

# EXPATHEALTH PLAN – PROPOSAL FORM



Please complete this form and return it to your agent / insurance broker.  
It is important that you complete this form fully.  
Failure to do so may result in the form being returned to you for completion.

All proposals are reviewed prior to acceptance and therefore no cover shall be granted until confirmation is provided.

## 1. Your personal details

Title (Mr/Mrs/Ms/Miss/Other): \_\_\_\_\_ Forenames: \_\_\_\_\_

Surname: \_\_\_\_\_ Date of Birth (DD/MM/YY): \_\_\_\_\_

Overseas Residential Address: \_\_\_\_\_  
Post/Zip Code \_\_\_\_\_

Telephone no: \_\_\_\_\_ Moblie no: \_\_\_\_\_

Fax No: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Post/Zip Code \_\_\_\_\_

Nationality: \_\_\_\_\_ Occupation: \_\_\_\_\_

Occupation of spouse: \_\_\_\_\_

Country of residence: \_\_\_\_\_ Home Country: \_\_\_\_\_

How long have you been resident in your country of residence (Years/Months)? \_\_\_\_\_

Have you or any of the people to be included in this proposal, ever been refused cover by an insurance company or been accepted on special terms ? Yes  No  If yes provide details on a separate sheet.

## 2. Cover Required

Date upon which annual cover to commence, or the date on which your proposal is accepted by insurers, whichever is the later.  
(DD/MM/YY) \_\_\_\_\_

Choose your area of cover and tick the relevant box:

- Area 1 Worldwide excluding the USA and Canada
- Area 2 Worldwide excluding the USA and Canada but with 90 days accident and emergency cover in the USA and Canada
- Area 3 Worldwide

Choose your level of cover and tick the relevant box:

- Bronze
- Silver
- Gold

If you would like to increase the standard excess please enter here (£/€/€/\$): \_\_\_\_\_

*Details of the excess options available are shown on the benefits table*

Please tick the currency in which you wish to pay premiums and receive benefits:

- US Dollar \$
- Sterling £
- Euro €

### 3. Dependants to be included

Full name of dependants	Relationship to proposer	Date of birth (DD/MM/YY)	Sex M/F	Nationality	Occupation
		(DD/MM/YY)			
		(DD/MM/YY)			
		(DD/MM/YY)			
		(DD/MM/YY)			
		(DD/MM/YY)			
		(DD/MM/YY)			
		(DD/MM/YY)			
		(DD/MM/YY)			
		(DD/MM/YY)			
		(DD/MM/YY)			

Do you or anyone included in this proposal, participate in any occupation, sport, pastime or activity which is likely to involve extra risk in connection with this plan ? (eg, Mountaineering , Hang Gliding or other sports) Yes  No   
 If Yes, please give details :

### 4. Medical declaration (If there is insufficient room, please continue answers on a separate sheet).

#### Statement one

Do you or any one included in this proposal have any physical defect or infirmity ? Yes  No  If yes give details below

Name	Nature of illness or injury	Details and dates of treatment	Present state of health / prognosis

#### Statement two

Have you or anyone included in this proposal, ever suffered from any recurring illness or injury, whether or not medical attention was sought? Yes  No  If yes give details below

Name	Nature of illness or injury	Details and dates of treatment	Present state of health / prognosis

### Statement three

Have you or anyone included in this proposal ever undergone a surgical operation or do you have reason to believe that a surgical operation will be required in the future? Yes  No  If yes give details below

Name	Nature of illness or injury	Details and dates of treatment	Present state of health / prognosis

### Statement four

Have you or anyone included in this proposal, consulted with a medical practitioner in the last 5 years or will need to do so in the foreseeable future? Yes  No  If yes give details below

Name	Nature of illness or injury	Details and dates of treatment	Present state of health / prognosis

### 5. Moratorium

This policy has a two year moratorium. This means that pre-existing conditions will not be covered during the first two years of the policy. After this a pre-existing condition may be covered if a period of two consecutive years has elapsed since any symptoms, treatment, medication, tests or advice was received for that condition.

### 6. Data Protection Act 1998

Morgan Price International Healthcare Ltd is registered under the data protection act 1998. We will collect information in the course of your dealings with us regarding your personal details (including but not limited to your sex, age, ethnic origin and state of health). Any information we do collect will only be used for the purpose of conducting our relationship with you and will be used for the purposes of underwriting your insurance cover, managing the policy we issue for you, and administering any claims you may make. We may need to transfer some or all of this information to our insurance underwriters, their claims handlers, medical assistance companies or other medical practitioners. You have the right to access any details that we hold about you and to amend or delete anything that you may believe is inaccurate or out of date. By signing this declaration you are consenting to us using the information we hold about you in the ways described above. Without this consent we are unable to offer you any insurance cover.

### 7. Declaration

- I / We have read the policy wording and I / We understand it to be part of the contract of insurance. In particular I/We have read, understand, and accept the definitions, benefits, exclusions of the policy especially the one relating to pre existing conditions.
- I / We have read, understand and accept sections 5 and 6 of this Proposal.
- To the best of my / our knowledge and belief the information given in connection with this proposal, whether in my hand or not, is true and I / We have not withheld any material facts. I / We understand that non-disclosure or misrepresentation of any material fact may entitle the insurer to void the insurance. A material fact is one which is likely to influence acceptance or assessment of this proposal by the insurer. If you are in any doubt as to whether a fact is material or not you must disclose it, on a separate sheet if necessary. This proposal and the information provided in connection therewith contains statements upon which the insurers will rely in deciding whether to accept this insurance and in determining the terms and conditions of such acceptance.
- I / We understand that the signing of this proposal does not bind me / us to complete, or insurers to accept this insurance.
- If I/We have elected to pay our premium by instalments using credit or debit cards and Morgan Price have agreed to this, I/we authorise Morgan Price to continue to deduct such instalments as and when they become due unless I/we cancel this credit card authorisation by giving at least 14 days notice in writing. I/we understand that if I/we have made a claim, no refund will be due and I/we will have to pay any outstanding instalments due in the current period of cover.

Signature of Primary Applicant

Date

## 8. Premium Payment

### A. Payment method

- Annually by credit card, cheque, bank transfer (details supplied on request)
- Semi annually by credit card
- Quarterly by credit card
- Monthly by credit card

### Additional surcharges (Credit/Debit Cards Only):

Annual payment	0%	(Amex +3%)
Semi annual payments	+4%	(Amex +6%)
Quarterly payments	+5%	(Amex +7%)
Monthly payments	+8%	(Amex not available)
Annual bank transfer	£10/€15/\$18	

\* If paying by Credit Card please complete the instruction below.

\*\* If paying by cheque, please remember to attach a cheque for the full annual premium to this form when you return it.

### B. Credit Card Authorisation form

#### Please only complete if you are paying by Credit Card

I authorise you, until further notice in writing, to charge my Credit Card Account unspecified amounts in respect of premiums for my ExpatHealth Plans subscription, as and when these become due, until this instruction is countermanded by my giving notice in writing. I understand I will be given at least one months notice of any subscription increase.

Name on card

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Visa    Mastercard    American Express    Other

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Credit Card Number

Expiry Date:

---

Payment frequency:

---

Address of Cardholder if different from Residential Address:

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Signature of Cardholder

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Date

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Agent Stamp

Agent Reference / Details – Office Use only

MPNA

Comm

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