Application Form for Journey individual health insurance Plans Extensive, Advanced and Premium

⚠ **Please note: We will not be able to process the application if any fields are left incomplete.**
For more information, please refer to the Terms and Conditions of Insurance.

Please read these instructions carefully before filling in the Application Form:

1. This document is governed by the Terms and Conditions of Insurance. Capitalised terms in this document shall have the same meaning as provided in the Glossaries, unless otherwise explicitly stated to the contrary.
2. For inbound Germany (policy purchased for expatriates moving to Germany), there is a maximum insurance period of 5 years, including all policy extensions and/or previous health insurance cover taken out with other insurance companies. Therefore, any applicant who has been residing in Germany for more than 5 years, is not eligible for the product.
3. Insurance cover applies to insured events occurring in the following areas, as selected by the applicant in the Application Form:

   Geographical Area I: Worldwide including United States of America
   Geographical Area II: Worldwide excluding United States of America

   Treatment abroad is excluded from Benefits if such Treatment was the sole reason or one of the reasons for traveling abroad.

   If any applicant relocates to a Geographical Area different from the one agreed to be covered under the Insurance Policy for any duration, such relocation must be immediately notified to the Insurer, and this change will affect the premium and any Benefits to be granted under the Insurance Policy.
4. This insurance product is designed for individuals living outside their home country for a temporary period. When staying in the United States of America, please note that it is not classified as Affordable Care Act (ACA) product. This product is intended as supplemental international cover for individuals who already have primary ACA-compliant health insurance. Please ensure the cover is suitable for your circumstances before purchasing.

I hereby apply for a health Insurance Policy for Global Health Journey for the persons to be insured as listed below.

A. Main applicant's personal details (applicant 1)

I act as Policyholder only and not as Insured Person I act as both Policyholder and Insured Person

Start date of insurance (dd/mm/yyyy)

Date of Signature Or specify future start date:

Gender M F	**Title**
First name	**Surname**
Date of birth (dd/mm/yyyy)	**Occupation and industry**

Correspondence address

Building name/number	**Street**
Postal/zip/area code AND town/city	**Country AND region**
Contact details: mobile number (+ country code / area code)	**Contact details: e-mail address**

Previous or existing customer of Globality S.A. and/or Foyer Global Health S.A.? **If yes, please provide insurance number(s)**

Yes
No

Nationality or nationalities

Country where the application is signed	**Country of future location (where applicant 1 will reside)**

Contractual language (all correspondence/documents will be provided in this language)

English German French Spanish

B. Applicants

Applicant 2

Start date of insurance (dd/mm/yyyy)

Date of signature Or specify future start date:

Gender M F	**Title**
First name	**Surname**

Relationship to the main applicant

Partner Child

Date of birth (dd/mm/yyyy)	**Occupation and industry**

Correspondence address Same address as the main applicant Different address

Building name/number	**Street**
Postal/zip/area code AND town/city	**Country AND region**
Contact details: mobile number (+ country code / area code)	**Contact details: e-mail address**

Previous or existing customer of Globality S.A. and/or Foyer Global Health S.A.? **If yes, please provide insurance number(s)**

Yes
No

Nationality or nationalities

Country where the application is signed	**Country of future location (where applicant 2 will reside)**

Applicant 3

Start date of insurance (dd/mm/yyyy)

Date of signature Or specify future start date:

Gender M F	**Title**
First name	**Surname**
Relationship to the main applicant Partner Child	
Date of birth (dd/mm/yyyy)	**Occupation and industry**
Correspondence address Same address as the main applicant Different address	
Building name/number	**Street**
Postal/zip/area code AND town/city	**Country AND region**
Contact details: mobile number (+ country code / area code)	**Contact details: e-mail address**
Previous or existing customer of Globality S.A. and/or Foyer Global Health S.A.? **Yes** **No**	**If yes, please provide insurance number(s)**
Nationality or nationalities	
Country where the application is signed	**Country of future location (where applicant 3 will reside)**

Applicant 4

Start date of insurance (dd/mm/yyyy)

Date of signature Or specify future start date:

Gender M F	**Title**
First name	**Surname**
Relationship to the main applicant Partner Child	
Date of birth (dd/mm/yyyy)	**Occupation and industry**
Correspondence address Same address as the main applicant Different address	
Building name/number	**Street**
Postal/zip/area code AND town/city	**Country AND region**
Contact details: mobile number (+ country code / area code)	**Contact details: e-mail address**
Previous or existing customer of Globality S.A. and/or Foyer Global Health S.A.? **Yes** **No**	**If yes, please provide insurance number(s)**
Nationality or nationalities	
Country where the application is signed	**Country of future location (where applicant 4 will reside)**

C. Plan level and Geographical Area

Contractual currency: EUR
USD
GBP
CHF

Applicant	Plan level			Geographical Area
1	Extensive	**Deductible:** None EUR 250 / USD 325 / GBP 210 / CHF 232.50 EUR 500 / USD 650 / GBP 420 / CHF 465 EUR 1,000 / USD 1,300 / GBP 840 / CHF 930	**Co-Payment:** 0% 10% 20% **Out-of-Pocket Maximum:** EUR 1,500 / USD 1,950 / GBP 1,260 / CHF 1,395	**Geographical Area I: Worldwide including United States of America** **Geographical Area II: Worldwide excluding United States of America**
	Advanced	**Deductible:** None EUR 250 / USD 325 / GBP 210 / CHF 232.50 EUR 500 / USD 650 / GBP 420 / CHF 465 EUR 1,000 / USD 1,300 / GBP 840 / CHF 930 EUR 3,000 / USD 3,900 / GBP 2,520 / CHF 2,790 EUR 5,000 / USD 6,500 / GBP 4,200 / CHF 4,650 EUR 7,000 / USD 9,100 / GBP 5,880 / CHF 6,510	**Co-Payment:** 0% 10% 20% **Out-of-Pocket Maximum:** EUR 2,500 / USD 3,250 / GBP 2,100 / CHF 2,325	
	Premium	**Deductible:** None EUR 250 / USD 325 / GBP 210 / CHF 232.50 EUR 500 / USD 650 / GBP 420 / CHF 465 EUR 1,000 / USD 1,300 / GBP 840 / CHF 930 EUR 3,000 / USD 3,900 / GBP 2,520 / CHF 2,790 EUR 5,000 / USD 6,500 / GBP 4,200 / CHF 4,650 EUR 7,000 / USD 9,100 / GBP 5,880 / CHF 6,510	**Co-Payment:** 0% 10% 20% **Out-of-Pocket Maximum:** EUR 2,500 / USD 3,250 / GBP 2,100 / CHF 2,325	
2	Extensive	**Deductible:** None EUR 250 / USD 325 / GBP 210 / CHF 232.50 EUR 500 / USD 650 / GBP 420 / CHF 465 EUR 1,000 / USD 1,300 / GBP 840 / CHF 930	**Co-Payment:** 0% 10% 20% **Out-of-Pocket Maximum:** EUR 1,500 / USD 1,950 / GBP 1,260 / CHF 1,395	**Geographical Area I: Worldwide including United States of America** **Geographical Area II: Worldwide excluding United States of America**
	Advanced	**Deductible:** None EUR 250 / USD 325 / GBP 210 / CHF 232.50 EUR 500 / USD 650 / GBP 420 / CHF 465 EUR 1,000 / USD 1,300 / GBP 840 / CHF 930 EUR 3,000 / USD 3,900 / GBP 2,520 / CHF 2,790 EUR 5,000 / USD 6,500 / GBP 4,200 / CHF 4,650 EUR 7,000 / USD 9,100 / GBP 5,880 / CHF 6,510	**Co-Payment:** 0% 10% 20% **Out-of-Pocket Maximum:** EUR 2,500 / USD 3,250 / GBP 2,100 / CHF 2,325	
	Premium	**Deductible:** None EUR 250 / USD 325 / GBP 210 / CHF 232.50 EUR 500 / USD 650 / GBP 420 / CHF 465 EUR 1,000 / USD 1,300 / GBP 840 / CHF 930 EUR 3,000 / USD 3,900 / GBP 2,520 / CHF 2,790 EUR 5,000 / USD 6,500 / GBP 4,200 / CHF 4,650 EUR 7,000 / USD 9,100 / GBP 5,880 / CHF 6,510	**Co-Payment:** 0% 10% 20% **Out-of-Pocket Maximum:** EUR 2,500 / USD 3,250 / GBP 2,100 / CHF 2,325	
3	Extensive	**Deductible:** None EUR 250 / USD 325 / GBP 210 / CHF 232.50 EUR 500 / USD 650 / GBP 420 / CHF 465 EUR 1,000 / USD 1,300 / GBP 840 / CHF 930	**Co-Payment:** 0% 10% 20% **Out-of-Pocket Maximum:** EUR 1,500 / USD 1,950 / GBP 1,260 / CHF 1,395	**Geographical Area I: Worldwide including United States of America** **Geographical Area II: Worldwide excluding United States of America**
	Advanced	**Deductible:** None EUR 250 / USD 325 / GBP 210 / CHF 232.50 EUR 500 / USD 650 / GBP 420 / CHF 465 EUR 1,000 / USD 1,300 / GBP 840 / CHF 930 EUR 3,000 / USD 3,900 / GBP 2,520 / CHF 2,790 EUR 5,000 / USD 6,500 / GBP 4,200 / CHF 4,650 EUR 7,000 / USD 9,100 / GBP 5,880 / CHF 6,510	**Co-Payment:** 0% 10% 20% **Out-of-Pocket Maximum:** EUR 2,500 / USD 3,250 / GBP 2,100 / CHF 2,325	
	Premium	**Deductible:** None EUR 250 / USD 325 / GBP 210 / CHF 232.50 EUR 500 / USD 650 / GBP 420 / CHF 465 EUR 1,000 / USD 1,300 / GBP 840 / CHF 930 EUR 3,000 / USD 3,900 / GBP 2,520 / CHF 2,790 EUR 5,000 / USD 6,500 / GBP 4,200 / CHF 4,650 EUR 7,000 / USD 9,100 / GBP 5,880 / CHF 6,510	**Co-Payment:** 0% 10% 20% **Out-of-Pocket Maximum:** EUR 2,500 / USD 3,250 / GBP 2,100 / CHF 2,325	

⚠ **Please note:**

- Deductibles and Co-Payments apply to Outpatient Treatments only. If the Co-Payment option is selected, the Out-of-Pocket Maximum will be applied automatically.
- This insurance product is designed for individuals living outside their home country for a temporary period. When staying in the United States of America, please note that it is not classified as Affordable Care Act (ACA) product. This product is intended as supplemental international cover for individuals who already have primary ACA-compliant health insurance. Please ensure the cover is suitable for your circumstances before purchasing.

Applicant	Plan level			Geographical Area
4	Extensive	**Deductible:** None EUR 250 / USD 325 / GBP 210 / CHF 232.50 EUR 500 / USD 650 / GBP 420 / CHF 465 EUR 1,000 / USD 1,300 / GBP 840 / CHF 930	**Co-Payment:** 0% 10% 20% **Out-of-Pocket Maximum:** EUR 1,500 / USD 1,950 / GBP 1,260 / CHF 1,395	**Geographical Area I: Worldwide including United States of America** **Geographical Area II: Worldwide excluding United States of America**
	Advanced	**Deductible:** None EUR 250 / USD 325 / GBP 210 / CHF 232.50 EUR 500 / USD 650 / GBP 420 / CHF 465 EUR 1,000 / USD 1,300 / GBP 840 / CHF 930 EUR 3,000 / USD 3,900 / GBP 2,520 / CHF 2,790 EUR 5,000 / USD 6,500 / GBP 4,200 / CHF 4,650 EUR 7,000 / USD 9,100 / GBP 5,880 / CHF 6,510	**Co-Payment:** 0% 10% 20% **Out-of-Pocket Maximum:** EUR 2,500 / USD 3,250 / GBP 2,100 / CHF 2,325	
	Premium	**Deductible:** None EUR 250 / USD 325 / GBP 210 / CHF 232.50 EUR 500 / USD 650 / GBP 420 / CHF 465 EUR 1,000 / USD 1,300 / GBP 840 / CHF 930 EUR 3,000 / USD 3,900 / GBP 2,520 / CHF 2,790 EUR 5,000 / USD 6,500 / GBP 4,200 / CHF 4,650 EUR 7,000 / USD 9,100 / GBP 5,880 / CHF 6,510	**Co-Payment:** 0% 10% 20% **Out-of-Pocket Maximum:** EUR 2,500 / USD 3,250 / GBP 2,100 / CHF 2,325	

D. Previous cover and Doctor details

⚠ **Mandatory: The following details (point 1. OR point 2.) are required.**

1. Do the applicants have or ever had health insurance cover within the last 3 years (including compulsory statutory/private health insurance)?

Applicant	Answer	Previous insurer	Insurance no.	Level of cover	Start date (dd/mm/yyyy)	End date (dd/mm/yyyy)
1	Yes No			Inpatient Outpatient Dental		
2	Yes No			Inpatient Outpatient Dental		
3	Yes No			Inpatient Outpatient Dental		
4	Yes No			Inpatient Outpatient Dental		

2. Please specify the name and address of the Doctor best able to provide further information regarding the applicants' health (last three years). If there is more than one Doctor/clinic associated with the persons in this application please provide any additional information in the information box at the end of Section E or include a separate page.

Applicant	Doctor's name	Address of the Hospital/clinic/Doctor	Phone no. and e-mail address
1			
2			
3			
4			

E. Medical history (Health questionnaire)

Important: All health questions listed below must be answered in detail. Symptoms, illnesses and the consequences of an Accident should be mentioned even if the applicant considers them to be unimportant. Dashes do not qualify as an answer. If more space is needed: continue on a separate sheet, specifying the number of the concerned applicant, and refer to that sheet in the Application Form. If the applicant does not wish to reveal certain information to the intermediary, this information must be provided directly to Foyer Global Health S.A. in writing within three days of the reception of the Application Form by Foyer Global Health S.A.. In this case, the applicant must indicate in the Application Form that the information is to be provided separately.

The Insurer draws the applicants' attention to the fact that, if the health questions in this Application Form, where of relevance for acceptance of the risk, are answered incorrectly or incompletely, the Insurer may – if the duty to provide information has not been willfully violated – terminate the Insurance Policy within one month of being informed of the violation, insofar as the Insurer can prove that the Insurer would not have insured the risk in any case. The Insurance Policy shall be null and void if the Insurer's assessment of the risk is affected by willful violation of the applicants' duty to provide information. In this case, the applicant is obliged to repay the insurance Benefits already received. The Insurer will not refund the paid premiums.

Conditions arising between signing the Application Form and the date of signing the Particular Conditions will equally be deemed to be Pre-Existing. Therefore it is necessary that the applicant advises the Insurer immediately of any material changes to the information provided, which would occur between submission of this Application Form and its acceptance by the Insurer (Please refer to "Responsibility for the information provided in the Application Form", page 13).

Pre-Existing Conditions
Pre-Existing Conditions refer to any Medical Conditions, Diseases, Bodily Injuries, or their consequences that the applicant was aware of, or received medical advice, diagnosis, or Treatment for, prior to signing the Application Form.

This includes:

i. Any condition for which the applicant underwent diagnostic testing (including preventive screenings or routine health check-ups) that resulted in abnormal findings, regardless of whether a formal diagnosis was made.
ii. Any signs or symptoms, whether diagnosed or not, as well as any physical or organic abnormalities, congenital anomalies, disabilities, or deformities.
iii. The presence of any medical devices such as Implants (excluding dental implants), stents, prostheses, or any other devices permanently or temporarily attached to the body.

Additionally, any illness, injury, or Medical Condition that arises between the date of signing the Application Form and the date of signing the Particular Conditions will also be considered a Pre-Existing Condition.

Pre-Existing Conditions may be covered under the Insurance Policy following a full medical underwriting.

If insurance cover already exists or existed with Globality S.A. or Foyer Global Health S.A., it is not necessary to specify any disorders or courses of Treatment during the last five years which are already fully known to Globality S.A. or Foyer Global Health S.A. on account of the invoices or medical certificates presented to Globality S.A. or Foyer Global Health S.A. in conjunction with the previously existing insurance contract.

General Questions (Level 1)					
No.	**Question**	**Applicant 1**	**Applicant 2**	**Applicant 3**	**Applicant 4**
1	What is your height in cm and weight in kg?	cm kg	cm kg	cm kg	cm kg
2a	Do you smoke more than 20 cigarettes or use more than 1 vape (10 mg/ml) per day?	Yes No If yes, how many?	Yes No If yes, how many?	Yes No If yes, how many?	Yes No If yes, how many?
2b	Have you ever been treated for, diagnosed with, or currently have a drug or substance addiction?	Yes No If yes, please provide further details such as Treatments or rehabilitation dates, current status, etc.	Yes No If yes, please provide further details such as Treatments or rehabilitation dates, current status, etc.	Yes No If yes, please provide further details such as Treatments or rehabilitation dates, current status, etc.	Yes No If yes, please provide further details such as Treatments or rehabilitation dates, current status, etc.
3	Do you drink more than 14 units of alcohol per week? Alcohol: units (1 unit = 250 ml beer / 100 ml wine/ 25 ml spirit)	Yes No If yes, how many?	Yes No If yes, how many?	Yes No If yes, how many?	Yes No If yes, how many?

General Health Questions (Level 1)					
No.	**In the last 5 years, ...**	**Applicant 1**	**Applicant 2**	**Applicant 3**	**Applicant 4**
1	Have you received, currently receiving, or is any inpatient, day care or Outpatient Treatment recommended or planned?	Yes No	Yes No	Yes No	Yes No
2	Are you currently taking, have you taken, or do you plan to take any prescription Medications, over-the-counter Medication, or alternative/herbal/traditional remedies?	Yes No	Yes No	Yes No	Yes No
3	Have you undergone or been recommended any diagnostic tests with or without a diagnosis, or have you received abnormal results from any preventative or health check-up tests?	Yes No	Yes No	Yes No	Yes No
4	Do you currently have any form of sickness or injury, undiagnosed signs or symptoms, physical/organic defects, congenital anomalies, any form of disabilty or deformity?	Yes No	Yes No	Yes No	Yes No
5	Do you have any implants (excluding dental implants), stents, prosthesis or any other devices internally fixed to your body?	Yes No	Yes No	Yes No	Yes No
6	Where applicable: Are you pregnant? If yes, what is the estimated due date?	Yes No Details if answered as “Yes”	Yes No Details if answered as “Yes”	Yes No Details if answered as “Yes”	Yes No Details if answered as “Yes”

7a	Do you visit your Dentist at least annually for routine dental check-ups? Please indicate the reason/s and date of last visit as well as Name and Address from Dentist.	Yes No More information: If no, submit a dental form sent by us depending on the age (adult or child form). This dental form must be completed, signed and stamped by a Dentist.	Yes No More information: If no, submit a dental form sent by us depending on the age (adult or child form). This dental form must be completed, signed and stamped by a Dentist.	Yes No More information: If no, submit a dental form sent by us depending on the age (adult or child form). This dental form must be completed, signed and stamped by a Dentist.	Yes No More information: If no, submit a dental form sent by us depending on the age (adult or child form). This dental form must be completed, signed and stamped by a Dentist.
7b	Are you currently having any dental diseases or conditions including signs, symptoms or receiving, planned or recommended any dental or orthodontic Treatments? (e.g. missing, not existing, unreplaced or cracked/broken tooth/teeth, existing dentures which require removal, re-fabrication or are older than 10 years, misaligned tooth/ teeth, complaints or illnesses to the jaw, clench or grind your teeth, suffering from periodontal disease)	Yes No If yes, submit a dental form sent by us depending on the age (adult or child form). This dental form must be completed, signed and stamped by a Dentist.	Yes No If yes, submit a dental form sent by us depending on the age (adult or child form). This dental form must be completed, signed and stamped by a Dentist.	Yes No If yes, submit a dental form sent by us depending on the age (adult or child form). This dental form must be completed, signed and stamped by a Dentist.	Yes No If yes, submit a dental form sent by us depending on the age (adult or child form). This dental form must be completed, signed and stamped by a Dentist.

If all general health questions 1–5 are answered with "No" please proceed to Section F.

General Health Questions (Level 2)	
No.	**Do the applicants suffer from any of the following health problems?**
1	Heart problems or circulatory disorders (e.g. high blood pressure, angina, chest pains, heart attack, heart insufficiency, abnormal heart beat, heart defects, aneurysms, varicose veins etc.) No Yes If yes, please give details on next page.
2	Respiratory disorders (e.g. breathing problems, asthma, COPD, pneumonia, bronchitis, tuberculosis, allergies, septum deviation etc.) No Yes If yes, please give details on next page.
3	Endocrine disorders (e.g. glandular disorders, diabetes (Type 1 or Type 2), thyroid problems, Cushing's syndrome, Addison's disease, Graves disease etc.) No Yes If yes, please give details on next page.
4	Gastrointestinal disorders (e.g. stomach, intestines, liver or gall bladder problems, stomach inflammation/ulcers, irritable bowel syndrome, Crohn's disease, colitis, change in bowel habits, hemorrhoids/piles, pancreatitis, liver inflammation, cirrhosis, gall stones, hernias etc.) No Yes If yes, please give details on next page.
5	Cancer, tumors or growths (e.g. polyps, benign growths, cysts, any cancers or precancerous condition etc.) No Yes If yes, please give details on next page.
6	Brain and nervous system disorders (e.g. stroke, dementia, migraine, chronic headaches, multiple sclerosis, epilepsy/ fits, sciatica, low muscle tone, Parkinson's disease etc.) No Yes If yes, please give details on next page.
7	Skin, hair, nail problems (e.g. eczema, dermatitis, rashes, alopecia areata, psoriasis, acne, cysts, moles that itch or bleed, etc.) No Yes If yes, please give details on next page.
8	Ear disorders (tinnitus, vertigo, hearing disorder, deafness) Problems with the eyes (e.g. glaucoma, cataracts, corneal problems, retinal detachment, etc.). Do you have impaired vision with 8 diopters or more? If yes, please specify diopters: right eye (RE); left eye (LE) No Yes If yes, please give details on next page.
9	Urinary & reproductive disorders (e.g. kidney failure, urinary infections, incontinence; testicular or prostate disorders, infertility, pregnancy/ childbirth problems (including caesarean sections), heavy or irregular periods, fibroids, endometriosis, abnormal smears, polycystic ovaries, etc.) No Yes If yes, please give details on next page.
10	Blood/infective/immune disorders (e.g. abnormal blood tests, coagulation problems, high cholesterol, anemia, malaria, autoimmune disorder, etc.) No Yes If yes, please give details on next page.
11	Psychiatric/Psychological disorders (e.g. depression, medically treated stress, anxiety, mental illness, schizophrenia, compulsive or eating disorders, Drug/ alcohol dependency, etc.) No Yes If yes, please give details on next page.
12	Muscle or skeletal problems (e.g. rheumatism, gout, arthritis, back problems, neck/shoulder problems, cartilage and ligament problems, joint replacements, fractures, osteoporosis, inflammatory conditions, disc prolapse etc.) Please indicate the side affected or spine level, if applicable. No Yes If yes, please give details on next page.
13	Have you ever been tested positive, awaiting Treatments, investigations, check-ups or the results of investigations for AIDS, HIV, Hepatitis B, C, D? No Yes If yes, please give details on next page.
14	Are there any other Medical Conditions not listed above for which you have had signs or symptoms without diagnosis at any time during the last 5 years, regardless of whether a health care professional has been consulted? No Yes If yes, please give details on next page.

⚠ **In case any of the above questions 1–14 under Level 2 on the previous page is answered with "Yes", please provide additional details.**

Please give as many details as you can, including dates (start and end or indicate if it is an ongoing condition), quantities, frequencies, diagnosis, any related tests and results, scans, related Treatments received or recommended Treatment and give details of the treating Doctor where applicable. Please provide supporting documents such as medical reports or test results where available.

Question No.	Applicant No.		
Diagnosis	Past history (i.e. since when or period)	Treatment (taken or recommended)	Start and end date
Name of medicine, period of medicine usage, dosage or quantity, frequency	Hospital and Doctor details	Additional details if any	Mention the attached supporting medical reports

Question No.	Applicant No.		
Diagnosis	Past history (i.e. since when or period)	Treatment (taken or recommended)	Start and end date
Name of medicine, period of medicine usage, dosage or quantity, frequency	Hospital and Doctor details	Additional details if any	Mention the attached supporting medical reports

Question No.	Applicant No.		
Diagnosis	Past history (i.e. since when or period)	Treatment (taken or recommended)	Start and end date
Name of medicine, period of medicine usage, dosage or quantity, frequency	Hospital and Doctor details	Additional details if any	Mention the attached supporting medical reports

In case you don't currently recollect your medical history or don't have required documents to provide, you can approach the treating Doctor and request for the following:

Please provide a medical report outlining the exact diagnosis, diagnostic findings including investigation reports, medical history, current status, current and past Treatments /therapies and planned Treatment or the applicant could also download our medical examination report and get it filled in by the Doctor.

Question No.	Applicant No.		
Diagnosis	Past history (i.e. since when or period)	Treatment (taken or recommended)	Start and end date
Name of medicine, period of medicine usage, dosage or quantity, frequency	Hospital and Doctor details	Additional details if any	Mention the attached supporting medical reports

Question No.	Applicant No.		
Diagnosis	Past history (i.e. since when or period)	Treatment (taken or recommended)	Start and end date
Name of medicine, period of medicine usage, dosage or quantity, frequency	Hospital and Doctor details	Additional details if any	Mention the attached supporting medical reports

Question No.	Applicant No.		
Diagnosis	Past history (i.e. since when or period)	Treatment (taken or recommended)	Start and end date
Name of medicine, period of medicine usage, dosage or quantity, frequency	Hospital and Doctor details	Additional details if any	Mention the attached supporting medical reports

Question No.	Applicant No.		
Diagnosis	Past history (i.e. since when or period)	Treatment (taken or recommended)	Start and end date
Name of medicine, period of medicine usage, dosage or quantity, frequency	Hospital and Doctor details	Additional details if any	Mention the attached supporting medical reports

In case you don't currently recollect your medical history or don't have required documents to provide, you can approach the treating Doctor and request for the following:

Please provide a medical report outlining the exact diagnosis, diagnostic findings including investigation reports, medical history, current status, current and past Treatments /therapies and planned Treatment or the applicant could also download our medical examination report and get it filled in by the Doctor.

Additional information and remarks:

F. Payment of premiums

Payment frequency

monthly quarterly semi-annually annually

Payment method

Direct debit (applies only for Euro premiums within the Eurozone*, UK and Denmark or where specifically supported by the applicant's bank).

*Eurozone includes: Austria, Belgium, Bulgaria, Croatia, Cyprus, Estonia, Finland, France, Germany, Greece, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Portugal, Republic of Ireland, Slovakia, Slovenia, Spain.

Premium payment by bank transfer

Credit card
Together with the welcome package, access will be provided to a secure webpage through which credit card details must be entered to activate insurance cover.

G. Declarations from all the persons to be insured including the main applicant

The following points are known to me:

Responsibility for the information provided in the Application Form

Before declaring the intention to conclude the Insurance Policy, the applicants must inform the Insurer of all circumstances known and requested by the Insurer, which are of importance for the Insurer's decision to provide the agreed insurance cover.

Conditions that arise between signing the Application Form and the date of signing the Particular Conditions are deemed to be Pre-Existing.

Attention is drawn to the above given information with regard to the legal consequences of incorrectly answering the questions concerning the state of health.

Professional secrecy, outsourcing, and outsourcing to cloud computing service providers

Foyer Global Health S.A. attaches great importance to respecting the professional secrecy and the confidentiality of its customer's data and undertakes at all times to implement all necessary and required measures to ensure the confidentiality of data according with the highest quality standards and in compliance with the regulations in force.

To guarantee a high level of quality of services and to provide the most advanced technologies to its customers, the Insurer may use service providers, subcontractors and technologies using cloud computing.

In any case, the data communicated will be protected according to high quality standards and in compliance with the regulations including those provided by the GDPR.

Within the framework of the execution of the Insurance Policy and in order to allow for the optimal provision of the related insurance services according to high quality standards, the Insurer relies on outsourcing service providers and the use of cloud arrangements. In this context, information and data pertaining to all the persons to be insured including the main applicant, notably personal identification data (such as gender, title, surname, first name, physical address, e-mail address, telephone number and date of birth) and communication data (such as reports of exchanges by call or e-mail or social networks or via a portal) are made available and disclosed to the relevant service providers.

By signing this Application Form, all the persons to be insured including the main applicant expressly acknowledge, accept, agree and consent to the aforementioned outsourcing and use of the cloud as well as the related necessary transfer and disclosure of information and data, which are further detailed in the Insurance Policy and on the website of the Insurer under the link https://www.foyer.lu/en/transparency.

All the persons to be insured including the main applicant also expressly acknowledge, accept, agree and consent to the fact that the information published on the Insurer's website may be changed and/or completed from time to time and expressly undertake to regularly consult such website.

The outsourcing table published on the Insurer's website specifies the currently existing outsourcing contracts, the exact nature of the outsourced services, the type of information that is transmitted and the country of establishment of the service provider(s). Should a service provider not be subject to an obligation of professional secrecy similar to that of the Insurer, the Insurer shall enter into a confidentiality agreement with the service provider in order to require it to comply with such a confidentiality obligation as part of the outsourcing concerned.

In the event of a change in the outsourcing table (examples: addition of a service provider, use of cloud computing), the main applicant shall be informed of the change by e-mail and/or any other relevant communication channel provided for under the Insurance Policy or agreed with the main applicant. The main applicant undertakes to inform all the persons to be insured of such change.

If, within 2 months of a change in the subcontracting table, the main applicant has not objected in writing to such change, all the persons to be insured including the main applicant shall be deemed to have irrevocably accepted the relevant change. In case of an objection by the main applicant, such objection must be notified to the Insurer by registered letter and such notification shall qualify as a termination event at the next expiry of the Insurance Policy.

If the main applicant holds several Insurance Policies with the Insurer, the main applicant shall notify one objection per Insurance Policy.

Previous insurance

Please append, for each applicant referred to herein, all data about previous health insurance or applicable state healthcare systems of the past 5 years (including any data pertaining to compulsory statutory/private/public health insurance) for inpatient, outpatient and dental cover.

Application and acceptance of the health insurance application

This Application Form does not bind either the applicant nor the Insurer to conclude the Insurance Policy. However, the Insurer shall notify the applicant, within 30 days of the receipt of the Application Form, of an insurance offer, the subjection of the insurance to an inquiry or survey, or the refusal to insure. The Insurer will provide insurance cover in good faith, assuming that the applicant has correctly and completely answered all the relevant questions raised before the start of the Insurance Policy (this is known as the 'precontractual duty to disclose information').

The conclusion of Insurance Policy is subject to the acceptance of the Application Form by the Insurer in writing. The payment of the first premium to the intermediary or the Insurer does not constitute an acceptance of the Application Form by the Insurer.

By signing this Application Form, the applicants confirm that they have read, understood, and expressly acknowledge, accept, agree to, and consent to the Terms and Conditions outlined in this Application Form, the General Conditions of Insurance, and the Special Conditions.

Furthermore, the applicants undertake to signing the Particular Conditions should the Insurer accept the Application Form.

The applicants agree, accept, and consent that any notices issued by the Insurer concerning the Insurance Policy may be addressed to the applicants. The main applicant undertakes to inform all the persons to be insured of such notices, where applicable, and the Insurer shall not be held responsible for any failure by the main applicant to fulfil this obligation.

Medical secrecy waiver

By signing this Form, the applicants give consent to professionals to provide Foyer Global Health S.A. with information on their health and Treatment as detailed in Section E.

If the applicants do not give this consent, they understand the following:

1. The applicants will have to decide, in each instance, whether or not they will give consent to the specified persons or institutions to forward information to Foyer Global Health S.A..
2. It may take longer to investigate their Claims, Benefits may be reduced, or the Insurer may be relieved from its obligation to pay Benefits if the obligation to pay Benefits cannot be fully established on the basis of the remaining sources of information.

All information and documents regarding the policy will be sent:

to the correspondence address of the main applicant

to the following insurance intermediary to whom the applicants give consent to receive them on their behalf:

To be completed by the insurance intermediary:	
The intermediary is authorised to act as the agent (mandataire) of the applicants, with the mandate to collect and receive, on their behalf and in their name, any information and documentation related to the Insurance Policy from the Insurer.	**When answering the questions in this form, did the applicants provide information which has not been recorded in this Application Form?** **No Yes** **If yes, please give details below:**

Direct marketing

By signing this form, the applicants herewith agree that information on special offers by Foyer Global Health S.A. may be sent to them in writing, electronically, and by telephone. This consent may be revoked at any time.

All persons aged 18 years and older have to sign. For minors and incapable adults, the authorized legal representative(s) have to sign. In case main applicant and applicant 1 are same, please sign once.

Place and date	Signature of the main applicant	Applicant 1 (if different to main applicant)
Applicant 2	Applicant 3	Applicant 4

Insurance intermediary name and number

Sub-intermediary 1 name and number

Signature of insurance intermediary

Sub-intermediary 2 name and number

Please return the fully completed Application Form by e-mail to sales@globalhealth.insurance

NAVIGATOR
Insurance Brokers Ltd.

NOTICE TO CLIENT AND ACKNOWLEDGEMENT

Advice to Clients of the Unauthorized Status of an Insurer in Hong Kong

(As per HK Insurance Regulations)

NOTICE TO INDIVIDUAL CLIENT

Your insurance contract has been arranged of effected wholly or partly with an insurer authorized in other jurisdiction but not authorized by the Insurance Authority to conduct insurance business in Hong Kong ("insurer not authorized in Hong Kong"). Such insurers are not subject to the provisions of the Insurance companies Ordinance (CAP. 41), which establishes a system of prudential supervision of authorized insurers in Hong Kong.

NOTICE TO CORPORATE CLIENT

The underwriting security of this insurance includes participation by an insurer authorized in other jurisdiction but not authorized by the Insurance Authority to conduct insurance business in Hong Kong. ("Insurer not authorized in Hong Kong"). You are reminded that such insurers are not subject to the provisions of the Insurance Companies Ordinance (Cap. 41), which establishes a system of prudential supervision of authorized insurers in Hong Kong.

DETAILS OF THE INSURER

a) Name: Foyer Global Health S.A.
b) Address: 12, rue Léon Laval - L-3372 Leudelange, Luxembourg
c) Country of incorporation: Luxembourg
d) Financial standing: Foyer had a solvency ratio above 200% at year-end 2024, per Milliman's analysis of Luxembourg SFCRs, placing it among the best-capitalized insurers in the market.
e) Laws governing the contract: Luxembourg

ACKNOWLEDGEMENT

I/We, _____ holder of policy with Foyer Global Health have read the above notice and acknowledge that the insurance contract has been/arranged or effected wholly or partly with an insurer authorized in other jurisdiction but not authorized under the Insurance Companies Ordinance (Cap.41) to conduct insurance business in or form Hong Kong.

_____ _____

Date Signature

Navigator Insurance Brokers Ltd
Unit E, 8/F Golden Sun Centre, 59-67 Bonham Strand West, Sheung Wan, Hong Kong
Tel 2530 2530 Fax 2530 2535
crew@navigator-insurance.com http://www.navigator-insurance.com

NAVIGATOR
Insurance Brokers Ltd.

Global Health
12 rue Léon Laval,
L-3372 Leudelange
Luxembourg

Dear Sir / Madam

Policy#

Full Name#

I hereby authorize Navigator Insurance Brokers Ltd. to act for and on my behalf in relation to the administration of the Global Health Plan and to receive on my behalf all relevant communication, to the extent applicable, which I understand may include the disclosure of sensitive health information.

This authorization will remain in place until I provide a written request to Global Health to revoke it.

The Brokers Details as Follow:

Navigator Insurance Brokers Ltd.

8E Golden Sun Centre
59-67 Bonham Strand West
Sheung Wan, Hong Kong

Contact Person: Zeeshan Hussain
IA Licence No. JF3940
Contact No.: 2530 2229

Please feel free to contact if you have any concern.

Thank You!

Signature_____

Name: