PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS USING BLACK INK

GlobalHealth Elite

APPLICATION FORM (INDIVIDUAL)

Pacific Prime International Ltd
10/F Capital Building, 6-10 Sun Wui Road,
Causeway Bay, Hong Kong.
Tel: +852 8202 7001
Fax: +852 2915 7770
Email: info@kwiksure.com

Are you a current policy holder? ❑YES Existing policy No.

YOUR PERSONAL DETAILS

First Names Surname Mr / Dr / Mrs / Ms / Miss

Postal address

Email address (home) Email address (work)

Telephone No. (home) Telephone No. (mobile/cell)

Telephone No. (work) Fax No.

Date of birth Sex ❑Male ❑Female

Occupation

Nationality Country of residence

DETAILS OF COVER REQUIRED

Make a plan selection and follow that column down to answer all other questions.

	BRONZE	SILVER	GOLD	PLATINUM
PLAN TYPE	❑	❑	❑	❑
CURRENCY				
UK Sterling £	❑	❑	❑	❑
US Dollars $	❑	❑	❑	❑
Euros €	❑	❑	❑	❑
EXCESS				
Nil	❑ Standard	n/a	n/a	❑
£30 / $50 / €45	n/a	❑ Standard	❑ Standard	❑ Standard
£60 / $100 / €90	n/a	❑	❑	❑
£250 / $400 / €375	❑	❑	❑	❑
£500 / $800 / €750	❑	❑	❑	❑
£1,000 / $1,600 / €1,500	❑	❑	❑	❑
£3,000 / $5,000 / €4,500	❑	❑	❑	❑
£6,000 / $10,000 / €9,000	❑	❑	❑	❑
AREA OF COVER				
Area 1: World-wide excluding the USA, or	❑	❑	❑	❑
Area 2: World-wide with cover in the USA limited to temporary trips of up to 45 days and a treatment limit of US$50,000, or	❑	❑	❑	❑
Area 3: World-wide with cover in the USA limited to temporary trips of up to 90 days and a treatment limit of US$200,000.	❑	❑	❑	❑
SEMI-PRIVATE ROOM DISCOUNT Only available to residents of Hong Kong and Singapore with Area 1 cover. Please tick if you are prepared to have your hospital treatment in a semi-private room, to achieve the following premium discounts:	❑ 8% discount	❑ 5% discount	❑ 5% discount	❑ 5% discount
OPTIONAL GLOBAL TRAVEL PLAN	❑ Self only ❑ Partner only ❑ Self & partner ❑ Whole family			
OPTIONAL GLOBAL ACCIDENT PLAN The Global Accident Plan excludes accidents arising from hazardous and/or manual occupations, private flying, motor-cycle riding and hazardous sports. If you, or your partner's, occupation is not 100% office based and/or you, or your partner, participate in any of the above activities or any hazardous sports, please give details here and we will advise the premium loading necessary to cover the increased risk.	❑ Self only ❑ Partner only ❑ Self & partner £50,000 / $75,000 / €75,000, or ❑ Self only ❑ Partner only ❑ Self & partner £100,000 / $150,000 / €150,000, or ❑ Self only ❑ Partner only ❑ Self & partner £150,000 / $225,000 / €225,000, or ❑ Self only ❑ Partner only ❑ Self & partner £200,000 / $300,000 / €300,000, or ❑ Self only ❑ Partner only ❑ Self & partner £250,000 / $375,000 / €375,000			

FAMILY MEMBERS TO BE INCLUDED IN THE PLAN

Please enter the names and details of all dependants for whom cover is required. You may include your partner and children, up to, and including age 17 or up to, and including age 24 if in full time education – proof will be required. Children aged 18 or over who are not in full time education must make their own application for cover.

First Name(s)	Surname	Date of Birth dd/mm/yy	Relationship to applicant	Country of residence	Occupation/Full time education
Partner					
Child					❑YES ❑NO
Child					❑YES ❑NO
Child					❑YES ❑NO
Child					❑YES ❑NO
Child					❑YES ❑NO

HEALTH DECLARATION

IMPORTANT. PLEASE READ THESE IMPORTANT NOTES PRIOR TO COMPLETING THE HEALTH DECLARATION.

THE GLOBAL HEALTH PLANS DO NOT COVER THE TREATMENT OF PRE-EXISTING CONDITIONS AND RELATED CONDITIONS. A PRE-EXISTING CONDITION MEANS ANY DISEASE, ILLNESS OR INJURY FOR WHICH YOU HAVE RECEIVED MEDICATION, ADVICE OR TREATMENT, OR YOU HAVE EXPERIENCED SYMPTOMS, WHETHER THE CONDITION HAS BEEN DIAGNOSED OR NOT, AT ANY TIME BEFORE THE START OF YOUR COVER. A RELATED CONDITION IS ANY DISEASE, ILLNESS OR INJURY THAT IS CAUSED BY A PRE-EXISTING CONDITION OR RESULTS FROM THE SAME UNDERLYING CAUSE AS A PRE-EXISTING CONDITION.

Please give full details about each condition by answering the questions in the health declaration in as much detail as possible. Please continue on a separate sheet if necessary. We cannot accept your application if this health declaration is incomplete.

1. Your height (cms) Your weight (kgs) Your partner's height (cms) Your partner's weight (kgs)

2. Have any persons named in this application ever:

A. Undergone a surgical operation?	❑YES ❑NO
B. Been a patient in a hospital clinic or sanitorium?	❑YES ❑NO
C. Been advised to have any medical tests or investigations?	❑YES ❑NO
D. Been tested HIV positive?	❑YES ❑NO
E. Had an application for insurance turned down or accepted at special terms?	❑YES ❑NO

3. Are any of the persons named in this application aware of any symptoms present now which may give rise to a claim? YES ❑ NO ❑

4. Are any persons named in this application currently taking any drugs or medication? ❑YES ❑NO

5. Have any persons named in this application ever suffered from, been diagnosed with, treated or prescribed drugs for:

A. Conditions of the eyes, ears, nose or throat?	❑YES ❑NO
B. Fainting, blackouts or fits?	❑YES ❑NO
C. Any high blood pressure, heart or circulatory conditions?	❑YES ❑NO
D. Diabetes?	❑YES ❑NO
E. Any rheumatic or arthritic conditions?	❑YES ❑NO
F. Any spine, bone, muscle or joint conditions?	❑YES ❑NO
G. Asthma, respiratory or allergic conditions?	❑YES ❑NO
H. Genito-urinary or renal conditions?	❑YES ❑NO
I. Stomach, liver or bowel conditions?	❑YES ❑NO
J. Cysts, tumour or cancer?	❑YES ❑NO
K. Any skin conditions?	❑YES ❑NO
L. Any gynaecological conditions?	❑YES ❑NO
M. Any physical defect, infirmity or congenital illness?	❑YES ❑NO
N. Any nervous, mental or psychiatric condition?	❑YES ❑NO
O. Any alcohol and/or drug dependency problem?	❑YES ❑NO
P. A higher than normal cholesterol level?	❑YES ❑NO
Q. Any other type of disease, injury or medical condition?	❑YES ❑NO

If you have answered YES to any question, please give full details on page 3.

IMPORTANT

IF WE NEED TO CONTACT YOU FOR FURTHER INFORMATION, PLEASE GIVE US A PERSONAL CONTACT NUMBER WE CAN USE:

Telephone: Fax: Email:

HEALTH DECLARATION

Question No.	Name of person who suffered the illness/injury	State the diagnosis of the illness, or, if an injury, give details	Name and address of the treating physician	Date(s) on which the illness/injury occurred	Full details of the treatment/ tests performed and the results	When did you last suffer from symptoms or receive treatment relating to this condition?	Is there any foreseeable need for further consultation or treatment for this condition? If yes, please give full details.

PLEASE GIVE DETAILS OF YOUR CURRENT/LAST REGISTERED DOCTOR, OR THE DOCTOR YOU LAST CONSULTED

Name

Practice name

Address

Telephone No.

METHOD OF PAYMENT

METHOD OF PAYMENT

- ❑ Cheque/draft – acceptable for annual payments only
- ❑ Bank transfer – acceptable for annual payments only
- ❑ Credit/debit card – please complete your card details
- ❑ Direct Debit – acceptable for sterling payments only from a UK bank account. Please complete a Direct Debit Mandate and send it to us. We must receive the original signed mandate before we can commence your cover.

FREQUENCY OF PAYMENT

- ❑ Annual
- ❑ Semi-annual
- ❑ Quarterly*
- ❑ Monthly*

*Payable by credit/debit card or direct debit only.

CREDIT/DEBIT CARD DETAILS

Credit/debit card ❑ VISA ❑ MASTERCARD ❑ AMEX ❑ SWITCH ❑ DOMESTIC MAESTRO ❑ DELTA ❑ SOLO ❑

Full card number

Expiry date Issue No (If applicable) Issue Date (If applicable)

Address to which card is registered (if different from the postal address given on page 1)

Name as on card

Signature (of card holder)

START DATE

IMPORTANT

IF A MEDICAL CONDITION MANIFESTS ITSELF BETWEEN THE TIME OF SIGNING THE APPLICATION FORM AND COVER STARTING, YOU MUST DECLARE THIS TO US IMMEDIATELY.

Date on which you wish your Global Health Elite plan to commence: ❑ On acceptance ❑ Other (please state)

Please note that we cannot commence your plan until we have accepted your application and received payment of your first premium.

DECLARATION

I hereby apply for cover under the Global Health Elite plan on behalf of all the persons named in this application form. I declare that I have read and understood the Global Health Elite plan agreement and that I am aware that cover shall be provided in accordance with the agreement. I have made a full and complete disclosure about the medical history of each person included in this application and I fully understand that pre-existing conditions as defined in the Global Health Elite plan agreement shall not be covered by this insurance plan. I authorise any doctor who has ever treated or advised any of the persons named in this application to provide William Russell Limited with any information they may require in connection with treatment related to any claim under this plan. I declare that the information given in this application is true and complete.

If I have applied for a travel insurance plan, I declare that at the time of purchasing this insurance or at the time of booking any future trip(s), I am aware of no reason why any journey or trip should be cancelled or curtailed or expense be incurred.

If I have indicated that I wish to pay by credit/debit card or by direct debit, I agree that William Russell Limited may debit my account with the appropriate premiums on or before their due dates, and all subsequent renewal premiums due as invoiced by William Russell Limited until I give written notice that I wish to terminate this agreement. I understand that my cover will terminate in accordance with the terms of the Global Health Elite plan agreement if William Russell Limited are unable to collect any premium - for whatever reason - and I do not provide William Russell Limited with an alternative method of payment immediately.

Signature of applicant: Date:

IMPORTANT

- PLEASE ENSURE YOU HAVE GIVEN AN ANSWER TO EVERY QUESTION. AN INCOMPLETE FORM WILL DELAY YOUR APPLICATION.
- IF AFTER COMPLETING, SIGNING AND DATING YOUR APPLICATION FORM ANY CHANGES OCCUR IN THE FACTS YOU HAVE GIVEN US, SUCH AS A CHANGE IN YOUR STATE OF HEALTH OR IN THE STATE OF HEALTH OF ANY OF YOUR DEPENDANTS, YOU MUST TELL US IN WRITING ABOUT THE CHANGE, AND WE RESERVE THE RIGHT TO DECLINE TO ACCEPT YOUR APPLICATION OR TO ACCEPT YOUR APPLICATION WITH SPECIAL TERMS.

GHIND/07

Contact Information

In order to help us work with you more effectively we ask you to complete the following contact data sheet. By completing this fully then we will be able to ensure you get the best possible service even though you may change your employer, country or location.

Policyholder

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other: ……..…… Family Name: ……..…..

Given Name: …… Middle Name(s): ……..……..

Home Address: ……..…

..... Country: ……..……

Contact info in the country you now live in

Mobile: …….. Home: …….. Work: ……..…….

Personal email (1): …….. Personal email (2): ……..

Work email: …….. Employer: ……..

Employers address: ……

..... Country: ……..……

Permanent contact information in your home country

Mobile: …….. Home: …….. Work: ……..….

Permanent Address: ……..……..……

..... Country: ……..……

Spouse

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other: …… Family Name: ……..…..

Given Name: …… Middle Name(s): ……..……..

Contact info in the country you now live in

Mobile: …….. Work: …….

Personal email (1): …….. Personal email (2): ……..

Work email: …….. Employer: ……..

Employers address: ……

..... Country: ……..……

Emergency Contact Person

In the event of an emergency whereby we are unable to contact you or your spouse or should you be incapacitated then please provide us with the permanent contact details of an immediate family member who we should contact in this situation.

Family Name: ……..…..... Given Name: …….

Mobile: …….. Home: …….. Work: ……..……

email: …….. Relationship to you: ……..

Home address: ……

..... Country: ……..……

Please help us by keeping us fully informed or all changes to your contact details as soon as possible. Please note all information given to us is only used to help us manage your insurance policy and is never used for any other purpose.