

# INTERGLOBAL SCHOOLS HEALTHCARE PLANS

## • INDIVIDUAL APPLICATION FORM •

### A - SCHOOL DETAILS

Pacific Prime International

Please complete in BLOCK CAPITALS

Name of School:

Address:

Telephone No.:

Fax No.:

Email:

### B - YOUR PERSONAL DETAILS

Title:  Mr  Mrs  Miss  Ms  Dr  Other:

Surname:

First Names:

Address<sup>1</sup>:

Country of residence:

How long have you lived there?:

Home country:

Nationality on passport:

Telephone No.:

Fax No.:

Email:

Occupation:

Date of Birth (dd/mm/yy):

<sup>1</sup> All correspondence will be sent to this address unless otherwise notified.

Please indicate your preferred communication channel  Email  Airmail  Fax  Telephone

### C - DEPENDANTS TO BE COVERED

Surname:

First names:

Relationship to you:

Date of birth (dd/mm/yy):

Surname:

First names:

Relationship to you:

Date of birth (dd/mm/yy):

Surname:

First names:

Relationship to you:

Date of birth (dd/mm/yy):

Surname:

First names:

Relationship to you:

Date of birth (dd/mm/yy):

### D - GEOGRAPHICAL AREA OF COVER YOU WOULD LIKE

Area 1 Europe

Area 2 Worldwide, not including the USA

Area 3 Worldwide

Area 4 Australia and New Zealand

### E - PLAN SELECTION

Gold Plan

Silver Plan

Bronze Plan

## F - VOLUNTARY EXCESS: GOLD PLAN AND SILVER PLAN

Standard excess on medical out-patient treatment claims is £30 for plans in GB pounds, \$50 for plans in US dollars or €45 for plans in euros. Do you want to accept a voluntary excess applicable to in-patient, daycare, and medical out-patient treatment claims?

Yes  No

If 'Yes', please tick the level of voluntary excess you want to accept

- |  |  |
|--|--|
| <input type="checkbox"/> £50/\$85/€75 excess = 5% premium discount     | <input type="checkbox"/> £1,000/\$1,700/€1,500 excess = 25% premium discount |
| <input type="checkbox"/> £100/\$170/€150 excess = 10% premium discount | <input type="checkbox"/> £2,500/\$4,250/€3,750 excess = 30% premium discount |
| <input type="checkbox"/> £250/\$425/€375 excess = 15% premium discount | <input type="checkbox"/> £5,000/\$8,500/€7,500 excess = 40% premium discount |
| <input type="checkbox"/> £500/\$850/€750 excess = 20% premium discount |  |

(Discount applies to HealthCare Plan premium only - not to optional add-on plan premiums.)

## G - NIL EXCESS: GOLD PLAN AND SILVER PLAN

Do you want to delete the standard excess of £30/\$50/€45  Yes  No

If 'yes', please tick your acceptance of 15% premium increase.  I accept the premium increase

Please note this does not apply to the 25% co-insurance applicable to all dental out-patient claims.

## H - VOLUNTARY EXCESS: BRONZE PLAN

- |  |  |
|--|--|
| <input type="checkbox"/> £500/\$850/€750 excess = 10% premium discount       | <input type="checkbox"/> £2,500/\$4,250/€3,750 excess = 30% premium discount |
| <input type="checkbox"/> £1,000/\$1,700/€1,500 excess = 20% premium discount | <input type="checkbox"/> £5,000/\$8,500/€7,500 excess = 40% premium discount |

(Discount applies to HealthCare Plan premium only - not to optional add-on plans.)

## I - OPTIONAL ADD-ON BENEFITS

Do you want to add any of the following?

Personal Travel Plan  Yes  No If Yes, please indicate type  Single  Couple  Family  Single Parent Family  
If Yes, please indicate trip duration  Standard 90 days  Extended 120 days<sup>2</sup>  Extended 180 days<sup>2</sup>

<sup>2</sup>Premiums in respect of extended trip durations are available upon request

Personal Accident Plan<sup>3</sup>  Yes  No If Yes, please indicate how many units selected, per person  1  2  3  4  5

<sup>3</sup>Please detail below the names of all persons named in this application who require Personal Accident benefit:

1	2	3
4	5	6

(The voluntary excess premium discount does not apply to these options.)

The Personal Accident Plan does not include accidents arising from manual or hazardous occupations, dangerous sports, pursuits, or activities. If your occupation is not purely office-based or you take part in any dangerous sports, pursuits or activities, please give full details on a separate sheet and include it with this Application Form. We will then advise what premium is necessary to cover the increased risk.

## J - CURRENCY

In which currency do you want your plan to be issued?

GB pounds (£)  US dollars (\$)  euros (€)

(The Plan currency you select also decides your premium currency.)

## K - PAYMENTS

I want to pay

Yearly  Quarterly

**Payment of quarterly premiums by credit card or direct debit. Credit cards accepted: MasterCard, Visa or American Express. Direct debits from UK Bank Accounts for GB£ plans only. Please contact us if you require a direct debit mandate.**

## L - HOW TO PAY

I want to pay by

Bank transfer       Bank draft       Cheque       Credit card       Direct debit

£ GB pound or \$ US dollar or € euro

Please make your cheque or draft payable to **InterGlobal Limited**

Please make your £ GB pound, \$ US dollar, or € euro bank transfer payable to

**InterGlobal Limited, HSBC Bank, No. 1 Queen Street, Auckland, New Zealand. Sort Code: HSBCNZ2A**

£ GB pound account ref: **004-005575-911**    \$ US dollar account ref: **004-005575-910**    € euro account ref: **004-005575-912**

**(Please make sure your name is clearly shown on the transfer.)**

**InterGlobal Limited is not liable for any bank charges.**

## M - DATE ON WHICH YOU WOULD LIKE YOUR COVER TO START

When we accept your application      Other:

## N - PLEASE PROVIDE DETAILS OF YOUR [FAMILY] DOCTOR(S) WHO HAS/HAVE TREATED YOU/YOUR FAMILY IN THE LAST 2 YEARS

Name:	Name:
Phone number:	Phone number:
Fax number:	Fax number:
Address:	Address:

## O - PRE-EXISTING MEDICAL CONDITIONS

Please carefully read Benefit Exclusion 1, which can be found in the Plan Guide accompanying this application form, before you agree to enrolment of you and your dependants under this plan. If after enrolment you are not happy with this plan, you are entitled to cancel your cover within 30 days from receipt of your plan documents.

If you do not have a copy of the Plan Guide, please contact us to receive one.

## P - DECLARATION

I hereby apply to be enrolled in the selected InterGlobal International Schools Plan together with the dependants listed in this application. I declare that to the best of my knowledge and belief that the information given in this application is true and complete. I have read, understood and agree to be bound by the terms and conditions detailed in the Plan Guide, along with all eligible dependants included in this application or any subsequent dependants enrolled after the commencement date of the plan. It is agreed that this declaration and information supplied in this application shall form the basis of the contract between myself, my dependants and InterGlobal Ltd.

I authorise and request the doctors named in section N and/or any other medical establishment, including any other health professional who has attended me and any of my dependants included under this plan for treatment of a medical condition, to provide InterGlobal Ltd with the information they may need in connection to any claim made under this plan.

I accept, if I do not provide the information required in section N that, in the event of a claim being made by me, or any of my dependants included under this plan, which is deemed as being treatment for a pre-existing medical or related medical condition by InterGlobal Ltd, such claim will be rejected.

Signature:

Date (dd/mm/yy):

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## CREDIT CARD AUTHORITY

### To InterGlobal Limited

I authorise you (until further notice in writing), to charge my card account, unspecified amounts in respect of premiums for my InterGlobal Healthcare Plan as and when these become due, until this instruction is countermanded by me giving notice in writing to InterGlobal Limited.

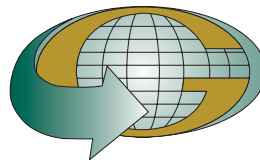
Please complete in BLOCK CAPITALS

Name (as it appears on your card):	
Please tick the appropriate:	<input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> American Express <input type="checkbox"/> Diners <input type="checkbox"/> JCB
My Card Number is:	<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"/>
Issue Date: <input type="text"/> <input type="text"/> <input type="text"/>	Expiry Date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
My Card billing address is:	

Please charge the above card (please tick):	<input type="checkbox"/> Yearly <input type="checkbox"/> Quarterly
Currency (please tick):	<input type="checkbox"/> £ GB pound <input type="checkbox"/> \$ US dollar <input type="checkbox"/> € euro
Signature:	Date (dd/mm/yy):

For use by InterGlobal Limited only (reference)	Broker/Adviser Details:
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**Pacific Prime International**



## INTERGLOBAL

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