

APPLICATION FORM A

PACIFIC PRIME INTERNATIONAL

(PLEASE USE BLOCK LETTERS)

FOR ADMINISTRATION USE

Ref. <input type="text"/>	Policy Number	# 3616-000-00
Date <input type="text"/>	<input type="text"/>	

COMMENCEMENT DATE

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

POLICYHOLDER

First name(s) <input type="text"/>	Date of birth (day/month/year) <input type="text"/>
Family name(s) <input type="text"/>	Sex (M/F) <input type="text"/>
Address <input type="text"/>	
Address <input type="text"/>	Postal Code <input type="text"/>
City <input type="text"/>	Telephone <input type="text"/>
Country <input type="text"/>	Fax <input type="text"/>
E-mail <input type="text"/>	

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) <input type="text"/>	Date of birth (day/month/year) <input type="text"/>
Family name(s) <input type="text"/>	Sex (M/F) <input type="text"/>

DEPENDANT 2

First name(s) <input type="text"/>	Date of birth (day/month/year) <input type="text"/>
Family name(s) <input type="text"/>	Sex (M/F) <input type="text"/>

DEPENDANT 3

First name(s) <input type="text"/>	Date of birth (day/month/year) <input type="text"/>
Family name(s) <input type="text"/>	Sex (M/F) <input type="text"/>

DEPENDANT 4

First name(s) <input type="text"/>	Date of birth (day/month/year) <input type="text"/>
Family name(s) <input type="text"/>	Sex (M/F) <input type="text"/>

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

<input checked="" type="checkbox"/> Hospital Plan	DEDUCTIBLE / CURRENCY		
<input type="checkbox"/> Module 1 - Non-Hospitalisation Benefits	<input type="checkbox"/> Nil	<input type="checkbox"/> Nil	<input type="checkbox"/> Nil
<input type="checkbox"/> Module 2 - Medicine & Appliances	<input type="checkbox"/> EUR 350	<input type="checkbox"/> GBP 250	<input type="checkbox"/> USD 400
<input type="checkbox"/> Module 3 - Medical Evacuation & Repatriation	<input type="checkbox"/> EUR 1,050	<input type="checkbox"/> GBP 750	<input type="checkbox"/> USD 1,600
<input type="checkbox"/> Module 4A - Dental & Optical	<input type="checkbox"/> EUR 4,000	<input type="checkbox"/> GBP 2,750	<input type="checkbox"/> USD 5,000
<input type="checkbox"/> Module 4B - Dental & Optical	<input type="checkbox"/> EUR 8,000	<input type="checkbox"/> GBP 5,500	<input type="checkbox"/> 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

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 illness **3616-000-00** please 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.

<p>a) Tumours: Benign <input type="radio"/> Malignant <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>b) Migraine <input type="radio"/> Neurological Disorders <input type="radio"/></p> <p>Epilepsy <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>c) Mental Illnesses <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>d) Eye Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>e) Asthma <input type="radio"/> Allergies <input type="radio"/></p> <p>Pulmonary Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>f) Cardiovascular Diseases <input type="radio"/></p> <p>Arterial Hypertension <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>g) Liver Diseases <input type="radio"/> Pancreas Diseases <input type="radio"/></p> <p>Stomach Diseases <input type="radio"/> Intestinal Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>h) Diabetes <input type="radio"/> Other Hormone Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p>	<p>i) Urinary Tract and Kidney Diseases <input type="radio"/></p> <p>Diseases of the Sexual Organs <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>j) Rheumatism <input type="radio"/></p> <p>Muscle, Joint or Bone Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>k) Back Problems <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>l) Skin Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>m) Cosmetic Operations <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>n) Any other diseases, disorders, illnesses <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>o) Have you ever had any fertility treatment? YES <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>p) Have you ever been tested for HIV-antibodies? YES <input type="radio"/> NO <input type="radio"/></p> <p>If YES, what was the result: HIV-Positive <input type="radio"/> HIV-Negative <input type="radio"/></p>
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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 _____

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