AIG American International Underwriters, Limited
(Insurance Agent Reg. No.: 95902947)
A Member of American International Group, Inc.

GlobalHealth®

INDIVIDUAL/FAMILY APPLICATION FORM I

To assist in processing your application please write using BLOCK CAPITALS

Proposer Details:

Name (last, first, middle): ______________________________

Location and Contact Details:

Residential Address (must be filled in)

Address: ______________________________

City: ______________ Postal Code: __________

Country: ______________________________

Telephone: ______________________________

Facsimile: ______________________________

Email: ______________________________

Correspondence Address (if different from residential address)

Address: ______________________________

City: ______________ Postal Code: __________

Country: ______________________________

Telephone: ______________________________

Facsimile: ______________________________

Email: ______________________________

	Global HK 100	Global HK 350	Global HK 400
Plan Requested	☐	☐	☐
Plan Options	**Global HK 100**	**Global HK 350**	**Global HK 400**
Worldwide (including North America)	N/A	☐	☐
Maternity	N/A	☐	☐
Dental	N/A	☐	☐
Annual Travel Protection	☐	☐	☐
Personal Accident – Sum Assured *(All Sum Assured limits are available to each plan level)*	US$100,000 ☐	US$250,000 ☐	US$500,000 ☐

Requested Effective Date ______________

Global HK 100 – Deductible Amount: US$ ______________

Global HK 100 Options: Increase Room and Board by ___ units of US$50 (max. of 7 units)

Increase Surgeon Fee Limit by ___ units of US$5,000 (max. of 5 units)

- If you have selected Personal Accident cover, please fill in the separate Personal Accident Application Form.
- For information on premium rates, please refer to the Premium Tables booklet.

Dependents to be Insured – Name (last, first, middle)

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(Please use a separate sheet if you have more dependents. Note, the Proposer and each Dependent must complete an Application Form II (Medical Questionnaire)

Declaration by Proposer

I/we hereby apply for a policy to be issued based on the statements contained in Forms I & II and declare that all answers to the foregoing questions are correctly recorded, and that they are full, complete and true. Except as declared herein, all persons to be insured are currently in good health. I/we agree that the policy as issued including all schedules, endorsements, and this application shall form the whole contract and that no insurance shall be in force until and unless the application has been accepted, and the appropriate premium paid.

Printed Name/Title Signature Date

Please send completed application and your cheque or money order in US Dollar or HK Dollar equivalent made payable to **GlobalHealth Asia Limited** to: GlobalHealth Asia Limited, Suite 1401-3, Chinachem Hollywood Centre, 1-13 Hollywood Road, Hong Kong.

DATA PRIVACY: It is hereby declared that as a condition precedent to the liability of the Company, the Insured Person(s) has agreed that any personal information collected or held by the Company is provided and may held, used and disclosed by the Company to individuals/organizations associated with the Company or any selected third party (within or outside Hong Kong) for the purpose of processing the application and providing subsequent services for this and other financial products and services, direct marketing, data matching, and to communicate with the Insured Person(s) for such purposes. The Insured Person(s) has the right to obtain access to and to request correction of any personal information held by the Company concerning the Insured Person(s). Such request can be made to the Company's Data Privacy Officer at GPO Box 456, Hong Kong.

(Please see reverse side for important premium payment information)

Premium Payment

☐ **A. Cheque Payment or Money Order**
Please make your US Dollar cheque or money order made payable to "GlobalHealth Asia Limited"

☐ **B. Bank Transfer**
For direct premium remittances, please send full payment (inclusive of all bank charges) to:

Intermediary Bank

ABA No.:	026009593
Recipient Bank:	Bank of America N.A., New York, USA CHIPS UID 009953
Account No.:	6550-4-90452
Swift Address:	BOFAUS3N

Beneficiary Bank

Bank:	The Bank of East Asia, Limited. Hong Kong
Account Holder:	GlobalHealth Asia Limited
Account No.:	015-521-50-00072-4 (US$ Account)
Swift Address:	BEASHKHH (SWIFT MT103)

Note:
1. All bank charges will be borne by the remitter
2. Please indicate your Policy Number as payment details to your bank
3. Please fax (+852 2526 0769) or email the bank remittance advice or instruction slip with your Policy Number to GlobalHealth for our accounting records and to issue an Official Receipt.

☐ **C. Credit Card.**
Premiums may be paid by Visa or MasterCard using the Credit Card Authorization below:

Credit Card Payment Authorization

I/we, the undersigned, authorize you to charge my credit card for payment of GlobalHealth insurance premiums as stated below:

☐ Visa ☐ MasterCard

Card Number : ☐☐☐☐ – ☐☐☐☐ – ☐☐☐☐ – ☐☐☐☐

Name of Issuing Bank : ______________________

Card Holder's Name : ______________________

Expiry Date : ☐☐ ☐☐
m m y y

☐ For US$ ______________

______________________ ______________________
Signature Date

Please note:
1. Card payment and effectiveness is subject to the credit card centre's approval.
2. All charges will be made in Hong Kong dollars at the exchange rate(s) then in force.

Producer Name: ______________ Producer Code: ______________
Address: ______________________
Contact No: ______________ Facsimile No: ______________
Email address: ______________________

Administrator: GlobalHealth Asia Limited
Suite 1401-3, Chinachem Hollywood Centre, 1-13 Hollywood Road, Hong Kong
Telephone: (852) 2526-0505 Facsimile: (852) 2526-0769
Email: globalhealth@globalhealthasia.com.hk Web: www.globalhealthasia.com

GH04/07

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GlobalHealth®

APPLICATION FORM II (MEDICAL QUESTIONNAIRE)

To assist in processing your application please write using BLOCK CAPITALS

Please Note: Each person seeking medical insurance must complete this form in full. This applies to all employees and their family members when applying as part of a Company Medical Policy and all family members of the Proposer for an Individual Medical Policy.

Proposer Details:

Name (last, first, middle OR Company Name): ______________________________
(When applying as part of a Company Medical Policy, the Proposer is the Company)

Employee Name:

Employee Name (in case of Company Medical Policy): ______________________________

Applicant's Details:

Relationship to Proposer OR Employee: (Employee, Self, Spouse, Child) ______________________________

Name (last, first, middle): ______________________________

Date of Birth: ____________ Sex: ☐ M ☐ F Height (cm): ________ Weight (kg): ________ Smoker: ☐ Yes ☐ No

Residential Address: ______________________________

______________________________ Email: ______________________________

Occupation (specific nature of business & duties): ______________________________

Citizen of: ______________________________ Passport/ID No.: ______________________________

Important note about filling in this form:
The answers you give to the questions contained in this Application will form the basis of any insurance policy issued, and will be incorporated into the contract. It is essential that you give accurate, truthful, and complete information for all persons to be insured, as inaccuracies may jeopardize coverage or invalidate a claim.

1. Does this person reside outside of the Usual Country of Residence shown on Form I? If yes, please state which country. ☐ Yes ☐ No

2. Does this person's occupation include any activities involving offshore, underwater, underground, or manual work, or work in a remote location? If yes, please give details. ☐ Yes ☐ No

3. Has this person previously applied for or held a GlobalHealth policy? If "Yes", please provide policy number. ☐ Yes ☐ No

4. Does this person have health insurance with another insurance company? If "Yes", please attach a copy of the policy and benefit schedules, and indicate if the other coverage will be continued if the GlobalHealth application is approved. ☐ Yes ☐ No

5. Has this person ever had a policy or application for life, sickness, accident disability, critical illness or medical insurance refused, postponed, declined, withdrawn, or had any special terms (including extra premium or exclusions) imposed? If "Yes", please provide full details. ☐ Yes ☐ No

6. Has this person been in a hospital for treatment or observation or undergone any surgical procedure? If "Yes", please provide the date, diagnosis, and nature of treatment. ☐ Yes ☐ No

7. Within the last five years, has this person suffered from, been treated for, sought advice on, or had symptoms relating to any of the following conditions:

   a) Cancer, leukaemia, tumour of any kind (benign or malignant) or blood disorder? ☐ Yes ☐ No

   b) Asthma, chronic bronchitis, chronic sinusitis, allergies, deviated nasal septum, tuberculosis, or any disease or disorder of the lungs? ☐ Yes ☐ No

   c) Chest pain, raised blood pressure, heart condition, rheumatic fever, varicose veins or circulatory disorder? ☐ Yes ☐ No

   d) Indigestion, gastric or duodenal ulcer, hernia, haemorrhoids or any disease or disorder of the bowel? ☐ Yes ☐ No

   e) Kidney stones, urinary tract infections or complaint, venereal disease, or any disease or disorder of the kidney, bladder, prostate or genitor-urinary tract? ☐ Yes ☐ No

   f) Diabetes or any disease or disorder of the gall bladder, pancreas or liver, including Hepatitis B or Hepatitis C? ☐ Yes ☐ No

   g) Disease of the brain, nervous system, stoke, epilepsy? ☐ Yes ☐ No

   h) Mental health disorder, depression, anxiety, nervous condition, stress, post traumatic stress disorder, behavioural problem, alcohol or drug addiction? ☐ Yes ☐ No

   i) Back or neck pain or strain, spinal condition, sciatica, whiplash, arthritis, bone fracture, joint injury e.g. knee, elbow, wrist, shoulder, hallux valgus (hammer toes) or experienced any symptoms of a muscle disorder or gout? ☐ Yes ☐ No

   j) Malaria, dengue fever, typhoid or any other tropical disease? ☐ Yes ☐ No

   k) HIV, AIDS (acquired immune deficiency syndrome), AIDS related condition or had any positive blood test for the HIV (also called AIDS or HTLV-III) virus? ☐ Yes ☐ No

   l) Pregnancy or any complications of pregnancy, abnormal smear test or any gynaecological disorder? (female only) ☐ Yes ☐ No

   m) Psoriasis, eczema, dermatitis or other skin condition or any disease or disorder of the eyes or ears? ☐ Yes ☐ No

   n) Any other ailment, impairment, injury or condition(s) not mentioned above? ☐ Yes ☐ No

   If yes to any of the above questions, please provide full details and include all relevant up-to-date medical reports. (Attach separate sheet if necessary)

8. Is this person taking any medication or receiving any form of treatment at the present time? If "Yes", please provide the medical condition, name of medication and dosage, and/or treatment. ☐ Yes ☐ No

9. Has this person been advised to have or do they intend to seek any medical advise, test, investigation, surgical procedure, hospitalization, or treatment in the near future? If "Yes", please provide the medical condition, attending physician, and recommended treatment. ☐ Yes ☐ No

10. Please provide the following information about this person's current usual doctor/personal physician/medical centre or hospital:

    Name: ______________________________

    Address: ______________________________

    Telephone: ______________ Facsimile: ______________ Email: ______________

    How long has this person been under this physicians care: ______________________________

    Date of last attendance & reason: ______________________________

Declaration by Applicant

I/we hereby apply for a policy to be issued based on the statements contained herein and declare that all answers to the foregoing questions are correctly recorded, and that they are full, complete and true. Except as declared herein, all persons to be insured are currently in good health. I/We agree that if the health status of the above intended insured person changes after this application is signed and before the Company issues a policy I/We shall immediately notify the Company of the change. I/we agree that the policy as issued including all schedules, endorsements, and this application shall form the whole contract and that no insurance shall be in force until and unless the application has been accepted, and the appropriate premium paid.

____

Printed Name/Title　　Signature　　Date

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