



April Medibroker
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Health Services Admin Office:
 Integra Global Ltd.
 Waldhofer Str. 102
 69123 Heidelberg, Germany
 Tel: + 1 888 753 1377 Fax: +1 800 774 3608

ENROLLMENT FORM

Primary Insured Details:

Last Name: _____ **First Name:** _____

Male Female **Date of Birth:** _____ **Citizenship:** _____

Country of Residence Outside the U.S. _____ **Job Title:** _____

Email address: _____

Tel: _____ **Fax:** _____

Height: _____ **Weight:** _____

Correspondence Mailing Address:

Country of Assignment Address (if different from above)

Coverage Details

Coverage is for:

Myself only Myself plus Spouse Myself plus Children Myself and Family

Choose your health cover:

Personal Health **Premier Personal Health**

Plan I - Worldwide Coverage Including the US and Canada

Deductible: \$100 (Premier only) \$200 \$500 \$1,000 \$5,000

Plan II - Worldwide Coverage Excluding the US and Canada

Deductible: \$100 (Premier only) \$200 \$500 \$1,000 \$5,000

Options

Dental Yes No

AD&D Cover \$50,000 \$100,000 \$150,000 \$250,000

Effective Date (1st, 11th and 21st of each month): _____

Payment Method: Annual Semi-annual Quarterly



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MEDICAL HISTORY for Primary Insured

Have you at any time been treated for or been told that you had trouble with any of the following within the last ten years?

	Yes	No
1. Heart / Blood vessels	<input type="checkbox"/>	<input type="checkbox"/>
2. Mental / Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>
3. Stroke / Blood Pressure / Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
4. Cancer	<input type="checkbox"/>	<input type="checkbox"/>
5. Respiratory Problems (Asthma)	<input type="checkbox"/>	<input type="checkbox"/>
6. Diabetes(Related problems)	<input type="checkbox"/>	<input type="checkbox"/>
7. HIV/AIDS or related diseases	<input type="checkbox"/>	<input type="checkbox"/>
8. Ortho Problems & Arthritis (Back, Joints, etc)	<input type="checkbox"/>	<input type="checkbox"/>
9. Urological Problems (Kidney Stones)	<input type="checkbox"/>	<input type="checkbox"/>
10. Neurological Disorder	<input type="checkbox"/>	<input type="checkbox"/>
11. Stomach / Intestines	<input type="checkbox"/>	<input type="checkbox"/>
12. Hernia	<input type="checkbox"/>	<input type="checkbox"/>
13. Ears / Eyes	<input type="checkbox"/>	<input type="checkbox"/>
14. Immune System Disorders	<input type="checkbox"/>	<input type="checkbox"/>
15. Sexually Transmitted Infections	<input type="checkbox"/>	<input type="checkbox"/>
16. Skin	<input type="checkbox"/>	<input type="checkbox"/>
17. Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
18. Are any inpatient or outpatient medical /surgical or dental procedures or oral surgery (including diagnostic testing) recommended / contemplated	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you been examined by or consulted with a physician in the last five years	<input type="checkbox"/>	<input type="checkbox"/>
20. Are you currently taking any medication	<input type="checkbox"/>	<input type="checkbox"/>
21. Do you use tobacco products	<input type="checkbox"/>	<input type="checkbox"/>
22. If female, are you pregnant? (If yes, please give due date)	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you ever had an application or an application for reinstatement of Life, Accident, or Health Insurance declined, postponed, rated or modified? (If yes, please give details)	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered YES to any of the above questions, please explain the details in full below.



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DEPENDENT DETAILS

(to be completed by Primary if requesting insurance for dependents)

Full Name	Relationship	Date of Birth	Height	Weight

Dependent's Address (if different from Primary Insured)

Medical History - Dependents Have you at any time been treated for or been told that you had trouble with any of the following within the last ten years?

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Heart / Blood vessels | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Mental / Nervous Disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Stroke / Blood Pressure / Hypertension | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Respiratory Problems (Asthma) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Diabetes(Related problems) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. HIV/AIDS or related diseases | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Ortho Problems & Arthritis (Back, Joints, etc) | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Urological Problems (Kidney Stones) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Neurological Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Stomach / Intestines | <input type="checkbox"/> | <input type="checkbox"/> |
| 12.Hernia | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ears / Eyes | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Immune System Disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Sexually Transmitted Infections | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Skin | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Thyroid | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Are any inpatient or outpatient medical /surgical or dental procedures or oral surgery (including diagnostic testing) recommended / contemplated | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you been examined by or consulted with a physician in the last five years | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Are you currently taking any medication | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you use tobacco products | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. If female, are you pregnant? (If yes, please give due date) | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever had an application or an application for reinstatement of Life, Accident, or Health Insurance declined, postponed, rated or modified? (If yes, please give details) | <input type="checkbox"/> | <input type="checkbox"/> |



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If you have answered YES to any of the above questions, please explain the details in full below.
 Give the question number with the relevant details.

Name of Dependent	Please state Condition and Details	Duration of Disability	Complete Recovery or Ongoing? Month / Year	Name and Address of Physicians / Hospitals

Declaration

- I hereby apply for membership to the Integra Global Healthcare Plan.
- I accept the benefits, terms, conditions and limits provided for in the terms of the insurance policy and I agree to be bound by such terms.
- I understand that this application is subject to written acceptance by LAMP Insurance Company Ltd.
- I confirm the correctness of the statements and information contained in this application and confirm the correctness of all other documents submitted now or in the future concerning this application. This clause will constitute a condition precedent to the payment of the benefits provided for in the terms of the Plan. We accept that LAMP Insurance Company Ltd will be relying on such statements and information when agreeing to accept this application. LAMP Insurance Company Ltd reserves the right to investigate where uncertainty exists about the validity of information provided.
- I, the applicant and the listed dependents, agree to being called upon to submit such medical examinations and tests as LAMP Insurance Company Ltd deems necessary.
- I acknowledge that LAMP Insurance Company Ltd reserves the right to cancel the membership of this Plan if any amount due is not paid by or on the due date concerned.
- I agree to give LAMP Insurance Company Ltd immediate written notice should any changes material to the assessment of this application occur before the date upon which LAMP Insurance Company Ltd grants written acceptance. This will give LAMP Insurance Company Ltd the opportunity to reconsider the terms of acceptance.
- **AUTHORISATION:** To all physicians/hospitals/healthcare institutions/insurers/medical or hospital service providers/employers: You are authorised to provide LAMP Insurance Company Ltd information concerning healthcare, advice, treatment, supplies, absence (including those relating to mental illness and/or AIDS/ARC/HIV) relating to me or any other members of my family for whom coverage has been requested. This information will be used to determine eligibility for coverage. This authorisation will be valid for twenty four months from the date of confirmation of this application.

Primary Applicant's Signature

Date

Agency	
Rep	

APRIL Medibroker Ltd
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 Whitley Bay
 Tyne & Wear
 NE25 9DA, UK
 Fax: +44 (0)191 251 6424