

DEPENDANTS INCLUDED IN THIS POLICY

	DEPENDANT 1		DEPENDANT 2		DEPENDANT 3	
Surname						
First name & other initials						
Sex M / F						
Relationship to Policyholder						
Date of Birth						
Height & Weight	cm	kg	cm	kg	cm	kg
Occupation						
Nationality						
	DEPENDANT 4		DEPENDANT 5		DEPENDANT 6	
Surname						
First name & other initials						
Sex M / F						
Relationship to Policyholder						
Date of Birth						
Height & Weight	cm	kg	cm	kg	cm	kg
Occupation						
Nationality						

COMMENCEMENT DATE

The inception date of this policy will be at the date at which this application is received and accepted at Exclusive Healthcare SA on behalf of the Insurers. However if you require an inception date in the future you may do so by completing the Commencement Date opposite. Under no circumstances will policies be backdated.

Commencement Date:

dd	mm	yy					

PREMIUM

€

LEVEL OF COVER

This plan enables you to choose various levels of cover in order to suit your personal requirements. Please tick the level that you have selected. Your policy will be issued on that basis.

PLAN GATEWAY

PLATINE HOSPITAL

PLATINE FRANCE

PLATINE GLOBAL

VOLUNTARY EXCESS: €NIL*

€240

€400

€800

€1,600

*For Platine Hospital and Platine France only.

PREMIUM PAYMENT

Choose your payment method and complete all details relevant to that method.

ANNUAL PAYMENT

MONTHLY INSTALMENT PLAN

Please tick one box above and one box below. If the Monthly Instalment Plan is selected the first three months are payable on or before the commencement of cover followed by 9 monthly instalments paid by Direct Debit.

PAYMENT BY CHEQUE:

All cheques must be payable to Exclusive Healthcare SA. Please ensure that the name of the policyholder is clearly stated on the reverse of the cheque.

PAYMENT BY CREDIT CARD:

(Available only for annual payments and the first three months' Deposit where the Monthly Instalment Plan is selected). Please complete details on back page.

PAYMENT BY DIRECT DEBIT (Instalment Payment Plan) EUROS ONLY:

The first three months' instalment is payable by cheque or Credit Card followed by nine monthly payments by Direct Debit in Euros drawn on a French Bank starting in the fourth and ending in the twelfth month. If the policy is renewed, monthly debits will continue unless we are notified to the contrary. If the Premium is increased you will be informed in good time and asked for your approval. Please complete the enclosed Direct Debit Authority if you wish to pay by instalments.

DECLARATION: I have read and understood the full Terms and Conditions of this Policy. I declare that to the best of my knowledge and belief the information given in this application is true and complete. 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. I confirm that I have checked and found correct any answers or statements in this application that are not in my own handwriting.

Proposer's Signature

Date
(must be completed)

dd		mm		yy			

CONFIDENTIAL MEDICAL INFORMATION

NAME AND ADDRESS OF YOUR USUAL DOCTOR

Name: _____

Medical Centre: _____

Address: _____

Telephone: _____

IF YOU HAVE BEEN REGISTERED WITH THE ABOVE DOCTOR FOR LESS THAN 2 YEARS PLEASE GIVE THE NAME AND ADDRESS OF YOUR PREVIOUS DOCTOR.

Name: _____

Medical Centre: _____

Address: _____

Telephone: _____

CONFIDENTIAL MEDICAL HISTORY

PLEASE COMPLETE THIS SECTION FULLY. Please consider the following questions as they apply to each of the people named. Answer each question clearly, ticking the correct answer.

QUESTION	PROPOSER	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
1. Has any in-patient stay in a hospital or nursing home taken place within the last 4 years?	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>
2. Has any specialist been consulted within the last 4 years?	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>
3. Has any general practitioner been consulted and/or provided prescriptions for any drugs/medication within the last 2 years?	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>
4. Are prescribed medications currently being taken?	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>
5. Does any chronic/long-term medical condition exist or is there any known disability, abnormality or recurrent illness or injury?	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>
6. Is there any known or foreseeable need to consult any doctor or other health professional (see * below)?	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>
7. Have you smoked any tobacco products during the last 12 months?	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>	YES NO <input type="checkbox"/> <input type="checkbox"/>
8. How many units of alcohol do you consume each week? (1 unit = 1/2 pint of beer or 1 small glass of wine or 1 single measure of spirits).					

If you have answered YES to any of the above questions, please give details, condition, treatment, ongoing treatment and current position in the spaces below, and if necessary on a separate sheet of paper. Following this you may be contacted by a member of the EXCLUSIVE medical staff to accurately assess the acceptance terms available to you.

* Please ensure that you fully disclose any known or suspected conditions and any symptoms experienced 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.

Name:	
Question Number:	Details:

Name:	
Question Number:	Details:

Name:	
Question Number:	Details:

Name:	
Question Number:	Details:

AFFIDAVIT OF RESIDENCY

Je déclare / Nous déclarons, par la présente, comprendre la législation courante concernant la Couverture Maladie Universelle.
I / we hereby declare that I / we understand the current legislation in France concerning the Couverture Maladie Universelle.

Prière de choisir la déclaration qui vous concerne:
Please indicate which one of the following statements is applicable to you:

1. Je suis / Nous sommes en train de déposer une demande d'affiliation au régime de Sécurité Sociale française mais celle-ci n'a pas encore été accordée.
 I am / We are in the process of applying for affiliation to the French Social Security system but my / our application has not yet been accepted.
2. Je ne suis pas / Nous ne sommes pas résident(s) permanent(s) de la France.
 I am / We are not permanent resident(s) of France.
3. J'ai / Nous avons déposé une demande d'affiliation au régime de Sécurité Sociale française mais celle-ci a été refusée.
 I / We have applied for affiliation to the French Social Security system but my / our application has been refused.
 Une copie de la lettre de refus est annexée.
 A copy of the refusal letter is attached.

Si ma / notre situation concernant la CMU devait changer à une date ultérieure, je vous en aviserai / nous vous en aviserons immédiatement.
In the event that my / our situation in relation to the CMU changes in the future, I / we will advise you immediately.

NOTE: Statement 1 is applicable to Applicants for the GATEWAY PLAN ONLY
Statements 2 or 3 are applicable to Applicants for the PLATINE PLANS ONLY.

