OPTIMUM GLOBAL
INTERNATIONAL INSURANCE SOLUTIONS

OG GEMS - APPLICATION FORM

Please complete this form in block capitals. Payment must be submitted before any cover can be granted. You must disclose in this form, fully and faithfully, all material facts. A material fact is one that is likely to affect the assessment of this health insurance application. Failure to do so may result in you not receiving any benefit from your policy.

Company Name: _____ Group Number: _____

If you are applying as an employee of a company, please insert the name of the company above. If you are applying as an individual or a family, please leave it blank. Please complete in block capitals.

1. YOUR PERSONAL DETAILS (MAIN APPLICANT)

Title: _____ First Names: _____

Family Name: _____

Gender (please circle): M / F Nationality: _____ Date of Birth (dd mm yy): _____

Occupation: _____

Usual Country of Residence: _____ Passport/ID number: _____

2. CONTACT DETAILS

Residential address of the country where you spend more than 6 months per year:

Address: _____

_____

Country: _____ Postal Code: _____

Email Address: _____

	Country Code	Area Code	Number		Country Code	Area Code	Number
Home Telephone:				Work Telephone:			
Fax Number:				Mobile Telephone:			

3. ADDITIONAL MEMBERS TO BE COVERED

Title: _____ First Names: _____

Family Name: _____

Gender (please circle): M / F Nationality: _____ Date of Birth (dd mm yy): _____

Occupation: _____

Usual Country of Residence: _____

Relationship to main applicant: _____

1st Child

Title: _____ First Names: _____

Family Name: _____

Gender (please circle): M / F Nationality: _____ Date of Birth (dd mm yy): _____

Occupation: _____

Usual Country of Residence: _____

2nd Child

Title: _____ First Names: _____

Family Name: _____

Gender (please circle): M / F Nationality: _____ Date of Birth (dd mm yy): _____

Occupation: _____

Usual Country of Residence: _____

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3rd Child

Title: _____ First Names: _____

Family Name: _____

Gender (please circle): M / F Nationality: _____ Date of Birth (dd mm yy): _____

Occupation: _____

Usual Country of Residence: _____

4. YOUR CHOICE OF MEDICAL COVER

Please tick one box only

Core Plan (Please select): **Plan 1:** Emerald ☐ **Plan 2:** Sapphire ☐ **Plan 3:** Ruby ☐ **Plan 4:** Jade ☐ **Plan 5:** Diamond ☐

Area of Cover (Please select):
Option 1: Worldwide including USA ☐
Option 2: Worldwide excluding USA ☐
Option 3: Asia (Bangladesh - Bhutan - Brunei - Cambodia - East Timor - India - Indonesia - Japan - Laos - Malaysia - Maldives - Mongolia - Myanmar - Nepal - Pakistan - Philippines - Sri Lanka - Taiwan - Thailand - Vietnam) ☐
Option 4: Africa (including India & Pakistan) ☐
Option 5: Principal Country of Residence within the African Continent and pre-authorised Centres of Excellence on the African Continent ☐

Policy Currency (Please select): USD $ ☐ EUR € ☐ GBP £ ☐

Do you wish to purchase the optional dental cover? Yes ☐ No ☐

Do you wish to purchase the optional optical cover Yes ☐ No ☐

Do you wish to purchase the optional maternity cover? (Not available on Emerald or Sapphire) Yes ☐ No ☐

Which female family members wish to benefit from the optional maternity cover : _____

Please note that remaining family members must choose the same Core Plan as those members opting for maternity cover.

Out-patient Co-Pay option (please select): Nil co-payment ☐ 10% co-payment ☐ 20% co-payment ☐

In-patient Deductible option (please select):
Option 1) Nil ☐
Option 2) USD $500 / EUR €400 / GBP £300 ☐
Option 3) USD $1,000 / EUR €800 / GBP £600 ☐
Option 4) USD $2,000 / EUR €1,600 / GBP £1,200 ☐
Option 5) USD $5,000 / EUR €4,000 / GBP £3,000 ☐
Option 6) USD $10,000 / EUR €8,000 / GBP £6,000 ☐

Do you wish to purchase the optional Life cover? (please note, this option is only available to members aged 18-64 yrs)

Please indicate which Life cover amount you are applying for along with the name of the applicant/s applying for this option:

Option a) $50,000 / €50,000 / £50,000 ☐ Name/s of applicant/s: _____

Option b) $100,000 / €100,000 / £100,000 ☐ Name/s of applicant/s: _____

Please note: If choosing this option, please complete the beneficiary nomination form.

5. METHOD OF PAYMENT AND CONTRACT DETAILS

Contract Details

Date you want cover to commence (dd mm yy): _____ (Please note this date cannot be prior to the date we receive this application form)

Payment Option:

Premium Annual ☐ Semi-Annual ☐ Quarterly ☐

*Any charges made by the remitting bank and receiving bank in the course of submitting funds to Optimum Global Limited must be borne by the applicants. This may mean that it is necessary to pay an amount in excess of the contribution due to the plan to cover these charges.
Please indicate your name and invoice number when remitting payment.
Please remit the amount to the currency denominated bank account of **Optimum Global Limited** as shown on your invoice.

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6. CONFIDENTIAL MEDICAL HISTORY

	Main Applicant		Spouse/ Partner		1st Child		2nd Child		3rd Child	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Smoker:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1. Has any person named in this form been admitted to a hospital or nursing home or had any medical tests done in the last 4 years?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Has any specialist been consulted and/or provided prescriptions for any drugs or medication in the last 4 years?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Has any application for life, accident, health or any other insurance been refused or had special terms applied?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Does any person named in this form anticipate the need or has been recommended to undergo any medical tests or investigations in the foreseeable future?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. Has any person named in this form ever suffered from or are suffering from any disease or condition stated below?
Please tick box if 'Yes'

Heart trouble or chest pains	☐
Blood pressure problems or circulatory disorders	☐
Fainting, blackouts, dizziness, seizures, fits	☐
Strokes or paralysis	☐
Asthma, persistent cough, breathlessness or other respiratory disorders	☐
Stomach ulcer, liver, hepatitis, gall bladder, intestinal or bowel disorders	☐
Kidney, bladder, prostate or genito-urinary disorders	☐
Gynaecological or hormone disorders or irregularity	☐
Diabetes, cholesterol problems or diseases or disorders of the blood	☐
Tumour, growth, cancer or glandular diseases or abnormalities	☐
Diseases or disorders of the eyes, ears, nose or throat	☐
Diseases or disorders of the back, bones, joints, muscles or skin	☐
Mental or nervous disorders	☐
AIDS, HIV or venereal diseases	☐
Any diseases, disorders or conditions which are long lasting or recurrent	☐
Treatment for drug or alcohol addiction or abuse	☐
Any other illnesses, disabilities or defects present that may require treatment that have not already been disclosed	☐

If you have answered 'yes' to any of the above questions, please complete the additional supplementary medical questionnaire, providing more details by indicating the question number, the condition, dates of consultation, the treatment received and the name and address of doctor. Please attach a copy of all medical reports if applicable. Attach these items to this form and indicate you have done so by ticking this box: ☐

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7. DECLARATION

Benefits may not be payable if you do not fully disclose any material facts requested within this application form and any supplementary medical questionnaires which you may be required to complete as part of the application process. Material facts are those which could influence our assessment and acceptance of this application and, if you are in any doubt as to whether any facts are material, you should disclose them.

Personal Data provided in this application form will be used and processed by us in line with our Privacy Policy which can be found on our website, or which can be requested from us at any time.

I hereby give my consent to Optimum Global Insurance Company Limited or its agent to process the data supplied in this application form for the purposes of insurance intermediation, selection and/or compliance. I accept that this data may be sent and processed outside the UK in a country without specific data protection laws (this only applies if you have lived or worked overseas).

I/We declare that all the information on this application form is true and complete. I am/We are unaware of the existence of any medical condition or circumstance foreseeably requiring my/our hospitalisation in the future, and understand that benefits will not apply to treatment or expense arising from medical conditions which originated or were known to exist or for which treatment, medication, advice or diagnosis was sought or received prior to my/our enrolment in the Policy unless such conditions are fully disclosed to and accepted by Optimum Global Insurance Company Limited prior to the inception of the Policy. I/We consent to Optimum Global Insurance Company Limited seeking information from any doctor who has attended to me/us and I/we authorise the giving of such information. I/We further authorise Optimum Global Insurance Company Limited to give such information obtained or information contained herein for the purpose of obtaining insurance cover under this application to my insurance representative. I/We understand that Optimum Global Insurance Company Limited may require further medical information from my doctor and I/we am/are aware that I am/we are responsible for obtaining and paying for such information should I/we wish to continue my/our application. I am/We are aware that I/we can seek advice from a qualified adviser before I/we sign this application form. Should I/we choose not to, I/we take sole responsibility to ensure that this product is appropriate to my/our financial needs and insurance objectives. I/We have received Optimum Global Policy Conditions and the product benefit table and they have been explained to my/our satisfaction.

I/We agree that any cover which I/we may purchase for the USA shall terminate upon informing Optimum Global Insurance Company Limited that I/we have become a resident of the USA. I/We agree that this application shall be the basis of the contract of insurance between me/us and Optimum Global Insurance Company Limited. I/We understand that the insurance shall not become effective until it is accepted and confirmed in writing by Optimum Global Insurance Company Limited or its agent.

Signature of Main Applicant: Date:

Signature of Spouse/Partner: Date:

Broker/Distributor details:

Distributor Number:

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8. LIFE INSURANCE BENEFICIARY DESIGNATION

Important notes:

- Only complete this form if you have purchased the optional Life benefit option
- If more than one person is purchasing the Life cover option, please complete one beneficiary designation form per person
- Use this form to name the persons or entities you want to receive your life insurance proceeds after your death.

1. Primary Beneficiaries

These parties are your first choice to receive the insurance proceeds after your death. If a primary beneficiary dies before you, we will divide their share(s) equally between the remaining primary beneficiaries.

You must name at least one (1) primary beneficiary.

Please complete the form fields below for each beneficiary you name. Having accurate information for your beneficiaries ensures that we distribute the proceeds the way you want.

Use the proceeds % field to tell us how you want us to distribute the proceeds. If you want a specific distribution, use whole numbers (no fractions or decimals) and make sure they add up to 100%.

THE BENEFICIARY FOR THE POLICY SHALL BE:

PRIMARY BENEFICIARY			
Name	Address	Relationship to the Covered Person	% of Death Benefit Payable to Beneficiary (must total 100%)

In the event, and only in the event, that all Primary Beneficiaries predecease me, then the proceeds shall be payable to the following Contingent Beneficiaries

2. About the Contingent Beneficiaries

Skip this section if you're not naming a contingent beneficiary. Contingent beneficiaries receive the insurance proceeds only if all the primary beneficiaries are deceased at the time of your death. If a contingent beneficiary dies before you, we will divide their share(s) equally between the remaining contingent beneficiaries.

Please complete the form fields below for each beneficiary you name.

Do not list the same person as both a primary and a contingent beneficiary.

Use the proceeds % field to tell us how you want us to distribute the proceeds. If you want a specific distribution, use whole numbers (no fractions or decimals) and make sure they add up to 100%.

CONTINGENT BENEFICIARY			
Name	Address	Relationship to the Covered Person	% of Death Benefit Payable to Beneficiary (must total 100%)

Please note, should all beneficiaries predecease the person covered, we will pay the life benefit to the estate of the deceased.

Insured's Signature:

Insured's Printed Name: Date: