GLOBAL HEALTH EMPLOYEE APPLICATION FORM (MORATORIUM)

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** Standard excess for Gold, Silver and Essential Care Plus. Not available for Bronze and Essential Care.

☐ **$100/£60/€90** Available for Gold and Silver only. 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.

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 of residence: 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.

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.

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	Country of residence	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.

PRE-EXISTING MEDICAL CONDITIONS AND RELATED CONDITIONS

IMPORTANT:

The Global Health plans do not cover 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 for which you have experienced symptoms, whether the condition has been diagnosed or not, any time in the 2 year period before the date on which your Global Health plan starts.

After two years continuous cover, some pre-existing medical conditions will become eligible for benefit, provided you have not consulted any doctor or medical practitioner for treatment, advice (including check-ups), taken medication (including injections), been advised to follow a special diet or suffered symptoms for that condition or related condition, for a continuous period of two years. For medical conditions where it is standard medical practice that it be monitored, then that condition and any related conditions will never be covered.

Examples of pre-existing conditions that will never be covered include diabetes, hypertension (raised blood pressure), hyperlipideamia (raised cholesterol levels), ischemic heart disease, cancer, thyroid disease and auto-immune disorders. Examples of related conditions are hypertension and strokes, diabetes and diabetic retinopathy.

GENERAL DECLARATION OF GOOD HEALTH

Please complete the following declaration of good health on behalf of yourself and all those named within the application form.

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. Been admitted to a hospital, emergency room or sanatorium, undergone an operation or taken medication for a period of longer than 4 weeks in the last 12 months?. .... ☐ YES ☐ NO

B. Suffered from, been diagnosed with, treated or prescribed drugs for any form of cancer, heart condition, psychiatric condition, any serious or chronic illness or any condition that requires regular medication and/or monitoring? . ... ☐ YES ☐ NO

Examples of serious or chronic illnesses include diabetes, high blood pressure and/or cholesterol, ischemic heart disease, cancer, spinal disc disease, thyroid disease, depression and auto-immune disorders (if you have a medical condition and are uncertain about whether it is chronic, you should disclose it).

C. Been tested <u>positive</u> for HIV/AIDs or Hepatitis B or C or are awaiting the results of any such test? .... ☐ YES ☐ NO

If you have answered YES to any question, please state the name(s) of the person(s) and details:

MEDICAL FACILITY CONTACT DETAILS

1. 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.

	Hospital, clinic or doctors name and address	
Applicant	Length of time you have known this hospital, clinic or doctor: .... Years .... Months Name: .... Address: .... Practice tel no: .... Practice email:	If you have known this hospital, clinic or doctor for less than 2 years, please provide details for your previous medical facilities: ....
Partner	Length of time you have known this hospital, clinic or doctor: .... Years .... Months Details same as Applicant: ☐ **YES** ☐ **NO** If NO, please provide details below: Name: .... Address: .... Practice tel no: .... Practice email:	If you have known this hospital, clinic or doctor for less than 2 years, please provide details for your previous medical facilities: ....
Child 1	Length of time you have known this hospital, clinic or doctor: .... Years .... Months Details same as Applicant: ☐ **YES** ☐ **NO** If NO, please provide details below: Name: .... Address: .... Practice tel no: .... Practice email:	If you have known this hospital, clinic or doctor for less than 2 years, please provide details for your previous medical facilities: ....
Child 2	Length of time you have known this hospital, clinic or doctor: .... Years .... Months Details same as Applicant: ☐ **YES** ☐ **NO** If NO, please provide details below: Name: .... Address: .... Practice tel no: .... Practice email:	If you have known this hospital, clinic or doctor for less than 2 years, please provide details for your previous medical facilities: ....
Child 3	Length of time you have known this hospital, clinic or doctor: .... Years .... Months Details same as Applicant: ☐ **YES** ☐ **NO** If NO, please provide details below: Name: .... Address: .... Practice tel no: .... Practice email:	If you have known this hospital, clinic or doctor for less than 2 years, please provide details for your previous medical facilities: ....

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

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. <u>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</u>.

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 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:**

Signature of employee's partner: **Date:**

If you are applying for cover on behalf of a dependant aged 18 or over, please ask them to read the above declaration and sign below.

Signature of dependant: **Date:**

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

Position in company:

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
Expatriate Insurance Specialists