Coversure℠ International Healthcare Application Form

Underwritten by Sirius International Insurance Corporation (publ) (the "Insurer") Administered, as agent for and on behalf of the Insurer, by International Medical Group®, Inc. ("IMG℠"). Coordinated, as agent for and on behalf of the Insurer for the purposes of receiving premiums, receiving and holding claims money; and receiving and holding premium refunds, by IMG Europe Ltd.

Please complete this form in block capitals using black ink.
For all sections please ensure you give an answer to every question. An incomplete form will delay the processing of your application.

SECTION 1. Your Personal and Cover Details

Please complete for all family members applying for cover.

1.1 Details About You

A. Applicant

Title: Mr / Mrs / Miss / Ms / Dr	**First Name(s):**		
Surname (Family Name):			
Date of Birth: DD/MM/YY	❑Male ❑Female	**Height:** ❑cm ❑in	**Weight:** ❑Kg ❑lb
Occupation:			
Nationality on Passport:	**Passport Number:**		

1.2 Details About Members of Your Family Applying for Cover

B. Spouse

First Name(s): **Title:** Mr / Mrs / Miss / Ms / Dr	**Surname (Family Name):**		
Date of Birth: DD/MM/YY	❑Male ❑Female	**Height:** ❑cm ❑in	**Weight:** ❑Kg ❑lb
Occupation:			
Nationality on Passport:	**Passport Number:**		

C. First Child (Below Age 19)

First Name(s):	**Surname (Family Name):**		
Date of Birth: DD/MM/YY	❑Male ❑Female	**Height:** ❑cm ❑in	**Weight:** ❑Kg ❑lb
Nationality on Passport:	**Passport Number:**		

D. Second Child (Below Age 19)

First Name(s):	**Surname (Family Name):**		
Date of Birth: DD/MM/YY	❑Male ❑Female	**Height:** ❑cm ❑in	**Weight:** ❑Kg ❑lb
Nationality on Passport:	**Passport Number:**		

E. Third Child (Below Age 19)

First Name(s):	**Surname (Family Name):**		
Date of Birth: DD/MM/YY	❑Male ❑Female	**Height:** ❑cm ❑in	**Weight:** ❑Kg ❑lb
Nationality on Passport:	**Passport Number:**		

❑ *Tick if you have any further dependents and please provide details on a separate sheet.*

1.3 Residential Address

Street Address:
Town/City:
State/County:
Postal Code:
Country:

1.4 Mail Forwarding Address (if different from address in 1.3)

Street Address:
Town/City:
State/County:
Postal Code:
Country:

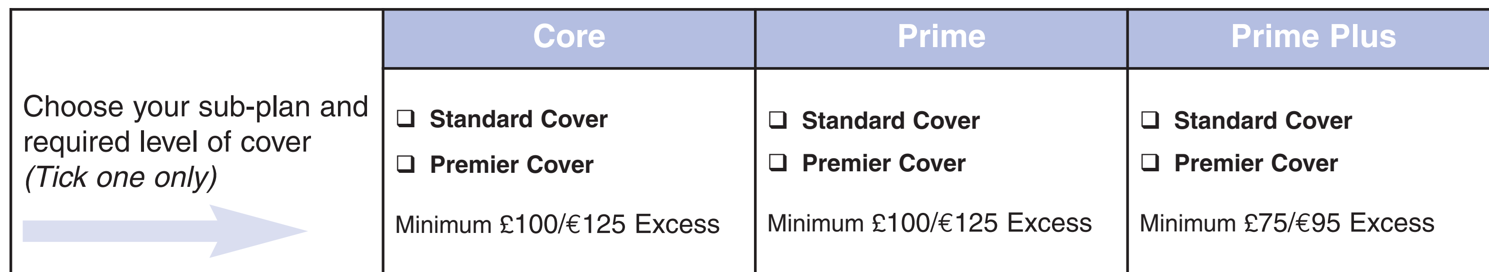
1.5 Contact Details

Primary Telephone: + Country (Area) Number	**Other Telephone:** + Country (Area) Number
Fax: + Country (Area) Number	**Email:**

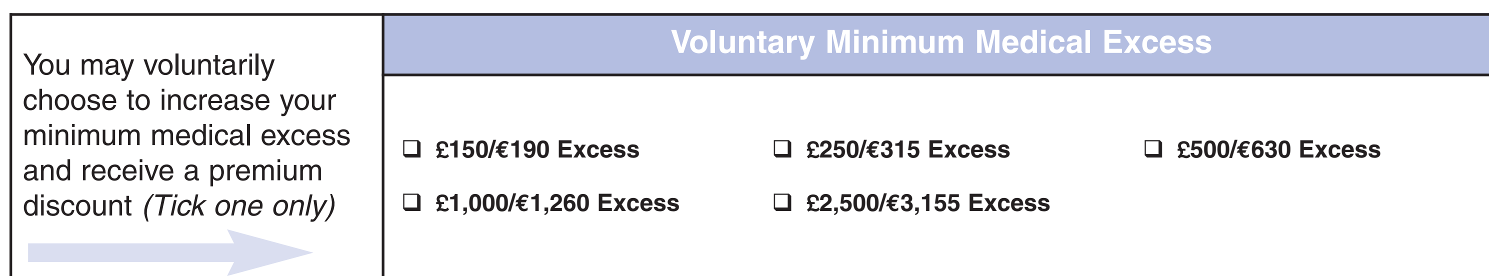
1.6 Select The Currency You Would Like for Your Plan *(Tick One)*

❑ GB Pounds (£)
❑ EU Euros (€)
The Plan currency also decides your premium currency.

1.7 Select Which Sub-Plan You Would Like *(Tick One Only)*



	Core	Prime	Prime Plus
Choose your sub-plan and required level of cover *(Tick one only)*	❑ **Standard Cover** ❑ **Premier Cover** Minimum £100/€125 Excess	❑ **Standard Cover** ❑ **Premier Cover** Minimum £100/€125 Excess	❑ **Standard Cover** ❑ **Premier Cover** Minimum £75/€95 Excess



	Voluntary Minimum Medical Excess		
You may voluntarily choose to increase your minimum medical excess and receive a premium discount *(Tick one only)*	❑ **£150/€190 Excess** ❑ **£1,000/€1,260 Excess**	❑ **£250/€315 Excess** ❑ **£2,500/€3,155 Excess**	❑ **£500/€630 Excess**

The Voluntary Minimum Medical Excesses and premium discounts apply only to Coversure International Healthcare and not to optional add-on plans or non-medical sections of cover.

SECTION 2. Health Declaration

Health Declaration **Please answer all questions for each applicant applying for cover.**		**If YES, show FAMILY MEMBER Using Letters from Section 1.**
1. Are you or any other applicant currently disabled, pregnant, or unable to perform normal activities?	❑Yes ❑No	
2. Are you or any other applicant presently hospitalised, or scheduled for or in need of hospitalisation or surgery?	❑Yes ❑No	
3. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder?	❑Yes ❑No	
4. Have you or any other applicant ever had, been recommended to have, or are you currently on a waiting list for any organ transplant (other than corneal)?	❑Yes ❑No	
If any applicant answered YES to any of the above four questions, he or she does not qualify for this insurance. Thank you for your interest.		
5. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past 5 years? If yes, please complete Section 3.3.	❑Yes ❑No	
If any applicant answered YES to the above question, he or she may not qualify for this insurance.		

SECTION 2. Health Declaration Continued

Questions 6 - 25 below must be answered for the applicant and every other member of your family applying for cover. For any question answered "YES," please identify the family member to whom the answer applies (use the letter that corresponds to the family member from Section 1), and provide complete details of the medical condition at issue in the space provided in Section 3.3 of this application, including the name, address and telephone number of all attending physician(s), diagnoses, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. IMG reserves the right to request additional medical information.

		If YES, show FAMILY MEMBER Using Letters from Section 1.
6. During the last 12 months, have you or any other applicant experienced manifestation or symptoms of, been diagnosed with, or received any consultation, examination, testing or treatment (including medications) for, any medical, health, mental, physical or nervous condition? If yes, please complete Section 3.3.	❑Yes ❑No	
7. Have you or any other applicant ever had an application for health, life or disability insurance or reinstatement rejected, cancelled, rated, declined, modified or postponed? If yes, please explain in Section 3.3.	❑Yes ❑No	
Have you or any other applicant ever experienced manifestation or symptoms of, suffered from, sought consultation, examination, testing or been treated for, or been diagnosed with, any disease, condition, illness, medical problem, disorder, sickness or other problem arising from, involving, or relating to any of the following:		
8. Heart, cardiac, cardiovascular and/or circulatory, including, but not limited to: congestive heart failure, heart attack, angina, chest pain, arteriosclerosis, atherosclerosis, elevated blood pressure, hypertension, swelling of feet/ankles, thrombosis, phlebitis, rheumatic fever, or heart murmur? If yes, please complete the following: a. Date of most recent BP reading? ____________ b. Result: ____________ c. Medications taken (Types & Dosage)____________	❑Yes ❑No	
9. Blood, blood vessels, arteries, veins or disorders of the blood, including, but not limited to: anaemia, haemophilia, leukemia, hepatitis, lymph glands, or high cholesterol?	❑Yes ❑No	
10. Diabetes, hyperglycemia or hypoglycemia? If yes to diabetes, please complete the following: a) Diabetic Type: I___ or II ___ b) Date diagnosed: ____________ c) Controlled by diet only? Yes__ No__ d) Medications (Types and Dosage) ____________ e) Date of most recent HbA1c Test? ____________ f) Results of HbA1c Test (1 - 10) ____________	❑Yes ❑No	
11. Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump or growth of any kind?	❑Yes ❑No	
12. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid or metabolic disorders, or obesity?	❑Yes ❑No	
13. Kidney, urinary tract functions, kidney or bladder stones or infections?	❑Yes ❑No	
14. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy pneumonia?	❑Yes ❑No	
15. Mental and nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, chemical or drug abuse or dependency, alcoholism, psychiatric counseling and/or support groups, depression, anxiety, chronic fatigue, or eating disorders?	❑Yes ❑No	
16. Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebral ischemic attacks?	❑Yes ❑No	

		If YES, show FAMILY MEMBER Using Letters from Section 1.
17. Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease, vertebrae, or any other back condition, rheumatism, arthritis, gout, tendonitis, osteoporosis or inflammation?	❑Yes ❑No	
18. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice, diagnosis or treatment?	❑Yes ❑No	
19. Congenital, genetic or hereditary condition or defect including, but not limited to: mental retardation, Down Syndrome, or other chromosome disorder, physical disorder, deformity or defect?	❑Yes ❑No	
20. Digestive system, stomach, or intestines, including, but not limited to: esophageal regurgitation, gastritis, ulcers, colon, or rectum disorders?	❑Yes ❑No	
21. Reproductive systems, including but not limited to: prostate or elevated PSA level, vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus?	❑Yes ❑No	
22. Eyes, ears, nose, mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation, chronic sinusitis, or TMJ?	❑Yes ❑No	
23. Any other disease, medical problem, illness, injury or condition of any kind not listed?	❑Yes ❑No	
24. Do you or any other applicant currently use or during the past 5 years have you or any other applicant used tobacco in any form?	❑Yes ❑No	
25. Have you or any other applicant ever applied for or purchased insurance through IMG? (If yes, please provide certificate number and details.) Certificate Number: ______________________________ Policy Undertaken: ______________________________	❑Yes ❑No	

SECTION 3. Confidential Medical / Prior Insurance Information

3.1 Medical Practitioner's Details

The name and address of my usual family doctor is as follows:

Doctor's Name:	**Telephone:** + Country (Area) Number
Address:	
Country:	**Postal/Zip Code:**
Date Last Seen:	**Reason:**

If the above details are different for any other applicant, please give details on a separate sheet and indicate that you have done so by ticking this box ❑

3.2 Prior Insurance Details

❑ Tick here if applying to transfer from another health insurance plan. Providing cover has been continuous, this insurance will take into account the extent of the previous in determining the two year (five years for cancer and heart conditions) moratorium. Insurers reserve the right to, carry over prior or apply new, personal medical exclusions, amend terms or premiums, or reject applications, at their sole discretion. Cover is not effective until this application has been accepted and approved by Insurers and a written Coversure Certificate of Insurance issued upon receipt of premium by Insurers. Acceptance is not guaranteed, do not cancel your existing cover until you have written confirmation of Coversure cover from Insurers.

Your Existing Plan		(Please attach - current policy schedule and your renewal notice)			
Current Insurance Plan Name	**Level of Cover / Sub Plan**	**Original Effective Date**	**Area of Cover**	**Excess Payable**	**Payment Frequency**
		DD / MM / YY			
Do you or any person applying for cover under Coversure have any medical conditions that are specifically listed and excluded from cover under your existing plan?					**No**___ **Yes**___ If yes, please complete below
Name	**Condition(s) / Exclusion(s) applied to existing plan**				

3.3 Further Medical Information / Prior Insurance

For any question answered "YES" in Section 2, please identify each applicant for whom the answer applies (using the corresponding letter(s) from Section 1), and provide complete details of the medical condition at issue, including the name, address and telephone number of the attending physician(s), hospital(s), clinic(s) and all other health care providers involved, diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. Please attach additional pages as necessary.

Question Number From Section 2	Family Member (USE LETTERS FROM SECTION 1.)	Condition(s)/Diagnosis, Prognosis, Past and Present Course of Treatment(s)	Physician/Hospital/Clinic/Health Care Provider Name(s), Address & Telephone	Date(s) of Treatment
(attach additional pages as necessary)				

If any applicant applying for cover has ever had an application for health, life, or disability insurance or reinstatement rejected, cancelled, rated, declined, modified or postponed (see Section 2, Question 7), please explain below.

____

____

(attach additional pages as necessary)

Declaration for Coversure International Healthcare:

AGREEMENT

I (we) understand and hereby agree that:

(i) I (we) apply for insurance under Coversure International Healthcare.

(ii) Cover will be provided in accordance with the Policy Wording; and I (we) will read it upon receipt and be bound by it unless I (we) cancel the plan within 30 days after receiving the Policy Wording.

(iii) This Application will be the basis for and form a part of any insurance issued.

(iv) I (we) have read all statements, questions and responses contained in this Application or they have been read to me (us) and I (we) understand them.

(v) My (our) responses to the statements and questions contained in this Application are true, accurate complete and correctly recorded in all respects, and I (we) will supplement such responses prior to the requested effective date in the event of any change or addition thereto.

(vi) The agent/broker assigned to or assisting with this Application is the representative of me (us) and is not an agent/broker of the Insurer, IMG or IMG Europe Ltd.

(vii) No agent/broker has the authority to modify or waive any statement, question or response in this Application or to modify or waive any term of the plan, or to waive any of the rights or requirements of the Insurer, IMG or IMG Europe Ltd.

(viii) No cover will be effective unless and until this Application has been duly accepted in writing by the Insurer, and there has been no change since the date of this Application Form in the insurability of all persons proposed for cover or in any responses to the statements and questions in this Application.

(ix) The subjects, risks and benefits of insurance for which I (we) apply for cover under the plan are not intended or considered by me (us) to be resident, located or performed in any state of the USA or any particular country.

(x) Premiums will be applied from the effective date forward and there will be no cover for any claim that begins prior to the effective date.

(xi) Any misstatement, misrepresentation or omission contained in this Application will void the insurance applied for, and any and all claims and benefits under the plan will be forfeited and waived.

(xii) The Insurer, IMG and IMG Europe Ltd., their employees, representatives, agents and any other persons or organisations performing services for them or on their behalf, may use, disclose or transfer to any organisation any information about me (us) obtained or collected in connection with this Application, (whether contained in this Application or otherwise) for the purpose of: (1) assessing this Application and providing on-going insurance and customer service; (2) processing and giving effect to credit/debit card payments; (3) providing marketing material in respect of insurance related services of IMG or its associated companies; and (4) processing claims or analysing the insurance.

AUTHORISATION

For purposes of determining my (our) insurability, I (we) authorise any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, pharmacy, medical records service, prescription history clearinghouse, other insurer, government agency, employer, social worker or family member to provide information about me (us), including my (our) entire medical record, to Sirius International Insurance Corporation (publ), International Medical Group, Inc. and IMG Europe Ltd., their employees, representatives, agents and any other persons or organizations performing insurance services for them or on their behalf. By my (our) signature below, I (we) acknowledge that any prior agreement I (we) have made to restrict or limit the disclosure of information about my (our) health does not apply to this authorisation.

This authorisation is valid from the date of my (our) signature shown below. A copy, image or facsimile of this authorisation is as valid as the original.

Signature of Applicant or Guardian: X   Date :

Signature of Spouse: X   Date :

GLOBAL PERSONAL ACCIDENT PLAN
GLOBAL DAILY INDEMNITY℠ - Hospital Income Plan
Optional Additional Covers Application Form

IMG Europe Ltd
36-38 Church Road, Burgess Hill
West Sussex, RH15 9AE
United Kingdom
Tel: +44 (0) 1444 46 55 55
Fax: +44 (0) 1444 46 55 50
e-mail: info@imgeurope.co.uk

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Global Personal Accident Plan and Global Daily Indemnity are only available at the time of application for, and with the purchase of, Coversure International Healthcare. To apply, simply complete Section 4 of this Application.

SECTION 4. Application For Global Personal Accident Plan and/or Global Daily Indemnity Insurance

Please indicate the name of each family member applying for Global Personal Accident Plan and/or Global Daily Indemnity.

	Name	Personal Accident First unit of cover	Personal Accident Second supplemental unit of cover	Daily Indemnity Cover
A. Applicant		❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
B. Spouse		❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
C. First Child		❑Yes ❑No	**NOT AVAILABLE**	❑Yes ❑No
D. Second Child		❑Yes ❑No	**NOT AVAILABLE**	❑Yes ❑No
E. Third Child		❑Yes ❑No	**NOT AVAILABLE**	❑Yes ❑No

	For each individual applying for life insurance, please indicate:		% of Death Benefit
Applicant A	Primary Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%
	Contingent Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%
Applicant B	Primary Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%
	Contingent Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%
Applicant C	Primary Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%
	Contingent Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%
Applicant D	Primary Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%
	Contingent Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%
Applicant E	Primary Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%
	Contingent Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%

Declaration for Global Personal Accident Plan and/or Global Daily Indemnity (If Applicable)

If accepted for the Coversure International Healthcare, I (we) understand that I (we) may qualify for Global Personal Accident Plan and/or Global Daily Indemnity underwritten by Insurer. I (we) hereby incorporate herein the certifications, representations, understandings, agreements, acknowledgements, authorisations, and warranties from the foregoing Application for the Coversure International Healthcare, and understand and agree that the terms, conditions, restrictions and penalties thereof shall likewise apply hereto. If a U.S. citizen, I (we) understand coverage for Global Personal Accident Plan will not be effective prior to the date of my (our) departure from the U.S. If I (we) have also applied for the optional Global Daily Indemnity plan, I (we) understand that only overnight hospital stays eligible under my (our) Coversure International Healthcare, excluding pregnancies, are covered. I (we) also understand: (i) there is an additional premium for Global Daily Indemnity, (ii) that in the event this Application is not accepted, the premium will be returned to me (us) and neither party will have any obligation, right or liability under the plan, (iii) that the death benefit will be determined by my (our) age at the time of my (our) death, and (iv) that the Global Personal Accident Plan and Global Daily Indemnity are issued in England and are governed by the Laws of England.

Signature of Applicant or Guardian: **X** Date :

Signature of Spouse: **X** Date :

SECTION 5. Method and Frequency of Payment

Please choose your method and frequency of payment. The currency you have selected for your plan will also be the currency in which your premium is to be paid.

❑	**A. Credit Card**				
	Frequency of Payment (Please Tick One Only)	❑ **Annually**	❑ **Semi-annually**	❑ **Quarterly**	❑ **Monthly**

Note: Choosing the semi-annual payment option results in total payments of 110% of the annual premium, choosing the quarterly payment option results in total payments of 112% of the annual premium, and choosing the monthly payment option results in total payments of 120% of the annual premium.

Your Credit/Debit Card Details

Credit Card Type: ❑Visa ❑MasterCard ❑American Express ❑Switch ❑Solo ❑Domestic Maestro			
Full Card Number:			
Start Date:	**Expiry Date:**	**Issue No.:**____________ **Issue Date:**____________ **(if applicable)**	**Security Number:** **(last 3 digits on signature strip or 4 printed on front of AMEX)**
Name as on card:			
Address to which card is registered: **(if different from the mailing address given)**			
Daytime Telephone: +(Country) (Area) Number			

If paying by credit/debit card, I authorise IMG Europe Ltd. to debit my credit/debit card account above for the total amount due (including any insurance premium taxes if applicable). In the event that I have chosen a semi-annual, quarterly, or monthly payment frequency, I hereby elect to pre-authorise future credit card payment installments for the balance of the annual period of cover (12 months from the Effective Date), and hereby request and authorise IMG Europe Ltd. to charge my credit card periodically as payment installments become due for premiums. This authorisation will remain in effect for 12 months, unless earlier revoked by me in writing and IMG Europe Ltd. actually receives notice of revocation, whereupon continuing cover may be impacted. At all subsequent renewals, I authorise IMG Europe Ltd. to collect the renewal premiums due at that time, on the same payment frequency basis as the previous year until I give written notice that I wish to terminate this agreement. Cover purchased by credit card is subject to validation and acceptance by a credit card company. I understand that I will be given advance notice of the renewal premiums and that they may vary each year.

Cardholder's Authorisation Signature	**X**	**Date:**	**DD/MM/YY**

If paying by bank transfer or cheque: To avoid delays, we recommend you check your premium calculation and any taxes (if applicable) with us or your agent.

❑	**B. Bank Transfer** (Annual Premium Payments Only)
	Once your Application has been processed, the necessary bank transfer information will be forwarded to you and your payment is required within 10 days. [Please ensure that the name of the Applicant (as declared in Section 1 of this form), is clearly stated on any transfer.] Liability for any bank transfer which does not clearly identify the proposer will not be accepted by the Insurer, IMG or IMG Europe Ltd.

❑	**C. Bank Cheque / Bankers Draft / Money Order**** (Annual Premium Payments Only)	
	Please make payable to: **IMG Europe Ltd.**	Please ensure that the name of the Applicant (as declared in Section 1 of this form), is clearly stated on the reverse of the cheque. ** UK£ Cheque for sterling contract, or Euro cheque for Euro€ contract

INTERNAL USE ONLY

________ X ________ = ________ + ________ + ________

Total Medical Premium — Excess Rate factor — — Optional Cover Premium — Insurance Premium Taxes/Levies

=________
Total Premium Due

SECTION 6. Requested Start Date

Date on which you wish your Coversure International Healthcare to commence:

❑On Acceptance or ❑Other / /

(Must be within 30 days after signature. Cover will in no event be effective until approved. Please note we cannot commence your plan until we have accepted your Application and received your first or annual premium payment.)

SECTION 7. Renewal Contact Information

Please specify the best way to contact you when it comes to renewing your cover:

❑ Mail (please provide address): ____________________

❑ Fax (please provide fax number): + (Country) (Area) Number

❑ E-mail (please provide e-mail address) ____________________

Express Mail Despatch Option

❑ Tick here if you would like your Certificate of Insurance express mailed to you. Please note there will be an additional fee of £15/€25 to be paid in addition to the premium to have your Certificate of Insurance express mailed to you after approval.

Please select the address where you would like your Certificate express mailed (as indicated in Section 1)

❑Residence address ❑Mail Forwarding address ❑Other (no P.O. Boxes please)____________________

SECTION 8. Insurance Advisor / Broker Use Only

IMG Producer Number #: 320259	Phone: +44 (0)191 296 6140
Company Name: APRIL Medibroker Ltd	Fax: +44 (0)191 257 6272
Contact Name or Stamp:	E-Mail: Andrew.wilson@medibroker.com
GA # (if applicable):	www.medibroker.com

Please mail or fax this application to:

Address change information or additional contact information should also be directed to this contact information.

IMG Europe Ltd
36-38 Church Road, Burgess Hill
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