PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS USING BLACK INK

GlobalHealth 2006

APPLICATION FORM

Intermediary Details:

Pacific Prime International
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YOUR PERSONAL DETAILS 1565

First Names **Surname** Mr / Dr / Mrs / Ms / Miss

Postal address

E-mail address **Tel No**

Date of birth **Sex** ❑ **Male** ❑ **Female** **Fax No**

Occupation **Nationality** **Country of residence**

FAMILY MEMBERS TO BE INCLUDED IN THE PLAN

Please enter the names and details of all dependants for whom cover is required. You may include your partner, and children up to age 17 or up to age 24 if in full time education – proof will be required. Children aged 18 or over who are not in full time education must make their own application for cover.

First Name(s)	Surname	Date of Birth dd/mm/yy	Relationship to applicant	Country of residence	Full time education?
Partner					
Child					❑ YES ❑ NO
Child					❑ YES ❑ NO
Child					❑ YES ❑ NO
Child					❑ YES ❑ NO
Child					❑ YES ❑ NO

DETAILS OF COVER REQUIRED

PLAN TYPE: ❑ **Select Care** ❑ **Premier Care** ❑ **Premier Plus**

CURRENCY: ❑ **Sterling** ❑ **Dollars** ❑ **Euros**

AREA OF COVER:

❑ **Area 1:** World-wide with cover in the USA & Canada restricted to US$30,000 and the first 45 days spent there during any annual period of cover in respect of accident and emergency treatment only.

❑ **Area 2:** World-wide with cover in the USA & Canada restricted to the first 30 days spent there during any annual period of cover.

❑ **Area 3:** World-wide cover including the USA & Canada.

EXCESS OPTION: The standard excess is £30 or $50 or €45. Please tick one of the options below if you require a different excess option.

❑ £60 or $100 or €90 ❑ £250 or $400 or €375 ❑ £500 or $800 or €750 ❑ £1,000 or $1,600 or €1,500

OPTIONAL TRAVEL PLAN REQUIREMENTS – ADDITIONAL COST £62/$104/€104 PER PERSON PER ANNUM*

❑ **Self only** ❑ **Self & partner only** ❑ **Whole family** *A 5% surcharge applies for monthly payments

OPTIONAL ACCIDENT PLAN REQUIREMENTS

❑ **£50,000/$75,000/€75,000** ❑ **£100,000/$150,000/€150,000** ❑ **£150,000/$225,000/€225,000** ❑ **£200,000/$300,000/€300,000** ❑ **£250,000/$375,000/€375,000**

The Accident Plan excludes accidents arising from hazardous and/or manual occupations, private flying, motor-cycle riding and hazardous sports. If your occupation is not purely office based and/or you participate in any of the above activities or any hazardous sports, please give full details here and we will advise the premium loading necessary to cover the increased risk.

OPTIONAL ACCIDENT PLAN REQUIREMENTS FOR PARTNER

❑ **£50,000/$75,000/€75,000** ❑ **£100,000/$150,000/€150,000** ❑ **£150,000/$225,000/€225,000** ❑ **£200,000/$300,000/€300,000** ❑ **£250,000/$375,000/€375,000**

Please give details here of your partner's occupation and/or any hazardous activities.

METHOD AND FREQUENCY OF PAYMENT

METHOD OF PAYMENT

❑ **Cheque/draft** – acceptable for annual payments only

❑ **Bank transfer** – acceptable for annual payments only

❑ **Credit/debit card** – please complete your card details

❑ **Direct Debit** – acceptable for sterling payments only from a UK bank account. Please complete a Direct Debit Mandate and send it to us. We must receive the original signed mandate before we can commence your cover.

FREQUENCY OF PAYMENT

❑ **Annual** ❑ **Semi-annual**

❑ **Quarterly*** ❑ **Monthly***

*Payable by credit/debit card or direct debit only.

CREDIT/DEBIT CARD DETAILS

Credit/debit card ❑ VISA ❑ MASTERCARD ❑ AMEX ❑ SWITCH ❑ DOMESTIC MAESTRO ❑ DELTA ❑ SOLO

Full card number

Expiry date **Issue No** (If applicable) **Issue Date** (If applicable)

Address to which card is registered (if different from the postal address given above)

Name as on card

Signature (of card holder)

START DATE

Date on which you wish your Global Health plan to commence: ❑ **On acceptance** ❑ **Other** (please state)

Please note that we cannot commence your plan until we have accepted your application and received payment of your first premium.

HEALTH DECLARATION

IMPORTANT – THIS INSURANCE DOES NOT COVER THE TREATMENT OF ANY PRE-EXISTING MEDICAL CONDITION. A PRE-EXISTING MEDICAL CONDITION IS ANY MEDICAL CONDITION, OR RELATED MEDICAL CONDITION THAT EXISTS, OR THAT HAS EVER REQUIRED TREATMENT, MEDICATION OR ADVICE FROM A MEDICAL DOCTOR OR MEDICAL PRACTITIONER, OR THAT HAS BEEN DIAGNOSED, OR FOR WHICH THE SYMPTOMS FIRST APPEARED, PRIOR TO THE COMMENCEMENT OF YOUR COVER. PLEASE TAKE THE GREATEST CARE TO ENSURE THAT YOU COMPLETE THIS DECLARATION FULLY AND ACCURATELY. WE WILL NOT PAY BENEFIT IN RESPECT OF AN UNDISCLOSED PRE-EXISTING MEDICAL CONDITION. IF YOU OMIT FACTS, OR GIVE INCORRECT OR INCOMPLETE FACTS, WE HAVE THE RIGHT TO DECLARE YOUR GLOBAL HEALTH PLAN VOID.

1. Your height (cms) ☐ **Your weight (kgs)** ☐ **Your partner's height (cms)** ☐ **Your partner's weight (kgs)** ☐

2. Have any persons named in this application ever:-

A. Undergone a surgical operation? ❑YES ❑NO
B. Been a patient in a hospital clinic or sanitorium? ❑YES ❑NO
C. Been advised to have any medical tests or investigations? ❑YES ❑NO
D. Been tested HIV positive? ❑YES ❑NO
E. Had an application for insurance turned down or accepted at special terms? ❑YES ❑NO

3. Are any of the persons named in this application aware of any symptoms present now which may give rise to a claim? ❑YES ❑NO

4. Are any persons named in this application currently taking any drugs or medication? ❑YES ❑NO

5. Have any persons named in this application ever suffered from, been diagnosed with, treated or prescribed drugs for:-

A. Conditions of the eyes, ears, nose or throat? ❑YES ❑NO
B. Fainting, blackouts or fits? ❑YES ❑NO
C. Any high blood pressure, heart or circulatory conditions? ❑YES ❑NO
D. Diabetes? ❑YES ❑NO
E. Any rheumatic or arthritic conditions? ❑YES ❑NO
F. Any spine, bone, muscle or joint conditions? ❑YES ❑NO
G. Asthma, respiratory or allergic conditions? ❑YES ❑NO
H. Genito-urinary or renal conditions? ❑YES ❑NO
I. Stomach, liver or bowel conditions? ❑YES ❑NO
J. Cysts, tumour or cancer? ❑YES ❑NO
K. Any skin conditions? ❑YES ❑NO
L. Any gynaecological conditions? ❑YES ❑NO
M. Any physical defect, infirmity or congenital illness? ❑YES ❑NO
N. Any nervous, mental or psychiatric condition? ❑YES ❑NO
O. Any alcohol and/or drug dependency problem? ❑YES ❑NO
P. A higher than normal cholesterol level? ❑YES ❑NO
Q. Any other type of disease, injury or medical condition? ❑YES ❑NO

IMPORTANT – If you have answered YES to ANY of the above questions, please give full details about each condition by answering the following questions in as much detail as possible. Please continue on to a separate sheet if necessary.

Question No:			
State the name of the person who suffered the illness/injury:			
State the diagnosis of the illness, or, if an injury, give details:			
State the name and address of the treating physician:			
State the date(s) on which the illness/injury occurred:			
Give full details of the treatment/tests performed and the results:			
When did you last suffer from symptoms or receive treatment relating to this condition?			
Is there any foreseeable need for further consultation or treatment for this condition? If yes, please give full details.			

IMPORTANT – We cannot accept your application if this Health Declaration is incomplete. If we need to contact you for further information, please give us a personal contact number we can use:-

Telephone: **Fax:** **Email:**

PLEASE STATE THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR FAMILY DOCTOR:-

HEALTH DECLARATION

I hereby apply for cover under the Global Health plan on behalf of all the persons named in this application form. I declare that I have read and understood the Global Health plan agreement and that I am aware that cover shall be provided in accordance with the agreement. I have made a full and complete disclosure about the medical history of each person included in this application and I fully understand that pre-existing conditions as defined in the Global Health plan agreement shall not be covered by this insurance plan. I authorise any doctor who has ever treated or advised any of the persons named in this application to provide William Russell Limited with any information they may require in connection with treatment related to any claim under this plan. I declare that the information given in this application is true and complete.

If I have applied for a travel insurance plan, I declare that at the time of purchasing this insurance or at the time of booking any future trip(s), I am aware of no reason why any journey or trip should be cancelled or curtailed or expense be incurred.

If I have indicated that I wish to pay by credit/debit card or by direct debit, I agree that William Russell Limited may debit my account with the appropriate premiums on or before their due dates, and all subsequent renewal premiums due as invoiced by William Russell Limited until I give written notice that I wish to terminate this agreement. I understand that my cover will terminate in accordance with the terms of the Global Health plan agreement if William Russell Limited are unable to collect any premium - for whatever reason - and I do not provide William Russell Limited with an alternative method of payment immediately.

Signature of applicant: **Date:**

PLEASE ENSURE YOU HAVE GIVEN AN ANSWER TO EVERY QUESTION. AN INCOMPLETE FORM WILL DELAY YOUR APPLICATION.

GHIND/06

W LL AM RUSSELL
Peace of mind wherever you are

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