

# 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.  
NOTE: Please select which address you want us to use for any claims correspondence 1.1  or 1.2  please tick one.

## 1. Your Personal Details

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

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

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

Telephone no: \_\_\_\_\_ Mobile No: \_\_\_\_\_

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

1.2 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	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)			
		(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. Any medical conditions declared in Section 4 above are subject to the 2 year moratorium and your disclosure does not alter, amend, waive or constitute acceptance for cover of these declared medical conditions.

### 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 and 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/debit card, cheque, bank transfer (details supplied on request)
- Semi annually by credit/debit card
- Quarterly by credit/debit card
- Monthly by credit/debit card

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

Annual payment	0%
Semi annual payments	+4%
Quarterly payments	+5%
Monthly payments	+8%

For Amex payments add an additional 3.5% to the surcharges above

Annual bank transfer      £10/€15/\$18

- (i) If paying by credit/debit card please complete the instruction below.
- (ii) If paying by cheque, please remember to attach a cheque for the full annual premium to this form when you return it.

### B. Credit/Debit Card Authorisation form

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

I authorise you, until further notice in writing, to charge my Credit/Debit 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.

- (i) If you have chosen to pay by instalment, the credit/debit card details provided must be in date for the entirety of the policy.

Name on card \_\_\_\_\_

Visa     Mastercard     Maestro     Other \_\_\_\_\_

Card Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Start Date: \_\_\_\_\_

Expiry Date: \_\_\_\_\_

Card Verification Code: \_\_\_\_\_

Issue No: (Maestro Only): \_\_\_\_\_

Payment frequency: \_\_\_\_\_

Address of Cardholder if different from Residential Address: \_\_\_\_\_

Signature of Cardholder \_\_\_\_\_

Date \_\_\_\_\_

- (ii) You must keep your credit/debit card details confidential and secure. For security reasons please do not email credit/debit card details to us. If you do so, it is entirely at your own risk.

Agent Stamp