NAVIGATOR
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Global Health Plans

Individual Application Form (Full Medical Underwriting)

Please complete this form in **BLOCK CAPITALS** using black ink, and return it to us by email, fax or post. You can find our contact details at the end of this form.

Your personal details

First name: …… Surname: …… Title: ……

Address: ……

……

Telephone number: …… Mobile number: ……

Email: …… Occupation: ……

Date of birth: …… Nationality: …… ☐ Male ☐ Female

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

Dependants to be included in your plan

Please enter details of all dependants. You may include your spouse/partner, and dependent children up to age 18 (or 25 if in full-time education). Children aged 18 and over, and not in full-time education, must complete their own application form.

	Spouse/partner	Child 1	Child 2	Child 3
First name				
Surname				
Date of birth				
Gender				
Relationship to you				
Country where they will be living				
Occupation/full-time education				

Start date required

When would you like your Global Health plan to start?

☐ On acceptance of your application ☐ Specific date: ……

Please note that your application is only valid for 28 days from the date we receive it. We cannot commence your plan until we have accepted your application and received payment of your first premium. If cover has not commenced within 28 days of receipt of your application, we reserve the right to request a new one. Cover cannot be backdated.

Previous/current insurance

Have you, or any persons named in this application, ever:

1. Applied for a William Russell plan?

☐ Yes ☐ No If YES, please state the plan number: …… Date of expiry of plan: ……

2. 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 details: ……

……

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Please choose either an **Elite plan** or an **Essential plan**, then select the **optional benefits** you require.

A) Elite plans

Plan:	Excess required:			
GOLD	☐ Nil	☐ $50/£30/€45 per claim ☐ $100/£60/€90 per claim	☐ $250/£150/€225 per annum	☐ $1,600/£1,000/€1,500 per claim
SILVER	☐ Nil	☐ $50/£30/€45 per claim ☐ $100/£60/€90 per claim	☐ $250/£150/€225 per annum	☐ $1,600/£1,000/€1,500 per claim
BRONZE	☐ Nil	☐ $250/£150/€225 per annum	☐ $1,600/£1,000/€1,500 per claim	

Additional benefits available with the Elite plans

☐ **Complex dental benefit** – only available with Gold.

☐ **Optional routine & complex dental benefit** – only available with Silver.

☐ **Semi-private room discount** – only available to residents of Hong Kong with Area One cover.

☐ **Out-patient direct billing in Hong Kong and China** – only available with Silver and Gold**.** Available to residents of Hong Kong with nil excess, and to residents of China with a nil or $50/£40/€30 excess. A 7.5% surcharge applies in China.

Choose your Elite Area of Cover

☐ **Area One** Provides worldwide cover excluding the USA.

☐ **Area Two** Provides worldwide cover, with cover in the USA limited to $100,000 during temporary trips of not more than 45 days.

☐ **Area Three** Provides worldwide cover, with cover in the USA limited to $250,000 during temporary trips of not more than 90 days.

☐ **Area Four** Provides cover in Africa & the Indian Subcontinent, plus cover for eligible, unforeseen emergency treatment received during temporary trips of up to 90 days outside Africa & the Indian Subcontinent up to $100,000/£62,500/€88,750. No cover is provided for any treatment in the USA, Canada, all Caribbean countries and islands, or within the London area.

B) Essential plans

Plan:	Excess required:		
ESSENTIAL CARE PLUS	☐ Nil	☐ $50 per claim	☐ $250 per annum
ESSENTIAL CARE	☐ Nil	☐ $250 per annum	

The Essential Area of Cover

Full cover is provided everywhere, except in the following restricted or excluded countries/regions.

Cover is restricted to eligible treatment for accidents or unforeseen illnesses only, and limited to $50,000 per period of cover if you travel to any European country, Bali, Japan, Hong Kong, Macau, China, Taiwan, Singapore, Australia or New Zealand.

No cover at all is provided in the USA, Canada, any Caribbean country or island, and any hospital in the London area.

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Optional benefits available with the Elite and Essential plans

GLOBAL TRAVEL PLAN ☐ You ☐ Spouse/partner ☐ Family

GLOBAL PERSONAL ACCIDENT PLAN ☐ You ☐ Spouse/partner

Please answer the following questions ONLY if you have opted for Personal Accident cover. If you have opted for cover for your spouse/partner, we also require details of their occupation and any hazardous activities.

Please select the level of Personal Accident benefit you require:

☐ $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

Is your occupation 100% office based? ☐ Yes ☐ No

If NO, please provide a job description, or full details of your non-office-based activities and how often you participate in them:

.....

Do you participate in any hazardous activities? ☐ Yes ☐ No

If YES, please provide full details of the activities you participate in and indicate how often:

.....

The Global Personal Accident plan does not cover accidents as a result of hazardous activities/occupations. Cover for hazardous activities/occupations may be subject to a premium loading, special terms, or we may decline to offer cover.

Hazardous activities include off-piste skiing, scuba diving to a depth of more than 30 metres (or any unsupervised scuba diving), rock climbing or mountaineering, pot-holing, hang-gliding, parachuting (including tandem), bungee jumping, kite surfing/windsurfing, hunting on horseback, driving or riding in any kind of race or competition, flying other than as a passenger in a commercial aircraft, riding a motorcycle (or riding pillion), motor scooter, moped or quad bike, or any other activity that places you in a similar degree of danger as any of those mentioned here.

Paying for your plan

Please select the currency in which you would like to pay your premiums:

☐ US Dollars ☐ GBP Sterling ☐ Euros

Your plan benefits and excess will be denominated in the currency in which you pay your premiums. The Essential plans are only available in US Dollars.

Please select your payment method and frequency:

Credit/debit card	☐ Annually	☐ Half-yearly	☐ Quarterly	☐ Monthly
Direct debit*	☐ Annually	☐ Half-yearly	☐ Quarterly	☐ Monthly
Bank transfer	☐ Annually			
Cheque	☐ Annually (payable to William Russell Ltd., and must be drawn on a UK bank account)			

*Direct debit payments are only available when you pay in Sterling from a UK bank account.

Half-yearly premiums are subject to a 3% surcharge. Quarterly or monthly premiums are subject to a 5% surcharge.

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Health Declaration

The Global Health plans are fully medically underwritten. This means that you will need to complete the following Health Declaration and provide us with full details of any medical conditions that existed before the start date of your plan. Medical conditions that existed before the start date of your plan (pre-existing conditions), and conditions related to pre-existing conditions, will not be covered unless you have told us about them and we have agreed to cover them. This includes conditions that arise between the time that you complete this application and the start date of your cover, so it is important that you contact us immediately if the information provided here changes.

Please answer all of the following questions for each person named on this form for whom cover is required. If you answer YES to any question, please supply full details in the spaces provided. Please answer the questions fully, accurately, and to the best of your knowledge and belief. If you do not answer the questions fully and accurately, your plan may be cancelled or claims may be rejected. If you are in any doubt as to whether you should tell us anything, please tell us anyway.

Please complete the following table for yourself and your spouse/partner only:

	You	Spouse/partner
Height (cm)		
Weight (kg)		
Do you smoke? If YES, how many cigarettes/cigars a day?		
Do you consume alcohol? If YES, how many units of alcohol a day?		

Medical questions for EACH person to be insured

① Has any person named on this form ever suffered from any of the following conditions?

a) **Brain or nervous system conditions?** ☐ Yes ☐ No
For example: stroke/transient ischemic attack (TIA), epilepsy, migraines or repeated headaches, multiple sclerosis, meningitis, shingles, nerve pain.

b) **Cancer, tumours or growths?** ☐ Yes ☐ No
For example: polyps, benign growths or cysts, lymphomas, any cancers or pre-cancerous conditions.

c) **Heart or circulatory conditions?** ☐ Yes ☐ No
For example: high blood pressure, angina/chest pains, heart attacks or failure, abnormal heartbeat, varicose veins, raised cholesterol, stroke, deep vein thrombosis.

d) **Psychiatric or psychological conditions, drug & alcohol issues or sleep disorders?** ☐ Yes ☐ No
For example: depression, anxiety, stress, anorexia nervosa, autism, bipolar disorder, insomnia, narcolepsy, sleep apnoea, alcohol or drug dependency.

② In the last five years, has any person named on this form seen a physician, or experienced any symptoms, or been admitted to a hospital or medical facility for an operation or procedure, or undergone any tests or investigations, for any of the following conditions:

a) **Auto-immune disorders?** ☐ Yes ☐ No
For example: HIV/Aids, rheumatoid arthritis, systemic lupus erythematosus, scleroderma.

b) **Back, joint, muscular or skeletal problems?** ☐ Yes ☐ No
For example: back or joint pain, whiplash, sciatica, degenerative changes, osteoarthritis, osteoporosis, gout, bunions, joint replacements, fractures, cartilage or ligament problems.

c) **Breathing or respiratory conditions (including allergies)?** ☐ Yes ☐ No
For example: asthma, chronic obstructive pulmonary disease (COPD), shortness of breath, chest infections, pneumonia, bronchitis, tuberculosis (TB), hay fever, allergies to food substances and animals.

d) **Diabetes, thyroid or any other endocrine disorder?** ☐ Yes ☐ No
For example: diabetes type 1 or 2, overactive or underactive thyroid, pituitary or adrenal problems, obesity.

e) **Eyes, ear, nose and throat or oral/dental conditions?** ☐ Yes ☐ No
For example: glaucoma, cataracts, retinal detachment, macular degeneration, hearing difficulties, repeated ear infections, tonsillitis, sinusitis, dental problems, wisdom teeth problems, gingivitis.

f) **Gynaecological or breast conditions?** ☐ Yes ☐ No
For example: complications of pregnancy, heavy or irregular periods, fibroids, endometriosis, ovarian cysts, abnormal smear tests, miscarriage, pre- and post-natal complications, breast lumps/cysts.

g) **Skin conditions (including allergies)?** ☐ Yes ☐ No
For example: eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed or allergic reactions.

h) **Stomach, liver/gall bladder, or digestive system conditions?** ☐ Yes ☐ No
For example: ulcers, irritable bowels, Crohn's disease, colitis, reflux/heartburn abdominal pain, anaemia, hepatitis, cirrhosis, gallstones, hernias, haemorrhoids/piles.

i) **Urinary, kidney or prostate conditions?** ☐ Yes ☐ No
For example: recurrent kidney infections, kidney stones, incontinence, prolapse, prostate problems, recurrent bladder or urine infections.

j) **Any alcohol and or drug dependency problems?** ☐ Yes ☐ No

k) **Any physical defect, infirmity or congenital condition?** ☐ Yes ☐ No

l) **Any other medical condition not mentioned above?** ☐ Yes ☐ No

③ **Is any person named on this form currently taking any medication, prescribed or otherwise?** ☐ Yes ☐ No

④ **Has any person named on this form experienced any signs or symptoms of any medical condition in the last six months, whether or not a physician has been consulted?** ☐ Yes ☐ No

⑤ **Is any person named on this form currently undergoing any treatment or periodic reviews for a medical condition, physical impairment, disability or recurrent illness not already mentioned, or is anyone named on this form currently pregnant?** ☐ Yes ☐ No

If you have answered YES to any of the above questions, please give full details

Question #: ..... Name of person affected by the condition: .....

Date(s) on which the illness/injury occurred: .....

What treatment was received, including details of any medication: .....

.....

.....

.....

Please provide the name and address of the treating physician: .....

Does this condition require any future treatment, including consultations with a physician and/or periodic tests or reviews?

.....

Question #: ..... Name of person affected by the condition: .....

Date(s) on which the illness/injury occurred: .....

What treatment was received, including details of any medication: .....

.....

.....

.....

Please provide the name and address of the treating physician: .....

Does this condition require any future treatment, including consultations with a physician and/or periodic tests or reviews?

.....

If you require more space, please continue on a separate sheet of paper.

Physician

Please provide details of the physician who is most familiar with the medical history of all those named in this application form. If any dependants regularly see a different physician, please provide this information on a separate piece of paper.

Name of physician: .....

Address: .....

Telephone number: ..... Email: .....

How long have you been known to this physician? .....

Save paper and make a donation to charity

At William Russell, we are committed to reducing waste. Unless you specifically request paper documents and a plastic membership card, we will email your insurance documents as PDF files. If you agree to accept your documents via email, we will donate $5 to our supported charity, Oxfam.

Please tick one of the boxes below:

☐ I would like to receive my documents as PDF files, please donate $5 to charity.

☐ I would like to receive hard copies of my documents and a plastic card.

OXFAM

Broker details

If you were introduced to William Russell through an intermediary/broker, please state their name and company.

Name of broker: ..... Name of company: .....

How we use your information

William Russell Limited will use your information within the provisions of the Data Protection Act 1998, for the purposes of underwriting, administration and processing your claims. We may also pass your information to the insurers and reinsurers of your plan.

We may pass your personal information to our emergency assistance service providers and cost control agents. If you require emergency assistance or treatment whilst you are outside the European Economic Area (EEA), we may need to pass your personal information to service providers outside of the EEA.

If required, we will pass your information to legal or regulatory bodies, and we may pass information to relevant third parties in the interests of fraud prevention.

By submitting this form you consent to us processing your personal information, including sensitive personal information, such as health information.

Declaration for your Global Health plan

Please read this section carefully and sign below.

I understand that this application is subject to written acceptance by William Russell Limited.

I declare that I have taken reasonable care to answer all questions honestly and fully for all persons named in this application and I confirm that I have checked with each person that the information I have given is a true representation of the facts.

I understand that misrepresentation could result in claims being rejected or not fully paid, and/or my plan being cancelled.

I understand that cover will not be available for any investigations or treatment for a condition or related condition which exists or existed before the start date of the plan, unless I have provided complete details of this condition to William Russell Limited and they have agreed to cover it. I also understand that my certificate of insurance will advise me of any medical conditions specifically excluded from cover based upon the information I have provided for myself and persons to be included in this plan.

I understand that I must inform William Russell Limited, in writing, of any changes in the facts included in this application, including any change in health of any persons named in this application that occurs before the start date of my plan.

I hereby give explicit consent, within the provisions of the Data Protection Act 1998, on behalf of myself and all persons included in this application for William Russell Limited to process our personal information with respect to our membership and I confirm that I have brought the Use of Personal Information notice to the attention of these persons.

I understand that in order to assess claims, William Russell Limited may need to obtain details of my medical history or that of persons included in this application. I give permission to any hospital and/or physician who has at any time been involved in the treatment or care of any persons included in this application, to provide William Russell Limited (and any third parties acting on their behalf) with any information, including medical records, and medical reports concerning our physical or mental health.

I authorise William Russell Limited to send my insurance documents as PDF files to the email address I have provided on this form. If I have applied through a broker or intermediary, I hereby give consent for these documents to be sent via email to that broker or intermediary.

I agree that this declaration and the answers given on this application shall form the basis of the contract between myself and William Russell Limited, and that this application, together with the relevant Plan Agreement and the certificate of insurance shall form the contract of insurance.

I understand that, as the legal holder of this plan, all correspondence, including claims correspondence for any insured dependant, will be sent to me, the plan holder. If any person aged 18 or over does not wish us to do this then they must take out a plan in their own right.

I understand that upon receipt of my insurance documents, if I am not entirely satisfied, I can cancel my application from inception and receive a full refund of the premium I have paid, provided I notify William Russell Limited within 30 days of the start date of cover and provided no claim has been made.

Name of applicant: .....

Signature of applicant: ..... **Date:** .....

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