GlobalSelect® International Healthcare Cover
Application Form

Underwritten by Sirius International Insurance Corporation (the "Insurer"). Administered, as agent for and on behalf of the Insurer, by International Medical Group®, Inc. (IMG®) Coordinated, as agent for and on behalf of the Insurer for the purposes of receiving premiums, receiving and holding claims money; and receiving and holding premium refunds, by IMG.

Please complete this form in block capitals using black ink. For all sections please ensure you give an answer to every question. An incomplete form will delay the processing of your application.

SECTION 1. Your Personal and Cover Details

Please complete for all family members applying for cover.

A. Applicant

1.1 Details About You

First Name(s): Title: Mr / Mrs / Miss / Ms / Dr		Surname: (Family Name)	
Date of Birth: DD/MM/YY	❑Male ❑Female	Height: ❑cm ❑in	Weight: ❑kg ❑lb
Occupation:			
Nationality on Passport:		Passport Number:	

B. Spouse

1.2 Details About Members of Your Family Applying for Cover

First Name(s): Title: Mr / Mrs / Miss / Ms / Dr		Surname: (Family Name)	
Date of Birth: DD/MM/YY	❑Male ❑Female	Height: ❑cm ❑in	Weight: ❑kg ❑lb
Occupation:			
Nationality on Passport:		Passport Number:	

C. First Child (Below Age 19)

First Name(s):		Surname (Family Name):	
Date of Birth: DD/MM/YY	❑Male ❑Female	Height: ❑cm ❑in	Weight: ❑kg ❑lb
Nationality on Passport:		Passport Number:	

D. Second Child (Below Age 19)

First Name(s):		Surname (Family Name):	
Date of Birth: DD/MM/YY	❑Male ❑Female	Height: ❑cm ❑in	Weight: ❑kg ❑lb
Nationality on Passport:		Passport Number:	

E. Third Child (Below Age 19)

First Name(s):		Surname (Family Name):	
Date of Birth: DD/MM/YY	❑Male ❑Female	Height: ❑cm ❑in	Weight: ❑kg ❑lb
Nationality on Passport:		Passport Number:	

❑ *Tick if you have any further dependents and please provide details on a separate sheet.*

1.3 Residential Address

Street Address:			
Town/City:	State/County:	Postal Code:	Country:

1.4 Mail Forwarding Address - If different from address in Section 1.3

Street Address:			
Town/City:	State/County:	Postal Code:	Country:

1.5 Contact Details

Primary Telephone: + Country (Area) Number	Other Telephone: + Country (Area) Number
Fax: + Country (Area) Number	Email:

1.6 Select the Geographic Area of Cover You Would Like *(Tick One)*

❑ **Area 1** - Europe	❑ **Area 2** - Worldwide excluding USA, Canada, China, Hong Kong, Macau, Japan, Singapore and Taiwan	❑ **Area 3** - Worldwide*

1.7 Select the Currency You Would Like *(Tick One)* - The plan currency also decides your premium currency

❑ GB Pounds (£)	❑ US Dollars ($)	❑ EU Euros (€)

*Important Note: USA Citizens & Persons Applying for Cover in the USA

Effective Dates:

USA Citizens - If you or any family member applying for cover are located in the USA on the date of this application, the effective date of this insurance, if issued, will be the later of: **a)** The effective date requested on the application; or **b)** The date the insured person departs the USA; or **c)** The date the application is accepted and required payment is received and the GlobalSelect International Healthcare Cover, including a certificate of insurance, is issued.

Special Eligibility:

USA Citizens -

Is your expected length of stay outside the USA at least 6 of the next 12 months? ❑ Yes ❑ No *(If your answer is NO, you are ineligible for this product.)*

Date you did (or will) Depart from the USA: ___/___/___ (DD/MM/YY)

Non USA Citizens applying for cover in the USA or located in the USA at time of application -

i) Are you or any family member present in the USA on the Effective Date of the Policy? ❑ Yes ❑ No

- If No, then no Affidavit of Eligibility is required, please proceed to Section 1.8
- If Yes, please answer question **ii** below

ii) Do you plan to be in the USA more than 6 of the next 12 months? ❑ Yes ❑ No

- If No, then no Affidavit of Eligibility is required, please proceed to Section 1.8

If You have answered Yes to the above two questions, an Affidavit of Eligibility (available from Us or Your Broker upon request) must be completed and submitted with Your Application. ***Note:*** *If You are still located in the USA at Your Renewal Date and Your expected stay thereafter in the USA will be at least 6 of the following 12 months, You will need to complete an Affidavit of Eligibility at Your Renewal Date.*

1.8 Select Which Sub-Plan You Would Like *(Tick One Only)* - The Voluntary Medical Excesses apply only to the GlobalSelect International Healthcare Cover and optional Maternity Coverage (if applicable) and not to optional add-on plans or to non-medical sections of cover. The premium discounts or increases apply only to the GlobalSelect International Healthcare Cover and not to the optional Maternity Coverage or add-on plans' premiums. Please choose carefully, as you cannot select a lower excess at renewal or a later date.

HeadStart	Basic	Standard	Executive
❑ £100/$180/€150 Standard Medical Excess	❑ £100/$180/€150 Standard Medical Excess	❑ £50/$90/€75 Standard Medical Excess	❑ £25/$45/€38 Standard Medical Excess
V O L U N T A R Y M E D I C A L E X C E S S E S			
		❑ Nil Excess 35% Premium Increase	❑ Nil Excess 10% Premium Increase
			❑ £50/$90/€75 Excess 14% Premium Discount
		❑ £100/$180/€150 Excess 10% Premium Discount	❑ £100/$180/€150 Excess 18% Premium Discount
❑ £250/$450/€375 Excess 20% Premium Discount	❑ £250/$450/€375 Excess 20% Premium Discount	❑ £250/$450/€375 Excess 20% Premium Discount	❑ £250/$450/€375 Excess 27% Premium Discount
❑ £500/$900/€750 Excess 25% Premium Discount	❑ £500/$900/€750 Excess 25% Premium Discount	❑ £500/$900/€750 Excess 25% Premium Discount	❑ £500/$900/€750 Excess 32% Premium Discount
❑ £1,000/$1,800/€1,500 Excess 30% Premium Discount	❑ £1,000/$1,800/€1,500 Excess 30% Premium Discount	❑ £1,000/$1,800/€1,500 Excess 30% Premium Discount	❑ £1,000/$1,800/€1,500 Excess 36% Premium Discount
❑ £2,500/$4,500/€3,750 Excess 35% Premium Discount	❑ £2,500/$4,500/€3,750 Excess 35% Premium Discount	❑ £2,500/$4,500/€3,750 Excess 35% Premium Discount	❑ £2,500/$4,500/€3,750 Excess 41% Premium Discount
❑ £5,000/$9,000/€7,500 Excess 40% Premium Discount	❑ £5,000/$9,000/€7,500 Excess 40% Premium Discount	❑ £5,000/$9,000/€7,500 Excess 40% Premium Discount	❑ £5,000/$9,000/€7,500 Excess 45% Premium Discount
❑ £10,000/$18,000/€15,000 Excess 45% Premium Discount	❑ £10,000/$18,000/€15,000 Excess 45% Premium Discount	❑ £10,000/$18,000/€15,000 Excess 45% Premium Discount	❑ £10,000/$18,000/€15,000 Excess 50% Premium Discount

1.9 Optional Maternity Coverage *(Tick if required, if you do not want this optional coverage please skip to Section 2.)* Note: Coverage is subject to a 12 month wait period from the Effective Date. Please choose carefully as this optional maternity coverage is only available to female applicants at the time of original application and cannot be added at renewal or a later date.

Optional Matenity Coverage Select Level of Cover and show Applicable Family Member(s) to the right using Letters from Section 1. Tick one box only: ❑ Level 1: Essentials ❑ Level 2: Premier	

SECTION 2. Health Declaration

Please answer all questions for each applicant applying for cover.		**If YES, show FAMILY MEMBER Using Letters from Section 1.**
1. Are you or any other applicant currently disabled or unable to perform normal activities?	❑Yes ❑No	
2. Are you or any other applicant presently hospitalised, or scheduled for or in need of hospitalisation or surgery?	❑Yes ❑No	
3. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV), Hepatitis C or any other Immune System Disorder?	❑Yes ❑No	
4. Have you or any other applicant ever had, been recommended to have, or are you currently on a waiting list for any organ transplant (other than corneal)?	❑Yes ❑No	
5. Do you or any other applicant participate in professional sports?	❑Yes ❑No	
If any applicant answered YES to any of the above five questions, he or she does not qualify for this insurance. Thank you for your interest.		
6. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past 5 years? If yes, please complete Section 3.2.	❑Yes ❑No	
7. If a non-USA citizen, have you or any other applicant resided continuously in the U.S. for the last 5 years?	❑Yes ❑No	
8. Are you or any other applicant currently pregnant? If yes, please provide due date: _____	❑Yes ❑No	
If any applicant answered YES to any of the above three questions, he or she may not qualify for this insurance.		
9. Have you or any other applicant ever applied for or purchased insurance through IMG? If yes, please provide certificate number and details. Certificate Number:_____ Policy Undertaken:_____	❑Yes ❑No	
10. Have you or any other applicant ever had an application for health, life or disability insurance or reinstatement rejected, cancelled, rated, declined or modified? If yes, please explain in Section 3.2.	❑Yes ❑No	
11. Are you applying for 'switch terms' to transfer from your existing medical insurance policy to a GlobalSelect plan? If yes, you need to complete and submit a GlobalSelect 'Switch Terms Application Form' with this Application Form.	❑Yes ❑No	

Choice of Medical Underwriting - Your application allows you a choice of either a Moratorium Underwriting Policy or a Full Medical Underwriting Policy as explained below. Please tick one only.

❑ **Option 1. Moratorium Underwriting Policy:** Enables you to apply for your Plan without completing a full health questionnaire. Instead, we apply blanket exclusions for any pre-existing medical conditions you have had. The 'moratorium' refers to the fact that if, after 24 months of continuous cover under your plan, you demonstrate two consecutive years without symptoms or treatment, consultation, advice (excluding routine check-ups), medication (including injections), or special diet for a pre-existing condition (or any related conditions), then should you need subsequent treatment for that condition, you will have cover for it subject to the plan's terms and conditions. Under the Moratorium Underwriting option, many pre-existing medical conditions, where you need regular or periodic treatment, medication, or checkups, which existed prior to your purchase of your plan, may never be covered. This is because each symptom or treatment, consultation, advice (excluding routine check-ups), medication (including injections), or special diet for a pre-existing condition (or any related conditions) starts the moratorium again. Moratorium Underwriting is subject to an annual recurring, non-refundable administrative fee per Insured Person. ***If you elect this option, please proceed to Section 3.***

❑ **Option 2. Full Medical Underwriting Policy:** You must complete a full medical questionnaire. Upon review of your responses and any additional information we require from you or your physician, we decide whether we can accept you for cover and any limitations on your cover. We then confirm any medical conditions that are excluded. Where cover is in effect for 24 continuous months under the plan, you are provided with pre-existing condition cover up to the annual and lifetime limits of the plan for eligible fully disclosed and accepted pre-existing medical conditions as defined by the plan and subject to the terms and conditions of the Policy Wording. This benefit is payable even if you have received consultation or treatment for the condition(s) during the 24 month period. Where we specifically have excluded cover for a disclosed pre-existing condition and after 24 months of cover your condition has improved, you may request review of that exclusion. Non-disclosed pre-existing conditions will never be covered. If you apply for a Full Medical Underwriting Policy and are declined on medical grounds, you may re-apply for a Moratorium Underwriting Policy. ***If you elect this option, Questions 12 - 30 below must be answered for the applicant and every other member of your family applying for cover. For any question answered "YES," please identify the family member to whom the answer applies (use the letter that corresponds to the family member from Section 1), and provide complete details of the medical condition at issue in the space provided in Section 3.2 of this application, including the name, address and telephone number of all attending physician(s), diagnoses, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. IMG reserves the right to request additional medical information.***

Health Declaration - Continued		**If YES, show FAMILY MEMBER Using Letters from Section 1.**
12. During the last 12 months, have you or any other applicant experienced manifestation or symptoms of, been diagnosed with, or received any consultation, examination, testing or treatment (including medications) for, any medical, health, mental, physical or nervous condition? If yes, please complete Section 3.2.	❑Yes ❑No	
Have you or any other applicant ever experienced manifestation or symptoms of, suffered from, sought consultation, examination, testing or been treated for, or been diagnosed with, any disease, condition, illness, medical problem, disorder, sickness or other problem arising from, involving, or relating to any of the following:		
13. Heart, cardiac, cardiovascular and/or circulatory, including, but not limited to: congestive heart failure, heart attack, angina, chest pain, arteriosclerosis, atherosclerosis, elevated blood pressure, hypertension, swelling of feet/ankles, thrombosis, phlebitis, rheumatic fever, or heart murmur? If yes, in addition to Section 3.2, please complete the following: a. Date of most recent BP reading? _____ b. Result: _____ c. Medications taken (Types & Dosage) _____	❑Yes ❑No	

Health Declaration - Continued		
14. Blood, blood vessels, spleen, arteries, veins or disorders of the blood, including, but not limited to: anaemia, haemophilia, leukemia, hepatitis, lymph glands, or high cholesterol?	❑Yes ❑No	
15. Diabetes, hyperglycemia or hypoglycemia? If yes to diabetes, in addition to Section 3.2, please complete the following: **a)** Diabetic Type: I___ or II ___ **b)** Date diagnosed: _____ **c)** Controlled by diet only? Yes__ No__ **d)** Medications (Types and Dosage) _____ **e)** Date of most recent HbA1c Test? _____ **f)** Results of HbA1c Test (1 - 10) _____	❑Yes ❑No	
16. Asthma or allergies? If yes, in addition to Section 3.2, please specify which one and complete the following: **a)** Date diagnosed:_____ **b)** Has hospitalisation or emergency room treatment been required? If yes, describe and list date(s):_____ **c)** Please list known triggers:_____ **d)** Medications (Types and Dosage):_____ **e)** Frequency of attacks:_____	❑Yes ❑No	
17. Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump, calcification or growth of any kind?	❑Yes ❑No	
18. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid or metabolic disorders, or obesity?	❑Yes ❑No	
19. Kidney, urinary tract functions, kidney or bladder stones or infections?	❑Yes ❑No	
20. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy or pneumonia?	❑Yes ❑No	
21. Mental and nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, ADD or ADHD, chemical or drug abuse or dependency, alcoholism, psychiatric counseling and/or support groups, depression, anxiety, chronic fatigue, or eating or sleeping disorders?	❑Yes ❑No	
22. Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebral ischemic attacks?	❑Yes ❑No	
23. Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease or disorder, vertebrae, degeneration or any other back or neck condition, rheumatism, arthritis, gout, tendonitis, osteoporosis or inflammation?	❑Yes ❑No	
24. For female applicants, miscarriage, complicated pregnancy or delivery, infertility consultation, advice, diagnosis or treatment, and disorders of the reproductive systems, including but not limited to: vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus, and hormone replacement therapy?	❑Yes ❑No	
25. For male applicants, disorders of the reproductive systems, including but not limited to: prostate or elevated PSA level, or erectile dysfunction?	❑Yes ❑No	
26. Congenital, genetic or hereditary or other birth condition or defect including, but not limited to: mental retardation, Down Syndrome, or other chromosome disorder, physical disorder, deformity or defect?	❑Yes ❑No	
27. Digestive system, stomach, or intestines, including, but not limited to: esophageal regurgitation, gastritis, ulcers, colon, or rectum disorders?	❑Yes ❑No	
28. Eyes, ears, nose, mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation, chronic sinusitis, or TMJ?	❑Yes ❑No	
29. Any other disease, medical problem, illness, injury or condition of any kind not listed?	❑Yes ❑No	
30. Do you or any other applicant currently use or during the past 5 years have you or any other applicant used tobacco in any form?	❑Yes ❑No	

SECTION 3. Confidential Medical Information

3.1 Medical Practitioner's Details - The name and address of my usual family doctor is as follows:	Family Member this applies to using Letters from Section 1:
Doctor's Name:	
Telephone: + Country (Area) Number	Email Address:
Address:	
Country:	Postal/Zip Code:
Date Last Seen:	Reason:

❑ **If the above details are different for any other applicant, please give details on a separate sheet and indicate that you have done so by ticking this box.**

3.2 Further Medical Information / Prior Insurance

For any question answered "YES" in Section 2, please identify each applicant for whom the answer applies (using the corresponding letter(s) from Section 1), and provide complete details of the medical condition at issue, including the name, address and telephone number of the attending physician(s), hospital(s), clinic(s) and all other health care providers involved, diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. **Please attach additional pages as necessary.**

Question Number From Section 2	Family Member (USE LETTERS FROM SECTION 1)	Condition(s)/Diagnosis, Prognosis, Past and Present Course of Treatment(s)	Physician/Hospital/Clinic/Health Care Provider Name(s), Address & Telephone	Date(s) of Treatment
		❑ (Tick if you have attached additional pages as necessary)		

If any applicant applying for cover has ever had an application for health, life, or disability insurance or reinstatement rejected, cancelled, rated, declined or modified (see Section 2, Question 10), please explain below.

_____

_____

(attach additional pages as necessary)

Declaration for GlobalSelect International Healthcare Cover:

AGREEMENT

I (we) understand and hereby agree that:

(i) I (we) apply for insurance under GlobalSelect International Healthcare Cover.

(ii) Cover will be provided in accordance with the Policy Wording; and I (we) will read it upon receipt and be bound by it unless I (we) cancel the plan within 30 days after receiving the Policy Wording.

(iii) This Application will be the basis for and form a part of any insurance issued.

(iv) I (we) have read all statements, questions and responses contained in this Application or they have been read to me (us) and I (we) understand them.

(v) My (our) responses to the statements and questions contained in this Application are true, accurate complete and correctly recorded in all respects, and I (we) will supplement such responses prior to the requested effective date in the event of any change or addition thereto.

(vi) If I (we) selected a Moratorium Underwriting Policy, that it excludes all pre-existing conditions as defined in the Policy for a minimum of 24 months continuous cover without symptoms or treatment of such conditions even if such conditions were disclosed, and that chronic or recurring pre-existing conditions such as diabetes (or any conditions that require regular checkup/treatment) will never be covered. I (we) also understand that non-disclosed pre-existing conditions will never be covered and can lead to cancellation of cover at point of claim.

(vii) The agent/broker assigned to or assisting with this Application is the representative of me (us) and is not an agent/broker of the Insurer, or IMG.

(viii) No agent/broker has the authority to modify or waive any statement, question or response in this Application or to modify or waive any term of the plan, or to waive any of the rights or requirements of the Insurer, IMG.

(ix) No cover will be effective unless and until this Application has been duly accepted in writing by the Insurer, and there has been no change since the date of this Application Form in the insurability of all persons proposed for cover or in any responses to the statements and questions in this Application.

(x) The subjects, risks and benefits of insurance for which I (we) apply for cover under the plan are not intended or considered by me (us) to be resident, located or performed in any state of the USA or any particular country.

(xi) Premiums will be applied from the effective date forward and there will be no cover for any claim that begins prior to the effective date.

(xii) Any misstatement, misrepresentation or omission contained in this Application will void the insurance applied for, and any and all claims and benefits under the plan will be forfeited and waived.

(xiii) The Insurer, and IMG, their employees, representatives, agents and any other persons or organisations performing services for them or on their behalf, may use, disclose or transfer to any organisation any information about me (us) obtained or collected in connection with this Application, (whether contained in this Application or otherwise) for the purpose of: (1) assessing this Application and providing on-going insurance and customer service; (2) processing and giving effect to credit/debit card payments; (3) providing marketing material in respect of insurance related services of IMG or its associated companies; (4) processing claims or analysing the insurance; (5) the identification and prevention of fraud and crime.

AUTHORISATION

For purposes of determining my (our) insurability, I (we) authorise any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, pharmacy, medical records service, prescription history clearinghouse, other insurer, government agency, employer, social worker or family member to provide information about me (us), including my (our) entire medical record, to Sirius International Insurance Corporation, International Medical Group, Inc. and IMG., their employees, representatives, agents and any other persons or organisations performing insurance services for them or on their behalf. By my (our) signature below, I (we) acknowledge that any prior agreement I (we) have made to restrict or limit the disclosure of information about my (our) health does not apply to this authorisation.

This authorisation is valid from the date of my (our) signature shown below. A copy, image or facsimile of this authorisation is as valid as the original.

Signature of Applicant or Guardian:
(Must be signed and dated)

Date:

X _____

Signature of Spouse
(Only required if applying for cover)

Date:

X _____

GlobalSelect®

GlobalSelect® Global Personal Accident Plan / Global Daily Indemnity℠ - Hospital Income Plan
Optional Additional Covers Application Form

Underwritten by Sirius International Insurance Corporation (the "Insurer"). Administered, as agent for and on behalf of the Insurer, by International Medical Group, Inc. ("IMG"). Coordinated, as agent for and on behalf of the Insurer for the purposes of receiving premiums, receiving and holding claims money, and receiving and holding premium refunds by IMG.

Global Personal Accident Plan and Global Daily Indemnity are only available at the time of application for, and with the purchase of, GlobalSelect International Healthcare Cover and cannot be added at renewal or a later date. To apply, simply complete Section 4 of this Application.

SECTION 4. Application For Global Personal Accident Plan and/or Global Daily Indemnity Insurance
Please indicate the name of each family member applying for Global Personal Accident Plan and/or Global Daily Indemnity.

	Name	Personal Accident First Unit of Cover	Personal Accident Second Unit of Cover	Daily Indemnity First Unit of Cover	Daily Indemnity Second Unit of Cover
A. Applicant		❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
B. Spouse		❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
C. First Child		❑Yes ❑No	NOT AVAILABLE		
D. Second Child		❑Yes ❑No			
E. Third Child		❑Yes ❑No			

	For each individual applying for Global Personal Accident Plan in respect of Accidental Death, please indicate:		% of Death Benefit
Applicant A	Primary Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%
	Contingent Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%
Applicant B	Primary Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%
	Contingent Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%
Applicant C	Primary Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%
	Contingent Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%
Applicant D	Primary Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%
	Contingent Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%
Applicant E	Primary Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%
	Contingent Beneficiary Name Address of Beneficiary	Relationship Phone No. + ( )	%

Declaration for Global Personal Accident Plan and/or Global Daily Indemnity (If Applicable)

If accepted for the GlobalSelect International Healthcare Cover, I (we) understand that I (we) may qualify for Global Personal Accident Plan and/or Global Daily Indemnity underwritten by Insurer. I (we) hereby incorporate herein the certifications, representations, understandings, agreements, acknowledgements, authorisations, and warranties from the foregoing Application for the GlobalSelect International Healthcare Cover, and understand and agree that the terms, conditions, restrictions and penalties thereof shall likewise apply hereto. If a U.S. citizen, I (we) understand coverage for Global Personal Accident Plan will not be effective prior to the date of my (our) departure from the U.S. If I (we) have also applied for the optional Global Daily Indemnity plan, I (we) understand that only overnight hospital stays eligible under my (our) GlobalSelect International Healthcare Cover, excluding pregnancies, are covered. I (we) also understand: (i) there is an additional premium for Global Daily Indemnity, (ii) that in the event this Application is not accepted, the premium will be returned to me (us) and neither party will have any obligation, right or liability under the plan, (iii) that the death benefit will be determined by my (our) age at the time of my (our) death, and (iv) that the Global Personal Accident Plan and Global Daily Indemnity are issued in England and are governed by the Laws of England.

Signature of Applicant or Guardian:
(Must be signed and dated)
Date:
X

Signature of Spouse
(Only required if applying for cover)
Date:
X

SECTION 5. Method and Frequency of Payment -

Please choose your method and frequency of payment. The currency you have selected for your plan will also be the currency in which your premium is to be paid.

❑ **A. Credit Card**

Frequency of Payment *(Please Tick One Only)*	❑ **Annually**	❑ **Semi-Annually**	❑ **Quarterly**	❑ **Monthly**

Note: *Choosing the semi-annual payment option results in total payments of 110% of the annual premium, choosing the quarterly payment option results in total payments of 112% of the annual premium, and choosing the monthly payment option results in total payments of 120% of the annual premium.*

Your Credit/Debit Card Details

Credit/Debit Card Type: ❑ Visa ❑ MasterCard ❑ American Express

Full Card Number:

Start Date:	**Expiry Date:**	**Issue No.:**_____ **Issue Date:**_____ **(if applicable)**	**Security Number:** **(last 3 digits on signature strip or 4 printed on front of AMEX)**

Name as on card:

Address to which card is registered:
(if different from the mailing address given)

Daytime Telephone: +(Country) (Area) Number

If paying by credit/debit card, I authorise IMG. to debit my credit/debit card account above for the total amount due (including any insurance premium taxes if applicable). In the event that I have chosen a semi-annual, quarterly, or monthly payment frequency, I hereby elect to pre-authorise future credit card payment instalments for the balance of the annual period of cover (12 months from the Effective Date), and hereby request and authorise IMG. to charge my credit card periodically as payment instalments become due for premiums. This authorisation will remain in effect for 12 months, unless earlier revoked by me in writing and IMG. actually receives notice of revocation, whereupon continuing cover may be impacted. At all subsequent renewals, I authorise IMG. to collect the renewal premiums due at that time, on the same payment frequency basis as the previous year until I give written notice that I wish to terminate this agreement. Cover purchased by credit card is subject to validation and acceptance by a credit card company. I understand that I will be given advance notice of the renewal premiums and that they may vary each year.

Cardholder's Authorisation Signature

Date: DD/MM/YY

X _____

If paying by bank transfer or cheque:

To avoid delays, we recommend you check your premium calculation and any taxes (if applicable) with us or your agent.

❑ **B. Bank Transfer (Annual Premium Payments Only)**

Once your Application has been processed, the necessary bank transfer information will be forwarded to you and your payment is required within 10 days. [Please ensure that the name of the Applicant (as declared in Section 1 of this form), is clearly stated on any transfer.] Liability for any bank transfer which does not clearly identify the proposer will not be accepted by the Insurer, IMG.

❑ **C. Bank Cheque / Bankers Draft / Money Order**** (Annual Premium Payments Only)

Please make payable to: **IMG.**	Please ensure that the name of the Applicant (as declared in Section 1 of this form), is clearly stated on the reverse of the cheque. ** UK£ Cheque for sterling contract, US$ cheque for dollar contract or Euro cheque for Euro€ contract

INTERNAL USE ONLY

_____ X _____ = _____ + _____ + _____ + _____

Total Medical Premium | Excess Rate factor | Optional Cover Premium | Moratorium Fee (if applicable) | Insurance Premium Taxes/Levies

= _____
Total Premium Due

SECTION 6. Requested Start Date

Date on which you wish your GlobalSelect International Healthcare Cover to commence:	❑ On Acceptance	❑ Other / /	*(Must be within 30 days after signature. Cover will in no event be effective until approved.) Please note we cannot commence your plan until we have accepted your Application and received your first or annual premium payment)*

SECTION 7. Renewal Contact Information - Please specify the best way to contact you when it comes to renewing your cover:
❑ Mail - Please provide address:
❑ Fax - Please provide fax number: + Country (Area) Number
❑ Email - Please provide email address:

Policy Fulfillment & Despatch Options: Please tick one of the following to indicate how you would like your Certificate of Insurance and Supporting Policy documentation sent to you.	
❑ Electronic E-mail Despatch: *(Preferred)*	Certificate of Insurance and supporting documentation sent direct to your email address shown in Section 1.5 in electronic format and no documentation will be sent by post.
❑ Standard Mail Despatch:	Paper Certificate of Insurance and printed supporting documentation will be mailed to your Mail Forwarding Address shown in Section 1.4 by regular international air-mail.
❑ Express Mail Despatch:	Paper Certificate of Insurance and printed supporting documentation will be mailed to you by EXPRESS international air-mail. Please note there will be an additional fee of £15/$25/€25 to be paid in addition to the premium to have your Certificate of Insurance express air-mailed to you after approval. (Confirm despatch address below.)
Express Mail Despatch Address Details: If you have selected Express Mail Despatch above, please select the address where you would like your Certificate of Insurance and supporting documentation mailed to (as indicated in Section 1) - Tick One Only:	
❑ Residence Address ❑ Mail Forwarding Address ❑ Other (No P.O. Boxes please) _____ _____	

SECTION 8. Insurance Advisor / Broker Use Only	
IMG Producer Number: 524041	Phone: 44 (0)1342 843560
Company Name: 189 Smallfield Road - Horley	Fax:
Contact Name or Stamp: Salt Insurance Services Ltd.	Email: laurence.brooks@saltinsurance.com
GA # (If Applicable):	Website:

PLEASE MAIL OR FAX THIS APPLICATION TO:

International Medical Group® (IMG®)
Kingsgate, High Street, Redhill,
Surrey RH1 1SH. United Kingdom
Telephone: +44 1737 306 710
Fax: +44 1737 860 600
Email: sales@imgeurope.co.uk

Address change information or additional contact information should also be directed to this contact information.

GlobalSelect®