1 April 2007

Pacific Prime International

InterGlobal
Innovations in International Private Medical Insurance

UltraCare Plan

Individual & Family Application Form

If you have any questions or need any assistance in completing this form call us on +44(0) 1252 745 900 and one of our sales advisers will be happy to help.

Please complete clearly in BLOCK CAPITALS.

If you have received a quotation from us, please write the quote number here:

Please note: if any of the details that you write on this form are different from the details that you gave when you got your quotation, your premium may be different.

A Your personal details

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family Name:	First Names:
Country of Residence: [1]	How long have you lived there?:
Home country:	Nationality on Passport:
Occupation:	Date of Birth (dd/mm/yy): Sex: ☐ M ☐ F

[1] Your country of residence will determine the value of Insurance Premium Tax that is added to your premium. Please speak to your adviser or call us on +44 (0)1252 745 900 if you are unsure whether your premium will be affected.

Residential Address [2]

Address:	
Town:	City:
Postal Code:	Country:
Telephone:	Fax:
Email:	

[2] All correspondence will be sent to this address unless you have completed the correspondence address details below.

It is very important that you tell us immediately of any changes to your contact or personal details.
A change in circumstances could affect your cover.

Correspondence Address - if different from residential address above

Address:	
Town:	City:
Postal Code:	Country:
Telephone:	Fax:
Email:	

Please indicate your preferred communication channel ☐ Email ☐ Airmail ☐ Fax ☐ Telephone

B Dependants to be Covered

Dependant 1

Family Name:	First Names:
Date of Birth (dd/mm/yy):	Sex: ☐ M ☐ F
Country of Residence:	Nationality on Passport:
Occupation:	Relationship to you:

Space for further dependants overleaf >>

B Dependants to be Covered (continued)

Dependant 2

Family Name:	First Names:
Date of Birth (dd/mm/yy):	Sex: ☐ M ☐ F
Country of Residence:	Nationality on Passport:
Occupation:	Relationship to you:

Dependant 3

Family Name:	First Names:
Date of Birth (dd/mm/yy):	Sex: ☐ M ☐ F
Country of Residence:	Nationality on Passport:
Occupation:	Relationship to you:

Dependant 4

Family Name:	First Names:
Date of Birth (dd/mm/yy):	Sex: ☐ M ☐ F
Country of Residence:	Nationality on Passport:
Occupation:	Relationship to you:

If you have any further dependants to be covered please provide details on a separate sheet of paper and submit it along with this application.

C Cover Start Date

Your cover will commence on the date when, subject to eligibility and the full completion of this form, we accept your application in writing. If you wish your cover to start at a later date please indicate this below. This date can be no more than 30 days after the date you complete this form. We cannot backdate cover under any circumstances.

Preferred Cover Start Date (dd/mm/yyyy):

D Your Cover Options

Area of Cover

Select the area of cover from the descriptions below based upon the location of your country of residence and your home country if you require the option of returning to your home country for treatment. Please see eligibility section in the Plan Guide for restrictions on US Citizens.

- ☐ **Area 1** Europe
- ☐ **Area 2** Worldwide, not including the USA
- ☐ **Area 3** Worldwide
- ☐ **Area 4** Australia and New Zealand

Level of Cover / Plan Type

Please indicate the UltraCare plan type that you require. Please be sure that you have read the policy summary and table of benefits before making your selection to ensure the product meets your needs and demands. Please contact us if you require copies of these documents.

Plus ☐	Comprehensive ☐	Select ☐	Standard ☐
All the benefits of the Comprehensive Plan, but with higher limits and cover for restorative dental treatment.	As the Select Plan but with higher limits and cover for primary consultations, emergency dental and wellness benefits.	Full in-patient and daycare treatment with limited cover for specialist out-patient treatment - includes evacuation.	Full in-patient and daycare treatment - includes evacuation.

Excess Options

If you wish to change the excess from the standard excess shown, please tick the appropriate box below.

	Plus	Comprehensive	Select	Standard
Nil Excess	☐ 10% Premium Loading	☐ 10% Premium Loading	☐ 10% Premium Loading	Standard
£25 / $42.50 / €37.50	Standard	Standard	Standard	N/A
£50 / $85 / €75	☐ 5% Premium Discount	☐ 5% Premium Discount	☐ 5% Premium Discount	N/A
£100 / $170 / €150	☐ 10% Premium Discount	☐ 10% Premium Discount	☐ 10% Premium Discount	N/A
£250 / $425 / €375	☐ 15% Premium Discount	☐ 15% Premium Discount	☐ 15% Premium Discount	N/A
£500 / $850 / €750	☐ 20% Premium Discount	☐ 20% Premium Discount	☐ 20% Premium Discount	☐ 10% Premium Discount
£1,000 / $1,700 / €1,500	☐ 25% Premium Discount	☐ 25% Premium Discount	☐ 25% Premium Discount	☐ 20% Premium Discount
£2,500 / $4,250 / €3,750	☐ 30% Premium Discount	☐ 30% Premium Discount	☐ 30% Premium Discount	☐ 30% Premium Discount
£5,000 / $8,500 / €7,500	☐ 40% Premium Discount	☐ 40% Premium Discount	☐ 40% Premium Discount	☐ 40% Premium Discount

The standard excess on medical out-patient treatment claims applies per medical condition per plan year.

If you have chosen a voluntary excess for the Plus, Comprehensive or Select plans to reduce your premium this will be applied to **all** (In-patient, Daycare and Out-patient) medical treatment. The Plus and Comprehensive plans also have a 25% co-insurance on out-patient dental treatment. This co-insurance cannot be removed.

If you have chosen a voluntary excess for the Standard plan this will be applied to all In-patient and Daycare medical treatment.

Discounts apply to main UltraCare Plan premiums only - not to optional add-on plan premiums.

E Optional Add-on Benefits

Do you want to add any of the following?

Worldwide Personal Travel Plan	☐ Yes	☐ No
If Yes, please indicate type	☐ Single	☐ Couple ☐ Family ☐ Single Parent Family
Maternity Benefit Plan	☐ Yes	☐ No
If Yes, please indicate level of co-insurance selected per person	☐ 10%	☐ 20%

The maternity plan is only available for female members who are aged between 18 and 44. Cover only becomes available for pregnancies that are conceived 6 months after the commencement date of this optional add-on plan.

Personal Accident Plan	☐ Yes	☐ No

If Yes, please circle the number of personal accident units required for each person on this application:

Main Planholder: 1 2 3 4 5	Dependant 1: 1 2 3 4 5	Dependant 2: 1 2 3 4 5
	Dependant 3: 1 2 3 4 5	Dependant 4: 1 2 3 4 5

The Personal Accident Plan does not include accidents arising from manual or hazardous occupations, dangerous or winter sports, pursuits, or activities. If your occupation is not purely office-based or you take part in any dangerous or winter sports, pursuits or activities, please give full details on a separate sheet and include it with this Application Form. We may then be able to advise if we are able to cover the increased risk.

F Paying Your Premiums

It is important that you keep your premiums up to date and notify us immediately of any changes to your payment details. Full payment details and information on unpaid or late payments are found in the UltraCare Plan Guide. **Please Note:** whilst premiums are outstanding all claims settlements will be suspended.

Currency

In which currency do you wish to pay your premiums?

☐ GB pounds (£) ☐ US dollars ($) ☐ euros (€)

This selection will also determine the currency of your benefit limits and excess.

Payment plans

Please select the frequency in which you wish to pay your premiums. Due to increased administration costs the annual total of any Monthly and Quarterly premium payments will be higher than the cost of paying Yearly.

	Cheque or Bank Draft	Bank Transfer	Credit Card	Direct Debit
Yearly	☐	☐	☐	☐
Quarterly	N/A	N/A	☐	☐
Monthly	N/A	N/A	☐	☐

PLEASE FOLLOW INSTRUCTIONS FOR YOUR CHOSEN PAYMENT METHOD

Note: Direct Debits can only be accepted for clients who have a UK Bank Account and have elected to pay their premiums in GB Pounds.

Payment Details

Cheque or Bank Draft

Please make all cheques and bank drafts payable to "InterGlobal Insurance Company Limited". Please ensure that your family name and date of birth are clearly shown on the reverse in case your payment becomes separated from this form.

Bank Transfers

Please ensure that your family name is clearly shown on any bank transfer and that the transfer is in the correct currency and sent to the correct details below:

GB Pound (£) Account

Bank:	HSBC Bank plc
Address:	33 The Borough Farnham, Surrey GU9 7NJ United Kingdom
Account No:	41611593
Sort Code:	40.21.05
Swift Code:	MIDLGB21
IBAN No:	GB84 MIDL 402105 41611593

US Dollar ($) Account

Bank:	HSBC Bank plc
Address:	33 The Borough Farnham, Surrey GU9 7NJ United Kingdom
Account No:	67348768
Sort Code:	40.05.15
Swift Code:	MIDL GB22
IBAN No:	GB68 MIDL 4005156 7348768

Euro (€) Account

Bank:	HSBC Bank plc
Address:	33 The Borough Farnham, Surrey GU9 7NJ United Kingdom
Account No:	67348776
Sort Code:	40.05.15
Swift Code:	MIDL GB22
IBAN No:	GB46 MIDL 400515 67348776

Credit Card

We can accept payments using the following Credit Cards - VISA, MasterCard and American Express. If your card is not in this list, please check with us as we may still be able to accept it. Please complete the Credit Card Authority Form attached to this application.

Direct Debit

We can only accept payments by Direct Debit if you have a UK Bank Account and have elected to pay your premiums in GB Pounds (£). Please complete the Direct Debit Form attached to this application.

G Doctor's / Medical Practitioner's Details

Please provide the contact details of your family doctor(s) or medical practitioner(s) who last treated you or your family in the last 2 years.

Name:	Name:
Hospital/Clinic/Practice:	Hospital/Clinic/Practice:
Telephone:	Telephone:
Fax:	Fax:
Email:	Email:
Address:	Address:
Postcode:	Postcode:

H Pre-existing Medical Conditions

Please carefully read Benefit Exclusion 1, which can be found in the Plan Guide accompanying this application form, before you agree to enrolment of you and your dependants under this plan.

In short - we will not pay benefits for costs arising from medical conditions or related medical conditions for which you have received medical treatment, had symptoms of, sought advice for or to the best of your knowledge existed in the 2 years prior to your application. These conditions may become eligible for benefit after two years continuous cover provided that during that time no treatment or advice was given and no symptoms or reoccurrence were apparent in respect of these conditions.

If after enrolment you are not happy with this plan, you are entitled to cancel your cover within 30 days from receipt of your plan documents.

If you do not have a copy of the Plan Guide, please contact us to receive one.

I Declaration

I hereby apply to be covered under the selected InterGlobal UltraCare Plan together with the dependants listed in this application. I declare that to the best of my knowledge and belief the information given in this application is true and complete. I have read, understood and agree to be bound by the terms and conditions detailed in the Plan Guide, along with all eligible dependants included in this application or any subsequent dependants enrolled after the commencement date of the plan. It is agreed that this declaration and information supplied in this application shall form the basis of the contract between me, my dependants and InterGlobal Insurance Company Limited. After reading all the terms & conditions and documents provided to me I am satisfied that the product selected meets my requirements at this time.

I authorise and request the doctor named in section G and/or any other medical establishment, including any other health professional who has attended me and any of my dependants included under this plan for treatment of a medical condition, to provide InterGlobal Insurance Company Limited with the information they may need in connection to any claim made under this plan.

I accept, if I do not provide the information required in section G that, in the event of a claim being made by me, or any of my dependants included under this plan, which is deemed as being treatment for a pre-existing medical or related medical condition by InterGlobal Insurance Company Limited, such claim will be rejected.

I confirm and agree that any personal information collected or held by InterGlobal Insurance Company Limited, whether contained in this application or otherwise obtained may be used by InterGlobal Insurance Company Limited, or disclosed to or transferred to any organisation for the purpose of i) assessing this application and providing on-going insurance cover, customer service and the processing of claims, ii) processing and effecting premium payments, iii) providing marketing communications in respect of InterGlobal Insurance Company Limited, its related products and services and those of its associated companies.

Signature: Date (dd/mm/yy):

Our full terms and conditions and details of our data protection policy can be found at www.interglobalpmi.com.

J Where did you hear about InterGlobal?

Broker/Adviser	☐	Please name: _____
Search Engine	☐	Please name: _____
Internet Advert/website	☐	Please name: _____
Magazine Advert	☐	Please name: _____
Exhibition	☐	Please name: _____
Other	☐	Please tell us where: _____

Broker/Adviser Details:

Pacific Prime International
Suite 503, 5th Floor
N. 15 Dong Pink Lu
Shanghai 200031
China

T +86 21 6445 4592
F +86 21 6467 0328
W www.pacificprime.com

Direct Debit

We offer Direct Debit as an alternative form of payment to all planholders who take out a GB£ plan and currently hold a UK Bank or Building Society account. If you would like to take advantage of this facility for your regular payments please complete the following form.

Please note: We must receive the original of this form in order to set up your direct debit payments as banks will not accept copies.

Instruction to your Bank OR Building Society to pay by DIRECT DEBIT

Please complete in BLOCK CAPITALS and send to:

InterGlobal Insurance Company Limited
Woolmead House East
The Woolmead
Farnham
Surrey GU9 7TX

DIRECT Debit

Originator's Identification:

2	4	2	5	8	4

Name(s) of Account Holder(s):

Bank/Building Society Account number:

Branch Sort Code:

Name and full postal address of your Bank or Building Society

To: The Manager — Bank/Building Society

Address:

Postcode:

Reference Number *(for InterGlobal Insurance Company Limited use only)*

Instruction to your Bank/Building Society

Please pay InterGlobal Insurance Company Limited Direct Debits from the account detailed in this instruction subject to the safeguards assured by The Direct Debit Guarantee.

I understand that this instruction may remain with InterGlobal Insurance Company Limited and if so details will be passed electronically to my Bank/Building Society.

Signature(s): Date (dd/mm/yy):

Banks and Building Societies may not accept Direct Debit Instructions for some types of accounts.

The Direct Debit Guarantee

DIRECT Debit

This guarantee should be detached and retained by the Payer

- This Guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by your own Bank or Building Society.
- If the amounts to be paid or the payment dates change InterGlobal Insurance Company Limited will notify you 10 working days in advance of your account being debited or as otherwise agreed.
- If an error is made by InterGlobal Insurance Company Limited or your Bank or Building Society you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us.

Credit Card Authority

To InterGlobal Insurance Company Limited

I hereby authorise the Card Account specified below may be debited with the current premium due, and all subsequent renewal premiums due as notified by InterGlobal until I give notice in writing that I wish to terminate this agreement. I understand that InterGlobal will give at least 4 weeks notice of renewal, and that the premiums may vary each year. I understand that InterGlobal cannot be held liable if my plan is lapsed should the credit card be declined and I do not respond to requests for alternative methods of payment.

Please complete in BLOCK CAPITALS.

Name *(as it appears on your card)*:

Please tick the appropriate:

☐ MasterCard ☐ Visa ☐ American Express

My Card Number is:

Issue Date: Expiry Date:

My Card billing address is:

Postcode:

Please charge the above card *(please tick)*

☐ Yearly ☐ Quarterly ☐ Monthly

☐ GB £ ☐ US $ ☐ euros €

Signature(s): Date (dd/mm/yy):

InterGlobal

Innovations in International Private Medical Insurance

1 April 2007

InterGlobal
Innovations in International Private Medical Insurance

UltraCare Plan

Individual & Family Application Form - addendum

Moratorium Underwriting Clause

It is important that you read, understand and accept all of the paragraphs in the following declaration for your InterGlobal application to be underwritten under this Moratorium Underwriting Clause.

This declaration applies equally to you and to any eligible dependant(s) you have included within the application form.

Moratorium means a waiting period of twenty-four (24) months from the date of joining, or the date specified on the special terms section of your Certificate of Insurance, that must have elapsed before claims for pre-existing medical conditions may be eligible for cover under the policy/plan.

Pre-existing means any medical or related medical condition which has one or more of the following characteristics:

- was foreseeable,
- manifested itself,
- the person had signs or symptoms of,
- the person sought advice for,
- the person received treatment for, or,
- to the best of the person's knowledge, was aware existed.

After a period of twenty-four (24) months continuous cover under the policy/plan, pre-existing medical conditions may become eligible for benefit, if the person concerned has not:

- experienced symptoms,
- sought advice,
- required treatment, medication, or special diet, or,
- received treatment, medication, or special diet

If the person concerned has experienced any of the above, he/she will be required to wait a further twenty-four (24) months from the last date of treatment and must meet the above criteria, before being eligible to claim benefit for the pre-existing medical condition in question. This constitutes the rolling part of the Moratorium.

Declaration

I confirm that I have read, understood and accept this Moratorium Underwriting Clause relating to pre-existing medical conditions and that it applies equally to any eligible dependant(s) included within the application form.

Signature:	Date:
Name (in block capitals):	

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.