International Healthcare

Your Insurance Intermediary

For internal use only

❑ New Individual ❑ Group transfer to individual

Easy Care+ Plans

Application Form Individuals *
Moratorium

* Do not use for individuals residing in Hong Kong. Please use specific

Important:

Please complete this application **in block capital letters**. All information supplied will be treated in strict confidence. Please keep a record (including copies of all letters) of all information supplied to us for the purpose of entering into this contract.

Commencement date: The inception date of this policy will generally be the date on which this application is received and accepted by the Insurers. However, should you require an inception date in the future (to take account of the expiry of current contracts elsewhere) you may do so by completing the commencement date box in section 1. Under no circumstances will policies be backdated from the date of acceptance.

Insurance year is a twelve month period.

This application is valid for 3 months. A fresh application will be required once 3 months have passed.

ALL INFORMATION must be filled. An incomplete form will delay your application.

For Group transfer to Individual:

Group Name: ______________________

____

PRN number: ______________________

____

1. Policyholder details

Family name: ______________________ Title: ____________

First & Middle name: ______________________ Marital Status: ______________________

Sex: (M/F): _____ Date of birth: ___ / ___ / ______ (dd/mm/yyyy) Nationality : ______________________

Residential address: ______________________

Postal code: ____________ City: ______________ Country: ______________________

Address for correspondence (if different from above): ______________________

Postal code: ____________ City: ______________ Country: ______________________

Contacts :

Phone number: (Office) ______________________ (Personal) ______________________

Mobile : (Office) ______________________ (Personal) ______________________

Email : (Office) ______________________ (Personal) ______________________

Occupation: ______________________ Nature of business: ______________________

Passport/ ID no.: ______________________

Commencement date (see above): ❑ ___ / ___ / ______ (dd/mm/yyyy)

❑ Upon acceptance of application

2. Dependants to be included in this plan

	Spouse / Partner	Dependant 1	Dependant 2	Dependant 3
Family name				
First name				
Middle name				
Other initials				
Sex (M/F)				
Relationship to policyholder				
Date of birth (dd/mm/yyyy)				
Occupation				
Passport/ ID no.				
Nationality				
Country of residence				

If there is insufficient space for inclusion of all dependants , please provide details on a separate sheet.

3. Medical questionnaire - No need to complete for group tranfer to individual

Please answer each of the questions in the following pages fully and accurately, for each person included on your application. In case you answer 'yes' to any question, please provide details in the additional information box on the next page.
All information supplied will be treated in strict confidence. All material facts relating to these questions must be disclosed. Failure to do so may invalidate the policy. A material fact is one which is likely to influence an insurer in the assessment and acceptance of this application. If you are in any doubt as to whether a fact is material then it should be disclosed. As proposer you should answer all questions and sign the declaration on behalf of all persons to be insured. If your state of health or that of people included in this application changes after the application has been signed and before the policy start date, the Company must be notified immediately of such change.

		Policy Holder		Spouse/ Partner		Dependants					
						1		2		3	
1	Height ❑ ft / ❑ cm										
	Weight ❑ pds / ❑ kg										
2. Have any persons named in this application ever:		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
2.1	Suffered from, been diagnosed with, treated or prescribed drugs for, any form of cancer, or heart disease, or any other serious or chronic illness that requires regular medication and/or monitoring?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
2.2	Been tested HIV and/or Hepatitis C positive?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
2.3	Female only – a. Are you pregnant?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
	– b. If so, how many months?	______		______		______		______		______	
	– c. Are there any complications?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
2.4	Had an application for insurance turned down or accepted at special terms?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

Additional information to Medical Questionnaire

If you answered "Yes" to any of the questions above, please provide details here : the name of the person, the precise question number, diagnosis, dates and duration of illness/injury/treatment and the names and addresses of attending physicians and medical facilities. Also, please provide all medical reports available, the lack of which may delay or invalidate this application.

Person	Question Nbr	Details

Please advise which physician is most familiar with your medical history?

	Policyholder	Spouse / Partner	Dependant 1	Dependant 2	Dependant 3
Name					
Tel. Nbr					
Fax					
Email					

The A+ Plans do not cover the Treatment of Pre-existing Medical Conditions and related conditions. A pre-existing condition means any disease, Illness or Injury for which the Insured has received medication, advice or Treatment, or which the Insured has experienced symptoms, whether the condition has been diagnosed or not, at any time before the date on which the Insured's Plan starts.

After two years continuous membership, any pre-existing medical conditions (and related conditions) will become eligible for benefit, subject to the terms and conditions of the Insured's plan, provided the Insured has not during that period:
a) consulted any Medical Practitioner or Specialist for Treatment or advice (including check-ups)
or
b) experienced further symptoms
or
c) taken medication or been advised to follow special Treatment (including drugs, medicine, special diets, injections, etc.)

Examples of Pre-existing Conditions that will **never** be covered include diabetes, hypertension (raised blood pressure), hyperlipidemia (raised cholesterol level), ischemic heart disease, cancer, thyroid disease, and auto-immune disorders. If the Insured has suffered from any of these conditions, or any other condition for which it is generally accepted medical advice that it be monitored in any way, then the condition - and any related conditions - will never be covered.

Examples of related conditions are raised cholesterol levels and heart disease and stroke. If the Insured has suffered from high cholesterol before the Insured's date of entry to the plan the Insured will never be covered for cardiac problems of strokes.

*** Note: You will be required to sign a declaration at the end of the Moratorium period to declare that you have met the terms detailed above.**

IMPORTANT:

Please ensure you have given an answer to every question. An incomplete form will delay your application.

Do you, at present, have a medical cover with another insurance company?	❑ Yes ❑ No
If yes, name of company: ________________________ Plan: __________________ Renewal Date: ________________	

4. Plans and Options available

A. Medical Plan [1]	❑ Plan 1 ❑ Plan 2 ❑ Plan 3 ❑ Plan 4
B. Currency [2]	US $
C. Optional Policy Deductibles [1&2]	❑ Nil ❑ 250 ❑ 500 ❑ 1,000 ❑ 5,000
D. Area of cover [1]	❑ Zone 1 (Worlwide excluding USA, Canada & Caribbean Island)
	❑ Zone 2 (EEC countries (excluding UK) and Africa (excluding South Africa))
	❑ Zone 3 (Bangladesh, Brunei, Burma/Myanmar, Cambodia, India, Indonesia, Laos, Malaysia, Philippines, Sri Lanka, Taiwan, Thailand, Vietnam)

[1] These elements must be chosen on a per family basis.
[2] Premiums and claims shall be payable in US$, according to the currency in which the medical policy has been concluded.

5. Premium payment

Your method of payment ❑ Annual ❑ Semi-annual* ❑ Quarterly* *(credit card only)*

❑ **Bank transfer**. If selected, please ensure your name is clearly stated on your transfer order and send a copy of your transfer order to your intermediary. Our bank details will be provided on the premium invoice.

❑ **Credit card** (Visa, MasterCard only) If selected, please complete the credit card authorisation section below.

Credit card authorisation ❑ Visa ❑ MasterCard

Credit card number : ____________ ____________ ____________ ____________ CVC Code : __________

Expiry date : ______ /___________ (mm/yyyy)

Credit card statement mailing address...

Exact name on credit card ___ __

Signature: ....Date: .__ __ / __ __ / __ __ __ __ (dd/mm/yyyy)

I hereby authorise A+ International Healthcare, or its agents, as of today and until further notice in writing, to charge my credit card account with unspecified amounts in respect of my premium payments as and when these become due. The Company will inform me in advance of any premium adjustments and I will have the possibility to cancel the policy.

Note: For payment by credit card, your premium will be collected upon receipt of this application which may be in advance of the commencement date. Future premiums will be collected 7 days in advance of the renewal date of this policy.

*Surcharges apply

6. Claims Reimbursement

❑ **Bank Transfer - if selected, please complete the following information**

Account Holder's name:

Account No. (IBAN for Euro zone) : Bank currency:

Full bank name and address :

BIC / SWIFT bank code :

Bank ID (If applicable) :

Note: Reimbursements by Telegraphic Transfer are effected in full by the insurer, net of bank charges. However additional bank charges may be passed on to you by

❑ **Cheque - Payee's name**: ______________________________

* Please note that bank transfers take up to 72 hours once claim is processed whilst cheques maybe delayed due to postal issues.

7. Declaration by Policyholder

1) I hereby apply for cover on behalf of all the persons named in this application form.
2) I certify that the statements made by me in answering the above questions are true, complete and to the best of my knowledge and belief. I understand that nullity of the insurance or reduction of the insured capital sum might be applied if it were proved that the person to be insured had established a false declaration. I confirm that I have checked and found correct any answers or statements in this application that are not in my own handwriting.
3) I accept that the policy will be subject to the policy terms and conditions effective at the time of commencement. I confirm that I have read and I understand the full definitions, benefits, exclusions and conditions of this policy.
4) In view of a smooth administration of the contract and/or settlement of insurance claims, and only for that purpose, I, the undersigned, hereby give my special permission regarding the processing of the medical data concerning me and/or the members of my family either directly with the Insurers or through A+ International Healthcare and/or its agents (French Law 78-17 of 6 January, 1978, relating to data freedom).
5) I agree to accept and conform to the terms of the policy when issued unless I cancel this policy within 15 days from the commencement date.
6) I certify that I have been made aware of the obligation to respond to the above questions and understand that incomplete or inaccurate answers would lead to the application of the Insurance Code article L 113-8 (contract nullity) or L 113-9 (benefits reduction). I undertake to communicate to the insurer information about the proposed insured and his dependents in strict compliance of the legislation on the processing of personal data in force. This information may be disclosed to authorized professional bodies, as well as all those involved in the management and execution of this contract. I have, as well as the members of the contract, the right to access and correct information concerning ourselves, with the Informations Clients Service - AXA 313 Terrasses de l'Arche 92727 Nanterre Cedex, France. The contract takes effect, subject to the payment of the premium, on the date stated in the policy schedule. This is based on the date of receipt of the application form and the results of the medical questionnaires and any medical reports. The decision of the insurer applies to all members under the same policy.
7) I have read and understood the Important Note below.
8) I have read Paragraph 3 on Page 2 and I understand that I will be required to sign a declaration at the end of the Moratorium period confirming that I have met the Moratorium terms.

Important Note: The policy is written in the English language and is intended for use only by persons who are able to read and understand its terms. Do not sign this application form if you do not understand the policy.

In an effort to go 'Green' A+ will be sending your policy pack via email. The Medicard will be sent to you by mail.

*** Please provide copy of all member's passport or any valid ID along with this application.**

Policyholder's signature ______________________________ Date ____ /____ / _________

Please send this application form back to your insurance broker or directly to the Insurers representative :

A Plus International Holdings Limited

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