Application Form for Journey individual health insurance Plan Short

⚠ **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. 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.
3. 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	**Short**	without Deductible	Fixed Co-Payment of 20%	**Geographical Area I: Worldwide including United States of America** **Geographical Area II: Worldwide excluding United States of America**
2	**Short**	without Deductible	Fixed Co-Payment of 20%	**Geographical Area I: Worldwide including United States of America** **Geographical Area II: Worldwide excluding United States of America**
3	**Short**	without Deductible	Fixed Co-Payment of 20%	**Geographical Area I: Worldwide including United States of America** **Geographical Area II: Worldwide excluding United States of America**
4	**Short**	without Deductible	Fixed Co-Payment of 20%	**Geographical Area I: Worldwide including United States of America** **Geographical Area II: Worldwide excluding United States of America**

⚠ **Please note:**

- Co-Payments apply to Outpatient Treatments only.
- 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.

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 3 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

⚠ **Pre-Existing Conditions are excluded from the Insurance Cover.**

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, 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.

Additional information and remarks:

F. Payment of premiums

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 confirmation of acceptance by the Insurer are deemed to be Pre-Existing.

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 Application Form, the applicants give consent to professionals to provide Foyer Global Health S.A. with information on their health and Treatment.

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

Signature of insurance intermediary

Sub-intermediary 1 name and number

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: