International Healthcare

Worldwide Plans
Application Form
Companies *

Your Insurance Intermediary			
For internal use only			☐MHD
☐FMU	☐CPME	☐Moratorium	☐EMD

* Do not use for companies registered in Hong Kong. Please use specific application form instead.

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.

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

1. Policyholder details

Company name :	
Address :	
Postal code :	**Town / City :**
State :	**Country :**
Nature of business :	

2. Details of company contact person

Last name :	**First name :**	**Title :**
Address (if different from above) **:**		
Postal code :	**Town / City :**	
Telephone :	**Mobile :**	
Email :	**Fax :**	

3. Correspondence

Correspondence to be sent to :	☐ Policyholder only	☐ Broker only	☐ Policyholder and broker
Membership Cards to be sent to :	☐ Policyholder	☐ Broker	

4. Group Medical condition (Applicable to **MHD group only**, if not go directly to question 5)

Please answer both questions below fully and accurately, for the whole group included on your policy. 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 people included in this application changes after the application has been signed and before the Company has approved the insurance, the Company must be notified immediately of such change.

		YES	NO
1.	To the best of your knowledge, has any member to be included on this scheme been diagnosed with, or received any form of treatment/ consultation for cancer in the past five years?	☐	☐
2.	To the best of your knowledge, does any member to be included on this policy have any medical condition that is likely to result in the need for an in-patient stay in hospital?	☐	☐

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

5. Plans and Options available

A. Medical Plan [1]	❑ Hospitalisation	❑ Global 80	❑ Global 100	❑ Global 100 Plus		
B. Currency [1&2]	**C. Optional Policy Deductibles** [1&2] **(in the same currency as the policy)**					
USD ❑	❑ Nil	❑ 675	❑ 1,350	❑ 2,700 [4]	❑ 6,750 [4]	
EUR [3] ❑	❑ Nil	❑ 500	❑ 1,000	❑ 2,000 [4]	❑ 5,000 [4]	
GBP [3] ❑	❑ Nil	❑ 450	❑ 900	❑ 1,800 [4]	❑ 4,500 [4]	
CHF [3] ❑	❑ Nil	❑ 750	❑ 1,500	❑ 3,000 [4]	❑ 7,500 [4]	

6. Policy start date

Start date (dd - mm - yyyy) __ __ / __ __ / __ __ __ __

7. Employees to be insured under the plan (please contact us in case you need assistance)

For all employees to be covered under the plan, our document (member's list) must be completed specifying the personal details and the exact cover needed for the employees and family members.

8. Premium payment

A. Your choice of currency is as per part B in section 4.

Note: The choice of currency has to be made by the Policyholder before the coverage takes effect, and can only be changed at the annual renewal date.

B. 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

9. Invoicing address (only if different from the principal company address)

Company name :	
Address :	
Postal code :	**Town / City :**
State :	**Country :**

10. Declaration by Policyholder

1) I hereby apply for cover on behalf of all the persons named with this application form.
2) I certify that the statements made and the information provided by me in this application 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 all the persons included in this application 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 30 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.

Important Note: This 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. If you wish to receive a hardcopy of your policy pack please tick this box. 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.**

Policy holder's signature and Company chop _____ Date __ __ /__ __ / __ __ __ __ dd/mm/yyyy)

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

A Plus International Holdings Limited
Correspondence Address
Room 4, 17th Floor, Westlands Centre, 20 Westlands Road, Quarry Bay, Hong Kong China S.A.R.
Tel: +852 2891 3608 Fax : +852 2891 3229 Email : cs@aplusii.com