

INTERGLOBAL HEALTHCARE PLANS

• INDIVIDUAL APPLICATION FORM •

Broker: Pacific Prime International

Please complete in BLOCK CAPITALS

A - YOUR PERSONAL DETAILS

Title: Mr Mrs Miss Ms Dr Other:

Surname: First Names:

Address¹:

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):

¹ All correspondence will be sent to this address unless otherwise notified.

Please indicate your preferred communication channel Email Airmail Fax Telephone

B - 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):

C - 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

D - ULTRACARE PLAN SELECTION

Plus Plan Comprehensive Plan Select Plan Standard Plan

E - VOLUNTARY EXCESS: PLUS PLAN, COMPREHENSIVE PLAN AND SELECT PLAN

Standard excess on medical out-patient treatment claims is £25 for plans in GB pounds, \$42.50 for plans in US dollars or €37.50 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

£50/\$85/€75 excess = 5% premium discount £1,000/\$1,700/€1,500 excess = 25% premium discount

£100/\$170/€150 excess = 10% premium discount £2,500/\$4,250/€3,750 excess = 30% premium discount

£250/\$425/€375 excess = 15% premium discount £5,000/\$8,500/€7,500 excess = 40% premium discount

£500/\$850/€750 excess = 20% premium discount

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

F - NIL EXCESS: PLUS PLAN, COMPREHENSIVE PLAN AND SELECT PLAN

Do you want to delete the standard excess of £25/\$42.50/€37.50 Yes No

If 'yes', please tick your acceptance of 10% 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.

G - VOLUNTARY EXCESS: STANDARD PLAN

£500/\$850/€750 excess = 10% premium discount £2,500/\$4,250/€3,750 excess = 30% premium discount
 £1,000/\$1,700/€1,500 excess = 20% premium discount £5,000/\$8,500/€7,500 excess = 40% premium discount

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

H - 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 days² Extended 180 days²

²Premiums in respect of extended trip durations are available upon request

Maternity Benefit Plan Yes No If Yes, please indicate level of co-insurance selected per person 10% 20%

Personal Accident Plan³ Yes No If Yes, please indicate how many units selected, per person 1 2 3 4 5

³Please 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.

I - 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.)

J - PAYMENTS

I want to pay

Yearly Quarterly Monthly

Payment of quarterly and monthly premiums by credit card or direct debit. Credit cards accepted: MasterCard, Visa or American Express⁴. Direct debits from UK Bank Accounts for GB£ plans only. ⁴No euro € payments through American Express.

H - HOW TO PAY

I want to pay by

Yearly Only Bank transfer Bank draft Cheque

Yearly, Quarterly, Monthly Credit card Direct debit

£ GB pound or \$ US dollar

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

Please make your £ GB pound or \$ US dollar bank transfer payable to
NatWest Bank plc, Farnham, Surrey, GU9 7NR United Kingdom

Bank sort code: **60.08.15**

£ GB pound account reference: **90306996**

\$ US dollar account reference: **140/0006502873**

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

€ euro

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

Please make your € euro bank transfer payable to

NatWest Bank plc, PO Box 1, 1 Stoke Road, Guildford, Surrey, GU1 4HN United Kingdom

Bank sort code: **60.08.15**

€ euro account reference: **08005192**

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

L - DATE ON WHICH YOU WOULD LIKE YOUR COVER TO START

When we accept your application

Other:

M - 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:

N - 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.

O - DECLARATION

I hereby apply to be enrolled in the selected InterGlobal UltraCare 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 M 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 M 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:

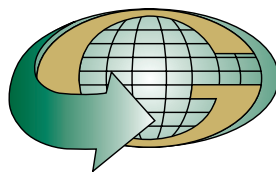
Date (dd/mm/yy):

INTERGLOBAL HEALTHCARE PLANS • INDIVIDUAL APPLICATION FORM •

Broker/Adviser Details:

Pacific Prime Insurance Brokers Limited.
10/F, Capital Building,
6-10 Sun Wui Road,
Causeway Bay,
Hong Kong.

For use by InterGlobal only (reference)



INTERGLOBAL

Woolmead House East, The Woolmead, Farnham, Surrey GU9 7TX United Kingdom
Tel: +44(0) 1252 745 940 Fax: +44(0) 1252 745 920
Email: csindividuals@interglobalpmi.com Internet: www.interglobalpmi.com

• CREDIT CARD AUTHORITY •

To InterGlobal Limited

I hereby authorise the Card Account specified below may be debited with the current premium due, and all subsequent renewal premiums due as notified by InterGlobal until I give notice in writing that I wish to terminate this agreement. I understand that InterGlobal will give at least 4 weeks notice of renewal, and that the premiums may vary each year. I understand that InterGlobal cannot be held liable if my plan is lapsed should the credit card be declined and I do not respond to requests for alternative methods of payment.

Please complete in BLOCK CAPITALS

Name (as it appears on your card)

Please tick the appropriate

MasterCard

Visa

American Express⁵

My Card Number is

Issue Date

Expiry Date

My Card billing address is

Please charge the above card (please tick)

Yearly

Quarterly

Monthly

GB £

US \$

euros €

Signature:

Date (dd/mm/yy):

⁵American Express cards cannot be used for premiums payable in euros €. Only GB £ and US \$ currencies are acceptable.

• DIRECT DEBIT •

We offer Direct Debit as an alternative form of payment to all planholders who take out a GB£ plan and currently hold a UK Bank or Building Society account. If you would like to take advantage of this facility for your regular payments please complete the following form.

Instruction to your Bank OR Building Society to pay by DIRECT DEBIT

Please complete in BLOCK CAPITALS and send to

InterGlobal Limited.
Woolmead House East,
The Woolmead,
Farnham,
Surrey GU9 7TX



Originator's Identification
Number:

6 7 9 2 0 4

Name(s) of Account Holder(s)	
Bank/Building Society Account number	Branch Sort Code
<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"/>
Name and full postal address of your Bank or Building Society	
To: The Manager	Bank/Building Society Name
Address	
Postcode	
Reference Number (for InterGlobal Limited use only)	

Instruction to your Bank/Building Society

Please pay InterGlobal Limited Direct Debits from the account detailed in this instruction subject to the safeguards assured by The Direct Debit Guarantee.

I understand that this instruction may remain with InterGlobal Limited and if so details will be passed electronically to my Bank/Building Society.

Signature(s):

Date (dd/mm/yy):

Banks and Building Societies may not accept Direct Debit Instructions for some types of accounts.

The Direct Debit Guarantee

This guarantee should be detached and retained by the Payer



- This Guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by your own Bank or Building Society.
- If the amounts to be paid or the payment dates change InterGlobal Limited will notify you 10 working days in advance of your account being debited or as otherwise agreed.
- If an error is made by InterGlobal Limited or your Bank or Building Society you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us.