GLOBAL HEALTH EMPLOYEE APPLICATION FORM (UNDERWRITTEN)

GLOBAL HEALTH®
Health Insurance for Expatriates

Please complete this form in block capitals using black ink

SECTION 1: TO BE COMPLETED BY THE EMPLOYER

EMPLOYER/EMPLOYEE DETAILS

Employer: Group no:

Employee name: Mr/Dr/Mrs/Ms/Miss Date of employment:

GLOBAL HEALTH ELITE PLAN REQUIRED

☐ **GOLD** ☐ **SILVER** ☐ **BRONZE**

Optional benefits required:

☐ **Semi-private room discount**. Available to residents of Hong Kong with Global Health Elite Area 1 cover.

☐ **Out-patient direct billing in Hong Kong and China on the Gold and Silver plans.** Available to residents of Hong Kong with a nil excess. Available to residents of China with a nil or $50/£30/€45 excess. A 7.5% premium surcharge will apply in China.

Area of cover required:

☐ **Area One** provides world-wide cover excluding the United States of America.

☐ **Area Two** provides world-wide cover, subject to cover in the USA being limited to US$100,000 during temporary trips of not more than 45 days duration.

☐ **Area Three** provides world-wide cover, subject to cover in the USA being limited to US$250,000 during temporary trips of not more than 90 days duration.

☐ **Area Four** provides cover in Africa & the Indian Sub-continent, plus cover for unforeseen emergency treatment, covered by your plan, and received during temporary trips of up to 90 days duration outside Africa & the Indian Sub-continent (up to US$100,000, £62,500 or €88,750). No cover is provided in this Area of Cover for any treatment received in the USA, Canada, all Caribbean countries and islands, or within the London area.

OR, GLOBAL HEALTH ESSENTIAL PLAN REQUIRED

☐ **ESSENTIAL CARE PLUS** ☐ **ESSENTIAL CARE**

Area of Cover

The Global Health Essential plans are available to expatriates everywhere outside Australia, Canada, all Caribbean countries and islands, Europe, New Zealand, Orchid countries, and the United States of America.

Emergency cover only is provided for unforeseen treatment, covered by your plan, and received during temporary trips of up to 90 days duration to any EU country, Andorra, Australia, Bali, Channel Islands, China, Gibraltar, Greenland, Hong Kong, Iceland, Japan, Liechtenstein, Macau, Monaco, New Zealand, Norway, San Marino, Singapore, Switzerland and Taiwan (up to US$50,000).

No cover is provided for any treatment received in the USA, Canada, all Caribbean countries and islands, and within the London area.

EXCESS REQUIRED

The excess will be applied per claim unless otherwise specified in your Plan Agreement or indicated as 'per annum' in the list below.

☐ **Nil** Standard excess for Bronze and Essential Care. Available for Gold, Silver and Essential Care Plus with a 7.5% premium loading.

☐ **$50/£30/€45** per claim Standard excess for Gold, Silver and Essential Care Plus. Not available for Bronze and Essential Care.

☐ **$100/£60/€90** per claim Available for Gold and Silver. Not available for Bronze and Essential plans.

☐ **$250/£150/€225 per annum** Available for Gold, Silver, Bronze, Essential Care Plus and Essential Care plans. This is the only per annum excess available, all other excesses are on a per claim basis.

☐ **$1,600/£1,000/€1,500** Available for Gold, Silver and Bronze. Not available for Essential Plans.

If you select a higher excess than the standard option for your plan, a discount will be applied to your premium.

OPTIONAL PLANS REQUIRED

Global Travel Who do you require cover for: ☐ **Employee** ☐ **Partner** ☐ **Whole family**

Global Personal Accident Who do you require cover for: ☐ **Employee** ☐ **Partner**

Please select the benefit limit:

☐ **$75,000/£50,000/€75,000** ☐ **$150,000/£100,000/€150,000** ☐ **$225,000/£150,000/€225,000**

☐ **$300,000/£200,000/€300,000** ☐ **$375,000/£250,000/€375,000**

NB: The Global Personal Accident plan does not cover accidents arising out of hazardous occupations and hazardous activities. When personal accident benefit cover is required for an employee whose occupation is not 100% office based and/or who participates in hazardous activities of any kind, a detailed job description and/or details of their hazardous activities must be submitted to us. Cover for hazardous occupations/activities may be subject to a premium loading, and/or special terms.

Signed on behalf of the employer: **Date:**

Position in company:

SECTION 2: TO BE COMPLETED BY THE EMPLOYEE

PERSONAL DETAILS

First name: Surname: Mr/Dr/Mrs/Ms/Miss

Address:

Telephone No (for correspondence): Telephone No (other): Fax No:

Email (home): Email (other):

Date of birth: Nationality: ☐ Male ☐ Female

Country where you will be living/working: How long have you lived here:

Occupation:

Is your occupation, and/or your partner's occupation 100% office based? ☐ **YES** ☐ **NO**

If NO, please provide a job description, and/or provide full details of any activities that are not office based and indicate how often you participate in them:

Do you and/or your partner participate in hazardous activities? ❑ **YES** ❑ **NO**

If YES, please provide a job description, and/or provide full details of any hazardous activities that you participate in, and indicate how often you participate in them:

NB: The Global Personal Accident plan does not cover accidents arising out of hazardous occupations and hazardous activities. Cover for your hazardous occupations/activities may be subject to a premium loading, and/or special terms.

Hazardous Activities include (but are not limited to) off-piste skiing, scuba diving to a depth of more than 30 metres and unsupervised scuba diving, rock-climbing or mountaineering normally involving the use of ropes or guides, pot-holing, hang-gliding, parachuting, bungee-jumping, hunting on horseback, or driving or riding in any kind of race or competition, flying other than as a passenger in a commercial aircraft, riding or pillion on motorcycles, motor scooters or mopeds, or any other activity that places you in a similar degree of danger as any of those mentioned here.

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 18 or up to age 25 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	Nationality	Country where you will be living	Occupation/ Full-time education
Partner						
Child 1						☐ YES ☐ NO
Child 2						☐ YES ☐ NO
Child 3						☐ YES ☐ NO

For additional children included on the plan, please supply the information requested above on a separate sheet.

PREVIOUS/CURRENT INSURANCE

Have you or any persons named in this application:

A. Previously applied for or held a policy, or are currently insured with William Russell Limited or Dubai Insurance Company? ❑ **YES** ❑ **NO**

If YES, please state the policy number: Date of expiry of policy:

B. Previously applied for, held or currently are insured with any other health insurer? ❑ **YES** ❑ **NO**

If YES, please provide the name of the insurer : Date of expiry of policy:

C. Had an application for insurance declined or accepted with special terms, or had an insurance policy cancelled by any insurance provider? ❑ **YES** ❑ **NO**

If YES, please provide full details.

PRE-EXISTING MEDICAL CONDITIONS AND RELATED CONDITIONS

IMPORTANT:

The Global Health plans do not cover the treatment of pre-existing conditions and related conditions. A pre-existing condition means any disease, illness or injury for which you have received medication, advice or treatment, or you have experienced symptoms, whether the condition has been diagnosed or not, at any time before the start of your cover. A related condition is any disease, illness or injury that is caused by a pre-existing condition or results from the same underlying cause as a pre-existing condition.

We rely on the information that you give us in this form when we decide whether or not to accept your application, and whether or not we need to apply special terms. Special terms are exclusions or conditions that we may apply to your cover. If you submit a claim for the treatment of any pre-existing condition or related condition which you omitted to tell us about here or you omit to tell us everything about, we will refuse to pay that claim. We also have the right to declare your Global Health plan void, or we may impose special terms on your plan which will apply retrospectively. Please therefore take the greatest care to ensure that this application form is completed fully and accurately. If you are uncertain about whether any particular fact needs to be disclosed, you should include it.

DECLARATION OF HEALTH

Please complete the following health declaration on behalf of yourself and all those named within the application form. Give full details about each condition by answering the questions in the following health declaration accurately and in as much detail as possible. Please continue on a separate sheet if necessary. We cannot accept your application if this health declaration is incomplete.

If someone else completes this form for you (for example your partner or financial adviser) you must check that all the details are correct before you sign the declaration.

If your application form is being sent via a third party, any medical information may be declared to us directly if preferred.

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 or been advised to undergo a surgical operation (including any cosmetic surgery or any refractive laser eye surgery)? ☐ **YES** ☐ **NO**

B. Been admitted to a hospital, emergency room or sanatorium? ☐ **YES** ☐ **NO**

C. Been advised to have any medical tests or investigations or had any abnormal medical test results? ☐ **YES** ☐ **NO**

D. Been tested **positive** for HIV/AIDs or Hepatitis B or C or been treated for any sexually transmitted diseases, or are awaiting the results of any test for a sexually transmitted disease? ☐ **YES** ☐ **NO**

3. Are any of the persons named in this application aware of any symptoms or abnormal signs 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**
e.g. glaucoma, cataracts, retinal or other eye disorders, tonsillitis, ear infections, loss of hearing, loss of sight, sinus problems

B. Any high blood pressure, heart or circulatory conditions? ☐ **YES** ☐ **NO**
e.g. angina/chest pains, heart attack, abnormal heartbeat, palpitations, varicose veins, stroke, deep vein thrombosis, high cholesterol

C. Diabetes or any other endocrine disorder? ☐ **YES** ☐ **NO**
e.g. underactive/overactive thyroid, goitre, hormonal problems

D. Any musculo-skeletal conditions? ☐ **YES** ☐ **NO**
e.g. inter vertebral disc problems, osteoporosis, back pain, neck pain, sciatica, tendon or ligament problems, fractures, rheumatoid arthritis, osteoarthritis, gout, inflammatory conditions

E. Any respiratory or allergic conditions? ☐ **YES** ☐ **NO**
e.g. asthma, bronchitis, chest infections, allergic rhinitis, hay fever, shortness of breath, tuberculosis, emphysema, other lung conditions

F. Genito-urinary or renal conditions? ☐ **YES** ☐ **NO**
e.g. prostate problems, incontinence, urinary retention, kidney stones, kidney failure, urinary tract infection

G. Conditions of the digestive system (stomach, intestine, liver, gallbladder)? ☐ **YES** ☐ **NO**
e.g. hernias, indigestion, ulcers, irritable bowel system, Crohn's disease, hepatitis, cirrhosis, gallstones, rectal bleeding, haemorrhoids (piles)

H. Cancer, growths or tumours? ☐ **YES** ☐ **NO**
e.g. benign growths, any type of cancer, pre-cancerous conditions

I. Any skin conditions? ☐ **YES** ☐ **NO**
e.g. acne, eczema, rashes including allergic rashes, psoriasis, cysts, dermatitis, changing moles, warts

J. Any gynaecological or breast conditions? ☐ **YES** ☐ **NO**
e.g. heavy or irregular periods, ovarian cysts, fibroids, endometriosis, infertility, breast lumps/cysts, abnormal smears

K. Any physical defect, infirmity or congenital illness? ☐ **YES** ☐ **NO**

L. Psychiatric conditions? ☐ **YES** ☐ **NO**
e.g. anxiety, bi-polar disorder, schizophrenia, stress, depression, eating disorders

M. Any alcohol and/or drug dependency problem? ☐ **YES** ☐ **NO**

N. Any neurological conditions (brain and central nervous system)? ☐ **YES** ☐ **NO**
e.g. epilepsy, multiple sclerosis, repeated headaches, migraines, neuralgia, fits, stroke, fainting, paralysis

O. Any other type of disease, injury or medical condition? ☐ **YES** ☐ **NO**

6. Are any persons named in this application currently pregnant or has any person named in this application ever suffered from any pre or post natal complications, complications of childbirth or suffered any miscarriage? ☐ **YES** ☐ **NO**

If you have answered YES to any question, please give full details below. Please continue on a separate sheet if necessary.

Question No: Name of person who suffered the illness/injury:

Date(s) on which illness/injury occurred: Date of last symptoms or treatment relating to this condition:

Diagnosis:

Treatment/tests performed and results:

Name and address of treating physician:

Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: Name of person who suffered the illness/injury:

Date(s) on which illness/injury occurred: Date of last symptoms or treatment relating to this condition:

Diagnosis:

Treatment/tests performed and results:

Name and address of treating physician:

Give details of any foreseeable need for further consultation or treatment for this condition:

7. Have any persons named in this application consulted a general practitioner, consultant, medical specialist or undergone a routine health check in the last two years? ..... ☐ YES ☐ NO

If YES, please provide details of the date of the last/most recent consultation, condition, treatment, outcome and clinic name and/or doctors name below?

	Date	Condition	Treatment	Outcome	Clinic Name / Doctor Name
Applicant					
Partner					
Child 1					
Child 2					
Child 3					

For additional children included on the plan, please supply the information requested above on a separate sheet.

MEDICAL FACILITY CONTACT DETAILS

Please give details of the hospital, medical clinic or doctor who is most familiar with the medical history of each person named in this application. If any dependants regularly see a different doctor, please provide details on a separate sheet.

Hospital, clinic or doctors name and address

Length of time you have known this hospital, clinic or doctor: ..... Years ..... Months

Name: .....

Address: .....

.....

Practice tel no: .....

Practice email: .....

CONTINUING DUTY OF DISCLOSURE

If after completing, signing and dating your application form any changes occur in the facts you have given us, such as a change in your state of health, you must tell us in writing about the change, and we reserve the right to decline to accept your application or to accept your application with special terms.

THE INSURERS

The insurer of the Global Health plan is Allianz Nederland Schadeverzekering NV. Coolsingel 139, Postbus 64, NL-3000 AB Rotterdam, Netherlands. Allianz Nederland Schadeverzekering NV is an E E A insurer registered in the Netherlands.

The insurer of your Global Travel plan and/or Global Personal Accident plan is SHUS Insurance PCC Limited - Cell SHUS. SHUS Insurance PCC Limited is a Guernsey registered Protected Cell Company under The Companies (Guernsey) Law 2008. A creditor of one cell is not entitled to claim against the assets of another cell. In the absence of a specific written recourse agreement a creditor will not have the right of recourse to any core assets. This transaction is with designated Cell SHUS. SHUS Insurance PCC Limited - Cell SHUS is licensed and regulated by the Guernsey Financial Services Commission.

DECLARATION AND AUTHORISATION

I hereby apply for cover on behalf of all the persons named in this application form for a Global Health plan as specified above. 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 the insurance plan. I have confirmed the information (including medical information) relating to all persons named in this application form with them.

I also understand that I must notify William Russell Limited of any changes in the facts contained in this application form, such as a change in the state of health of any person named in it. 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.

I, and all those named in this application, understand that in order to assess my claim, William Russell Limited may need to obtain details of my medical history. I, and all those named in this application, hereby authorise any physician, healthcare professional, hospital, clinic and other healthcare institution to disclose to William Russell Limited, to the extent allowed by applicable law, any information concerning the medical history, services, supplies, or treatment provided to anyone listed on this application, including those services involving dental, substance abuse and HIV/AIDS.

I understand that William Russell Limited may rely on this information to administer my policy and claims and to determine policy coverage according to applicable laws and regulations.

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.

I understand that if I leave my current employment my eligibility to this group scheme will no longer be valid, therefore my cover on the plan will cease with immediate effect. I understand that if I wish to take out an individual policy with William Russell Limited, I may need to reapply, and new terms may be issued.

I hereby give William Russell Limited authorisation to send my insurance documents in pdf format by email to the email address I have stated in this application. If I have applied through an intermediary, I hereby give William Russell Limited authorisation to send my insurance documents in pdf format by email to my intermediary.

I understand that my personal data will be processed in accordance with the Data Protection Act (1988) and the EU Data Protection Directive 95/46/EC.

I understand that William Russell Limited will hold and process my personal data for the purposes of processing my Global Health plan, processing any claims submitted under my Global Health plan and providing other related services, which may include sharing my personal data with the insurers of my plan, doctors and other medical professionals involved in my treatment or care (or the treatment or care of other persons insured under my Global Health plan), William Russell Limited's emergency assistance providers and other agents. I understand that this may include the transfer of personal data to countries outside the European Union and in signing this form I consent to such transfer and use.

I also understand that my personal data may be disclosed to any regulatory body that may require William Russell Limited to disclose it and that, in the event of fraud or suspected fraud, my personal data may be disclosed to other parties, including but not limited to, the appropriate law enforcement agencies.

I consent to William Russell Limited processing personal and sensitive data about me and other persons included on this application form. I understand that all personal data I supply must be accurate and confirm that I have the specific consent of all other persons included on this application to disclose their personal data.

I understand that telephone calls to and from William Russell Limited may be recorded and monitored.

I understand that I may ask to review my personal or healthcare information and request amendments, to the extent allowed by law, and that I may revoke this authorisation at any time.

This authorisation shall remain valid for the term of my Global Health plan, including any periods of cover following subsequent renewals, or for so long as allowed by law.

Signature of employee: **Date:**

IMPORTANT:

- **Please ensure you have given an answer to every question. An incomplete form will delay your application. If after completing, signing and dating your application form any changes occur in the facts you have given us, such as a change in your state of health or in the state of health of any of your dependants, you must tell us in writing about the change, and we reserve the right to decline to accept your application or to accept your application with special terms.**
- **This application form will be valid for 28 days from the date on which it is signed. If cover is not commenced within 28 days, we reserve the right to request that a new application form is completed.**

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WilliamRussell
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