



BRITSURE EXPATRIATE HEALTH INSURANCE APPLICATION FORM

Please read through the following before completing this application and complete in **BLOCK CAPITALS**. All information supplied will be treated in the strictest confidence.

1. All material facts must be disclosed. Failure to do so could invalidate the Policy. A material fact is one which would be likely to influence an Insurer in the acceptance or assessment of the risk. State any material facts on a separate sheet. If in doubt as to whether a fact is material, then it should be disclosed to the Insurers
2. No liability is undertaken until the proposal is accepted by the Insurers and the premium paid. The Insurers reserve the right to ask for special terms or to decline the proposal.
3. You should keep a record (including copies of letters) of all information supplied to the Insurers for the purpose of entering into this contract. A copy of this proposal form will be supplied to you on request within three months of receipt.
4. As the proposer, you should answer all questions, sign the document on behalf of all persons to be insured, and confirm that you have checked and found correct any answers or statements in this application that are not in your handwriting.
5. Benefits will not be payable for treatment of any illness or condition which originated prior to the date of acceptance of this application until a period of two years (five years in the case of Heart and Cancer conditions) has passed and no medical advice has been given in respect of that illness, injury or condition unless accepted by BRITSURE Expatriate Health Insurance.

PROPOSER

Title		First Names	
Surname			
Nationality on Passport		Date of Birth	
Height		Weight	
Occupation			
Home Address			
Postal Address			
Telephone		Fax	
E-Mail		Mobile	

SPOUSE / PARTNER

Title		First Names	
Surname			
Nationality on Passport		Date of Birth	
Height		Weight	
Occupation			

CHILD 1 (UNDER 19)

Title		First Names	
Surname			
Nationality on Passport		Date of Birth	
Height		Weight	
Occupation			

CHILD 2 (UNDER 19)

Title		First Names	
Surname			
Nationality on Passport		Date of Birth	
Height		Weight	
Occupation			

EXISTING INSURANCE ARRANGEMENTS

Do you currently have a Healthcare Plan? Yes No

If Yes, please advise date of expiry: _____

Has your current insurer applied any special terms to your policy? Yes No

If Yes, please give details: _____

YOUR INSURANCE REQUIREMENTS

Date Cover to Start _____ Plan Required Silver Gold
 Country of Cover* _____

* If country of cover differs from home address please contact your agent

POLICY EXCESS	SILVER	GOLD
Clients up to 64	£100	£150
Clients aged 65 - 74	£150	N/A
Clients aged 75 - 79	£250	N/A

Voluntary Policy Excess	Rate Discount	
£150.00	10% rate discount (Silver Only)	€ Yes € No
£250.00	15% rate discount (N/A if aged over 65 years)	€ Yes € No
£500.00	20% rate discount (N/A if aged over 65 years)	€ Yes € No
£1,000.00	25% rate discount (N/A if aged over 65 years)	€ Yes € No

Please consider the following questions as they apply to each of the people named on this proposal form. Answer each question clearly, ticking one of the corresponding boxes shown under the heading 'YES' or 'NO'.		Proposer Spouse/		Partner		Child 1		Child 2	
		Please answer ALL questions							
1	Has any inpatient stay in a hospital or nursing home taken place within the last four years?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2	Has any specialist been consulted within the last four years?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3	Has any general practitioner been consulted and/or provided prescriptions for any drugs or medications during the last two years?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4	Are prescription medications currently being taken?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5	Does any chronic/long-term medical condition exist or is there any other known disability, abnormality, or recurrent illness or injury?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6	Is there any known or foreseeable need to consult any doctor or other health professional? (See * below).	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

7	Have you smoked any tobacco products during the last 12 months?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8	How many units of alcohol do you consume each week? (1 unit = 1 pint of beer; 1 glass of wine; or 1 measure of spirits).	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

* Please ensure that you fully disclose any known or suspected conditions and any symptoms by anybody included in this application. This applies even if professional advice has not yet been sought. Typical examples are varicose veins, allergies, backache, bunions, piles, gynaecological problems (including any irregularities of menstruation), any ear, nose or throat problems, or any pains, swellings or lumps.

If you have answered YES to any of the above questions, please give details – including dates, condition, treatment, ongoing treatment, and current position in the space overleaf – ensuring that your information is shown against the family member and the appropriate question number to which the information relates. Where necessary, please continue on a separate sheet of paper.

Following this you may be contacted by a member of the BRITSURE HEALTH INSURANCE medical staff to accurately assess the acceptance terms available to you.

MEDICAL INFORMATION

Name: _____

Question	Details

Name: _____

Question No	Details

Name: _____

Question No	Details

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Name: _____

Question No	Details

DETAILS OF YOU DOCTOR

Current Doctors Details	
Name	
Address	
Telephone	

Last Doctors Details in Your Home Country	
Name	
Address	
Telephone	

DECLARATION

To the best of my knowledge and belief, the information provided in connection with this proposal, whether in my hand or not, is true and I have not withheld any material facts. I understand that non-disclosure or misrepresentation of a material fact may entitle the Insurers to void the insurance and that I must notify the Insurers of any change in circumstances that may affect the coverage provided by this policy.

I understand that this policy is an annual contract and is operative for twelve months from the start date and that at each renewal date the Insurer reserves the right to alter or discontinue the benefits, terms, conditions and premiums of this policy.

In the event of a claim I authorise the Insurers or their appointed agents to contact the doctors named above, or any other doctor who may have provided medical treatment, to obtain additional information. This agreement is given under the terms of the 'Access to Medical Records Act 1988'.

Provided that:

1. If you withhold your consent we may not be able to process your claim
2. You may see the report before it is sent to the Insurers or their appointed agents.
3. You may see the report for up to six months after the report is completed.
4. You may ask the doctor to amend any part of the report that you consider to be incorrect or misleading. If the doctor does not agree with your request, you may attach your comments to the report

Signature of Proposer _____ On Behalf of ALL Applicants

Date _____

**Once you have completed ALL sections of this Application Form,
please return it to Your Broker or send to:**

**ALL SEASONS UNDERWRITING AGENCIES LIMITED
BRITSURE EXPATRIATE HEALTH INSURANCE
AVALON HOUSE, BRICKYARD ROAD, WALTHAM BUSINESS PARK, SWANMORE, HAMPSHIRE SO24 2AA**

April Medibroker
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