

Application Form

Asian Plans. Pacific Prime International

Please read the following carefully, completing all relevant information in BLOCK CAPITALS and ticking the relevant boxes.

1. Policyholder details.

Title: Mr Mrs Ms Miss Other First name

Other initials Surname

Correspondence address

Telephone: Home Office

Mobile Fax

E-mail address

Please indicate by which method you would prefer us to communicate with you.

Fax Phone E-mail Mail

The following details are only to be completed if you are applying to join an existing group scheme.

Group name

Group number *(if available)*

2. Details of persons to be covered.

Please enter the details of all persons to be covered under this policy including the policyholder. This can include your spouse/partner and any children financially dependent on the policyholder and not more than 18 yrs old, or not more than 24 years old if in full-time education. Where the child is greater than 18 years old, please attach a letter from college/university confirming student status.

	Policyholder	Dependant 1	Dependant 2	Dependant 3
Title (Mr, Mrs, Ms, Miss, Other)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Surname	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
First name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Gender	Male <input type="radio"/> Female <input type="radio"/>	Male <input type="radio"/> Female <input type="radio"/>	Male <input type="radio"/> Female <input type="radio"/>	Male <input type="radio"/> Female <input type="radio"/>
Relationship to Policyholder	n/a	Spouse <input type="radio"/> Child <input type="radio"/>	Spouse <input type="radio"/> Child <input type="radio"/>	Spouse <input type="radio"/> Child <input type="radio"/>
Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Occupation	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Home Country	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Country of Residence	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Nationality	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Passport Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Details of any current domestic or international health insurance				
Name of insurer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Policy number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Start date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If there is not sufficient space for all dependants, please use another Application Form.

3. Policy commencement date.

Please indicate the month on which you wish your cover to commence

Please note that for individual policyholders, your policy can only commence on the first day of the month.

However, if you are applying to join a group scheme, please indicate the day of month you require cover from

Cover is conditional upon acceptance of your Application, which is only confirmed when an Insurance Certificate is issued to you.

4. Plan details - this section does not be completed if you are applying as part of a group scheme.

Please tick to indicate the type of plan(s) you require

Core Plan	Out-patient	Optional Out-patient Deductible	Repatriation
Elite <input type="radio"/>	OP1 <input type="radio"/>	\$0 <input type="radio"/> \$625 <input type="radio"/>	Repatriation Plan <input type="radio"/>
Select <input type="radio"/>	OP2 <input type="radio"/>	\$125 <input type="radio"/> \$1250 <input type="radio"/>	
Essential <input type="radio"/>		\$250 <input type="radio"/>	

Please note that the out-patient and repatriation plans can only be purchased in addition to a core plan, they cannot be purchased separately. Also, please note that the type of plan you select can only be amended at policy renewal.

Please tick to indicate the area of cover you require

Worldwide Worldwide excluding USA & Canada

5. Payment details - this section does not be completed if you are applying as part of a group scheme.

No payment should be made until you have been notified of your insurance number.

Please tick to indicate the payment frequency and method you will use.

	Annual	Half Yearly	Quarterly	Monthly
Credit card	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cheque	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A
Bank transfer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A

Please note the following administration charges:

- Payments received by credit card will be subject to additional credit card charges; 2% for annual payments, 3% for half yearly payments, 5% for quarterly payments and 7% for monthly payments.
- Payments received by other payment methods are subject to the following additional administration surcharges; 2% for half yearly payments, 3% for quarterly payments and 4% for monthly payments. There are no administration charges for annual payments received by cheque or bank transfer.

All cheque payments must be made payable to Allianz Worldwide Care, with the policyholder's name and insurance number marked clearly on the back of the cheque. All bank transfers must be clearly marked with the policyholder's name and insurance number. We will only accept payment by credit card via MasterCard or VISA. Allianz Worldwide Care does not accept liability for any payment, which does not clearly identify the policyholder.

Please note that insurance premium tax and other government levies may apply. Where such taxes or levies apply, they will be detailed on your invoice/payment details.

If you choose to pay by credit card please provide the following information:

Type of credit card: MasterCard VISA

Card number
Expiry date

Credit Card Authorisation

I authorise Allianz Worldwide Care to charge my credit card account unspecified amounts in respect of premiums for my healthcare cover as and when these become due, until the instruction is cancelled by my giving written notice to Allianz Worldwide Care. I understand I will be given one month's notice of any premium increase.

Cardholder's name

Cardholder's signature _____ Date

6. Pre-existing conditions.

Pre-existing conditions are not covered unless they have been declared by you in the health declaration section and accepted by Allianz Worldwide Care. Conditions arising between signing the Application Form and confirmation of acceptance by the underwriting department of Allianz Worldwide Care, will equally be deemed to be pre-existing. Therefore, it is necessary that you advise us of any material changes to the information provided, between submission of this application and acceptance by us.

You are hereby obliged on request to provide any further information that we might require.

Pre-existing conditions are medical conditions or any related conditions, for which symptom(s) have been shown at some point during the five years prior to commencement of cover, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition about which you or your dependants know, knew or could reasonably have been assumed to have known, will be deemed to be pre-existing.

7. Health declaration.

All information supplied will be treated in strict confidence. All material facts including those relating to these questions must be disclosed. Failure to do so may invalidate the policy. A material fact is any information that would be likely to influence the insurer's assessment and acceptance of this Application Form. If you are in any doubt whether a fact is material then it should be disclosed.

	Policyholder	Dependant 1	Dependant 2	Dependant 3
1. Height/weight	cm <input type="text"/> <input type="text"/> kg <input type="text"/> <input type="text"/>	cm <input type="text"/> <input type="text"/> kg <input type="text"/> <input type="text"/>	cm <input type="text"/> <input type="text"/> kg <input type="text"/> <input type="text"/>	cm <input type="text"/> <input type="text"/> kg <input type="text"/> <input type="text"/>
2. Are you currently suffering from any complaints, illnesses, after-effects of an accident, mental or physical disabilities, psychiatric disorders and chronic/long term medical or dental conditions?	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
3. Have you ever suffered from, been in hospital with, or received treatment, tests or investigations for;				
(a) Rheumatism, gout, arthritis or disease of the muscles or joints including the back	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
(b) Epilepsy or other neurological disorder	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
(c) Any digestive disorder including stomach and/or bowel problems	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
(d) Anxiety, depression or psychiatric or mental illness	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
(e) Gynaecological disorders	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
(f) Any disorder of the kidneys, bladder or liver/pancreas including diabetes	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
(g) Any lump, cyst, mole or cancer	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
(h) Any skin disorder	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
4. Have you ever been advised to consult a doctor for a recurrent complaint, or been advised to have any diagnostic test or treatment which has not been completed or that you still await the results of?	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
5. Have you been tested for HIV-antibodies?	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
If yes, please state when	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Was the result HIV-positive?	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
6. Have you ever suffered from or been in hospital for any other disorder or as a result of an accident which required that you:				
(a) Received more than 14 days treatment?	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
(b) Were off work for more than one week?	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
(c) Had specialised treatment?	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
7. Are you pregnant?	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
Please state expected date of childbirth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

8. Dental declaration - should only be completed if you are purchasing dental cover.

	Policyholder	Dependant 1	Dependant 2	Dependant 3
a) Are you currently undergoing, or have you been advised to undergo, any treatment?	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
b) Do you have missing teeth which have not been replaced (excluding wisdom teeth)?	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
c) Have you denture sets (crowns, inlays, implants, bridges etc.)?	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
d) Do you suffer from parodontosis?	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
e) Have you had a dental check up within the last five 5 years?	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
If yes, when and what was the result: <i>Date</i>	(d,d) (m,m) (y,y)	(d,d) (m,m) (y,y)	(d,d) (m,m) (y,y)	(d,d) (m,m) (y,y)
<i>Outcome</i>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If you answered yes to questions A to D, your family dentist will need to complete a dental questionnaire, which can be downloaded from our website www.allianzworldwidecare.com (under section called "Forms").

Please state the name, address and telephone number of your family dentist.

Name

Address

Telephone

9. Data protection legislation.

Allianz Worldwide Care would like to assure you that all personal information and medical data will be dealt with in strict confidence and in accordance with European Union data protection legislation. Personal data may be given to hospitals and / or medical providers in relation to medical insurance claim services provided by us to you. You have a right to access the personal data that is held about you. You also have the right to amend or delete any information we hold about you if you believe that it is inaccurate or out of date.

Allianz Worldwide Care, any of the Allianz Group companies or an organisation appointed by us, might contact you in the future in relation to other products/services that you might be interested in.

If you do not wish to receive information on other products or services from us, please tick this box.

10. Declaration.

- (a) I declare, that all information supplied above is true and complete, including those answers that are not in my own handwriting. I also declare that I have not suppressed, misrepresented or misstated any material fact. I understand that this application shall be the basis of the contract between Allianz Worldwide Care and I, and that any false, incorrect or misleading statement may render this insurance null and void.
- (b) I undertake to inform Allianz Worldwide Care immediately in writing of any changes in my or my dependants' state of health occurring after the Application Form has been signed and before the commencement date.
- (c) I understand that I can withdraw my application in writing by letter, e-mail or fax, within 14 days from the policy commencement date and provided that I have not submitted a claim, I am entitled to a full refund of the premium.
- (d) I accept that it is my responsibility to check the accuracy of the information contained within the Insurance Certificate once issued. If the content is not in accordance with the Application Form, the situation will be considered accepted if I enter no protest within 14 days following the issue date of the Insurance Certificate.
- (e) I consent to the fact that Allianz Worldwide Care, if it considers it appropriate, will check statements concerning my health condition and will check with other health insurers all statements concerning previous, or existing contracts applied for. I authorise all such practitioners, physicians, dentists, members of medical professions, employees of hospitals and health authorities as well as medical facilities to release my medical records to Allianz Worldwide Care. I also make this statement for my co-insured children as well as for the co-insured persons for whom I am responsible, or those who cannot assess the meaning of this statement.
- (f) I accept that this policy will be subject to the standard Policy Terms and Conditions effective at the time of policy commencement. I confirm that I have read and understand the full definitions, benefits, exclusions and conditions of this policy including the exclusion relating to pre-existing conditions.

Policyholder signature

Signature of all adult dependants

Date

Please return this fully completed form to the address below.

For office use only:

Agent details

STAMP

Pacific Prime International

Allianz Worldwide Care,
20D Beckett Way, Park West Business Campus,
Nangor Road, Dublin 12, Ireland.
Fax: +353 1 630 1399
Helpline: + 353 1 630 1301
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