_____	_____

Are any of the dependent children eligible for benefits from any Social Security or government plan or does she/he have any other medical insurance in force today? NO YES if YES, please give details: _____

D. Medical Cover Required

- 1) Choose the area of cover you require: World-wide cover Excluding USA World-wide cover Including USA

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

- 2) Choose the Currency you wish your plan to be in: US Dollar (USD\$) Euro (EUR€) Sterling (GBP£)

- 3) Choose the plan most suited to your needs:
- Plan 1 - HEALTHCARE EXECUTIVE
 - Plan 2 - HEALTHCARE PREMIUM
 - Plan 3 - HEALTHCARE PLUS
 - Plan 4 - HEALTHCARE STANDARD
 - Plan 5 - HEALTHCARE EMERGENCY PLUS

Choose the Excess Option you wish to include:

The Deductible for the **Emergency Plus Plan** is set at
 US\$/EUR€ 2,000 or GBP£ 1,400.

- Zero Deductible (only applicable to Premium and Executive Plans)
- US\$/EUR€ 250 or GBP£ 175 Deductible
- US\$/EUR€ 1,000 or GBP£ 700 Deductible

- Choose your Co-Pay Option: Nil 10% (5% discount) 20% (10% discount) 30% (15% discount)

This is limited to the first USD\$/EUR€ 20,000 or GBP£ 16,500 of covered expenses.

Preferred start date: _____

E. Optional Cover

- 1) Choose the amount of Personal Accident Cover you require:

All applicants over the age of 18 are automatically insured for Personal Accident cover up to USD\$/EUR€ 25,000 or GBP£ 15,000. However, you can opt to have this increased in increments of USD\$/EUR€/GBP£ 10,000 up to USD\$/EUR€ 125,000 or GBP£ 115,000. (This option is not available to children under the age of 18). This amount must be in the same currency as your Plan above.

Please select additional amounts of cover required: Policyholder: _____ Spouse: _____

- 2) Check the following option if you want Dental Cover:

- Policyholder Spouse Child1 Child2 Child3 Child4

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

F. Health Declaration

STATEMENT OF HEALTH BY APPLICANT (to include Spouse and/or Dependent Children listed in Section C). 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 5 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) Do you or any of your dependents have any physical defect or infirmity? YES NO
- 2) Have you or any of your dependents suffered from any recurring illness or injury, whether or not medical attention was sought? YES NO
- 3) Have you or any of your dependents undergone a surgical operation or do you have reason to believe that a surgical operation will be required in the future? YES NO
- 4) Have you or any of your dependents consulted with a medical practitioner in the last two years or will need to do so in the foreseeable future? YES NO
- 5) Are you or any of your dependants involved in hazardous or dangerous activities or sport? If YES, please state activities and sports below. YES NO

(Eligible claims for Hernia and Kidney Stones will be subject to a 50% copay if claimed within the first 30 days)

Additional information or observations: _____

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

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

H. Additional Health Insurance Information

1) Family Doctors (if any)

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

Additional Family Doctors (if any)

Name: _____
 Address: _____
 Telephone: _____
 Fax: _____
 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 your 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) Additional Information

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

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

I. Representations, Acknowledgments and Authorisations

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 policy year, I may still be liable to pay the balance of the premium if I have elected to pay the premium by instalments. 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 my HealthCare International membership or claims denial.

The membership plan shall be governed exclusively by the laws of Bahamas. Sagicor Capital Life Insurance Company Limited underwrite 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 received by HealthCare International.

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 authorised representative will receive a copy of this authorisation 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.

HealthCare International 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.

I authorise 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.

Date Signed: _____ Signature of Applicant: _____

J. Method of Payment

Please choose how often you would like your premium collected.

1) **By Debit / Credit Card:** AMEX MasterCard VISA Other: _____
Period of Payment: Monthly Quarterly Six Monthly Annually
Card Holder's Name: _____ Card Number: _____
Expiry Date: _____ Amount: _____
Billing Address (if different to Principal Residence): _____

2) **By Credit Transfer:** Provisional cover can only commence when the transfer has been completed. **Annual Payments only.**
Please instruct your bank to make sure that the transfer identifies you as the source beneficiary of the transfer, and the CM/Policy Number.

Bank:	HSBC	Address:	20 Eastcheap London EC3M 1ED, UK
Account Name:	HealthCare International		
Accounts:	US Dollar (\$)	Sort Code: 400515	Account: 59763170
	Euro (€)	Sort Code: 400515	Account: 59763197
	Sterling (£)	Sort Code: 400231	Account: 11365320

3) **By Cheque:** Made payable to: HealthCare International (**Annual Payments only**)

Please put your name, address and CM/Policy Number on the back of the cheque. Provisional cover cannot commence until the cheque has cleared.