A member of the BUPA group

International Health Insurance danmark a/s

APPLICATION FORM A

PACIFIC PRIME INTERNATIONAL

(PLEASE USE BLOCK LETTERS)

INTERNATIONAL HEALTH AND HOSPITAL PLAN

FOR ADMINISTRATION USE

Ref.

Policy Number

3616-000-00

Date

COMMENCEMENT DATE

I / we request that the policy commences from 0 1 day month year

POLICYHOLDER

First name(s)

Date of birth (day/month/year)

Family name(s)

Sex (M/F)

Address

Address

Postal Code

City

Telephone

Country

Fax

E–mail

IBAN NUMBER AND BIC NUMBER

If you would like us to transfer future reimbursements to your bank account, please state your IBAN number and BIC number

IBAN number

BIC number

DEPENDANT 1

First name(s)

Date of birth (day/month/year)

Family name(s)

Sex (M/F)

DEPENDANT 2

First name(s)

Date of birth (day/month/year)

Family name(s)

Sex (M/F)

DEPENDANT 3

First name(s)

Date of birth (day/month/year)

Family name(s)

Sex (M/F)

DEPENDANT 4

First name(s)

Date of birth (day/month/year)

Family name(s)

Sex (M/F)

Please continue on page 2

COVER – *PLEASE CHOOSE COVER, CURRENCY AND DEDUCTIBLE BY TICKING THE RELEVANT BOXES*

Cover	DEDUCTIBLE / CURRENCY		
✗ Hospital Plan			
❍ Module 1 - Non-Hospitalisation Benefits	❍ Nil	❍ Nil	❍ Nil
❍ Module 2 - Medicine & Appliances	❍ EUR 350	❍ GBP 250	❍ USD 400
❍ Module 3 - Medical Evacuation & Repatriation	❍ EUR 1,050	❍ GBP 750	❍ USD 1,600
❍ Module 4A - Dental & Optical	❍ EUR 4,000	❍ GBP 2,750	❍ USD 5,000
❍ Module 4B - Dental & Optical	❍ EUR 8,000	❍ GBP 5,500	❍ USD 10,000

Please note that the chosen currency is binding.

PREMIUM PAYMENT

❍ Annual ❍ Semi-annual ❍ Quarterly

REQUEST FOR PAYMENT FROM A BANK OR ANOTHER ADDRESS *(IF DIFFERENT FROM RESIDENTIAL ADDRESS)*

Name(s)

Address — Account No. (if bank)

Address — Postal Code

City — Country

REQUEST FOR PAYMENT BY INTERNATIONAL CREDIT CARD

I / we wish to pay the premium via credit card. International Health Insurance danmark a/s will charge the credit card company directly.

❍ American Express ❍ VISA ❍ Eurocard / MasterCard

❍ JCB ❍ Diners

Card no. — Expiry date (m/y) — CVC code* (except American Express)

* CVC code: The last three digits after the card number on the back of the card or the last three digits in the signature field.

Cardholder's data if cardholder and policyholder are not the same person:

Name(s)

Address

Address — Postal Code

City — Country

❍ I also authorise International Health Insurance danmark a/s, 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.

Please note that the Company will need the original, signed form to be able to charge the credit card.

Cardholder's signature ______________________ Date ______________

PACIFIC PRIME INTERNATIONAL

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E-mail: ihi@ihi.com ■ www.ihi.com ■ Reg. CVR No. 88076516 ■ 24-Hour Emergency Service: +45 33 15 33 00 / E-mail: emergency@ihi.com

International Health Insurance danmark a/s

INTERNATIONAL HEALTH AND HOSPITAL PLAN

MEDICAL QUESTIONNAIRE B

PACIFIC PRIME INTERNATIONAL

(PLEASE USE BLOCK LETTERS)

A Medical Questionnaire B must be completed for each person aged 10 years or over applying for cover, and also for any adopted children or any child under the age of 10 with a pre-existing condition or who is not in good health. All the Medical Questionnaires should be sent together with the Application Form A to the insurer.

FOR ADMINISTRATION USE

Ref. ______ Policy Number ______ # 3616-000-00

Date ______

APPLICANT *(PLEASE UNDERLINE THE NAMES YOU WISH TO BE INDICATED ON YOUR INSURANCE CARD, MAX. 29 FIELDS)*

First name(s) ______ Occupation ______

Family name(s) ______

Date of birth (day/month/year) ______ Nationality ______

Age ______ Sex (M/F) ______ Height (cm) ______ Weight (kg) ______ / Height (inches) ______ Weight (pounds) ______

OTHER INSURANCE

Do you have a health insurance with another company? NO ❍ YES ❍

Company name ______ Policy Number ______

Do you intend to continue being insured with the other company? NO ❍ YES ❍

Have you ever had an application for health or life insurance declined or accepted subject to exclusions or at a premium above the insurer's standard rates? NO ❍ YES ❍ If yes, please enclose complete information.

MEDICAL HISTORY

If you have or previously have had any of the following illne 3616-000-00 se tick the appropriate box and provide details. If you have any additional comments, please state details under "Further remarks" (question 8). All questions must be answered.

a) Tumours: Benign ❍ Malignant ❍ NO ❍
Details ______

b) Migraine ❍ Neurological Disorders ❍
Epilepsy ❍ NO ❍
Details ______

c) Mental Illnesses ❍ NO ❍
Details ______

d) Eye Diseases ❍ NO ❍
Details ______

e) Asthma ❍ Allergies ❍
Pulmonary Diseases ❍ NO ❍
Details ______

f) Cardiovascular Diseases ❍
Arterial Hypertension ❍ NO ❍
Details ______

g) Liver Diseases ❍ Pancreas Diseases ❍
Stomach Diseases ❍ Intestinal Diseases ❍ NO ❍
Details ______

h) Diabetes ❍ Other Hormone Diseases ❍ NO ❍
Details ______

i) Urinary Tract and Kidney Diseases ❍
Diseases of the Sexual Organs ❍ NO ❍
Details ______

j) Rheumatism ❍
Muscle, Joint or Bone Diseases ❍ NO ❍
Details ______

k) Back Problems ❍ NO ❍
Details ______

l) Skin Diseases ❍ NO ❍
Details ______

m) Cosmetic Operations ❍ NO ❍
Details ______

n) Any other diseases, disorders, illnesses ❍ NO ❍
Details ______

o) Have you ever had any fertility treatment? YES ❍ NO ❍
Details ______

p) Have you ever been tested for HIV-antibodies?
YES ❍ NO ❍
If YES, what was the result:
HIV-Positive ❍ HIV-Negative ❍

Please continue on page 2

1. Do you take or have you taken any kind of medicine on a regular basis? YES ❍ NO ❍

   If YES, please state type and daily dosage

   Diagnosis Expense per month

2. Have you ever been hospitalised or received treatment for any illness? YES ❍ NO ❍

   If YES, please state name of hospital / clinic / doctor. (You can use Further Remarks (question 8) if you have more info.)

   Name

   Address

   Telephone Fax

   E-mail

   Diagnosis Date

3. Do you suffer from any side effects or consequences of the above conditions? YES ❍ NO ❍

   If YES, please enclose complete information.

4. Do you use spectacles or contact lenses – if so please indicate strength

5. For women only: are you currently pregnant? YES ❍ NO ❍

6. Family Doctor

   Name

   Address

   Telephone Fax

   E-mail

7. Do you have additional medical information? YES ❍ NO ❍

   All relevant up-to-date medical reports should be enclosed in the event of any pre-existing medical conditions.

8. Further remarks, if any: ______

9. Applicant's signature

If your state of health changes after the application has been signed and before the Company has approved the insurance, the Company must be notified immediately of such a change. In this case and in case of other pre-existing conditions, you are requested to enclose any relevant up-to-date medical reports.

I, the undersigned, solemnly declare that I and any co-insured children are in completely good health and do not, apart from the aforementioned, suffer or have suffered from any recurring illness or physical debility. I have answered in accordance with the truth and hereby give International Health Insurance danmark a/s permission to seek such information from treating doctors and hospitals concerning my / our state of health as the Company deems necessary.

If supplementary insurance for dental treatment is required: I am / we are not under or about to undergo dental treatment, and hereby give the Company permission to seek information from treating dentists concerning my / our dental status or any dental treatment.

Date (day/month/year) ______ Signature ______

PACIFIC PRIME INTERNATIONAL

INTERNATIONAL HEALTH AND HOSPITAL PLAN

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