Pacific Prime International - Asian Plans

Application Form

Please read the following carefully, completing all relevant information in **BLOCK CAPITALS** and ticking ☑ the relevant boxes

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1 Applicant's Details.

It is important that you notify us of any change of contact details so we can ensure that all correspondence reaches you.

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other _____ First Name _____

Other Initials _____ Surname _____

Correspondence Address _____

_____

_____

Home Telephone COUNTRY CODE _____ – AREA CODE _____ – _____

Office Telephone COUNTRY CODE _____ – AREA CODE _____ – _____

Mobile Telephone COUNTRY CODE _____ – NETWORK CODE _____ – _____

Fax COUNTRY CODE _____ – AREA CODE _____ – _____

Email Address _____

Are these the contact details that we can use to contact you for reimbursement of Claims and to arrange Treatment Guarantee? Yes ☐ No ☐

Please indicate by which method you would prefer us to communicate with you: Fax ☐ Phone ☐ Email ☐ Mail ☐

The following details are only to be completed if you are applying to join an existing Group Scheme:

Group Name _____

Group Number _____

2 Details of Persons to be Covered - Policyholder.

Please enter the details of all persons to be covered under this policy including the policyholder. This can include your spouse/partner and any children financially dependant on the policyholder and not more than 18 years old, or not more than 24 years old if in full-time education. Where the child is greater than 18 years old, please attach a letter from college/university confirming student status.

Policyholder

Gender Male ☐ Female ☐ Date of Birth d d m m y y

Occupation _____

Home Country _____

Country of Residence _____

Nationality _____

Passport Number _____

Details of any current domestic or international health insurance:

Name of Insurer _____

Policy Number _____ Start Date d d m m y y

Details of Persons to be Covered - Dependants.

Dependant 1

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other | First Name

Surname

Relationship to Policyholder: Spouse ☐ Child ☐ | Gender: Male ☐ Female ☐ | Date of Birth d d m m y y

Occupation

Home Country

Country of Residence

Nationality | Passport Number

Details of any current domestic or international health insurance:

Name of Insurer

Policy Number | Start Date d d m m y y

Dependant 2

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other | First Name

Surname

Relationship to Policyholder: Spouse ☐ Child ☐ | Gender: Male ☐ Female ☐ | Date of Birth d d m m y y

Occupation

Home Country

Country of Residence

Nationality | Passport Number

Details of any current domestic or international health insurance:

Name of Insurer

Policy Number | Start Date d d m m y y

Dependant 3

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other | First Name

Surname

Relationship to Policyholder: Spouse ☐ Child ☐ | Gender: Male ☐ Female ☐ | Date of Birth d d m m y y

Occupation

Home Country

Country of Residence

Nationality | Passport Number

Details of any current domestic or international health insurance:

Name of Insurer

Policy Number | Start Date d d m m y y

Dependant 4

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other | First Name

Surname

Relationship to Policyholder: Spouse ☐ Child ☐ | Gender: Male ☐ Female ☐ | Date of Birth d d m m y y

Occupation

Home Country

Country of Residence

Nationality | Passport Number

Details of any current domestic or international health insurance:

Name of Insurer

Policy Number | Start Date d d m m y y

If there is not sufficient space for all Dependants, please use another Application Form.

3 Policy Commencement Date.

Please indicate the month and year on which you wish your cover to commence.

Please note that for individual policyholders, your policy can only commence on the first day of the month: 0 1 m m y y

However, if you are applying to join a Group Scheme, you can specify the date you require cover from: d d m m y y

Cover is conditional upon acceptance of your Application, which is only confirmed when an Insurance Certificate is issued to you.

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4 Plan Details.

(This section does not need to be completed if you are applying as part of a Group Scheme).

Please tick ☑ to indicate the type of plan(s) and deductible you require:

Core Plan		Out-patient		Out-patient Deductible		Repatriation	
Elite	☐	OP1	☐	0	☐	Repatriation Plan	☐
Select	☐	OP2	☐	$125	☐		
Essential	☐	OP3	☐	$250	☐		
Vital	☐			$625	☐		
				$1,250	☐		

Please note that the out-patient and repatriation plans can only be purchased in addition to a core plan, they cannot be purchased separately. Also, please note that the type of plan you select can only be amended at policy renewal.

Please tick ☑ to indicate the area of cover you require: Worldwide ☐ Worldwide excl. USA & Canada ☐

5 Payment Details.

(This section does not need to be completed if you are applying as part of a Group Scheme).

No payment should be made until you have been notified of your Insurance Number.

5.1 Payment Frequency and Method

Please tick ☑ to indicate the payment frequency and method you will use:

	Annual	Half yearly	Quarterly	Monthly
Credit Card	☐	☐	☐	☐
Cheque	☐	Not Available	Not Available	Not Available
Bank Transfer	☐	Not Available	Not Available	Not Available

5.2 Credit Card Payment Details

If you choose to pay by credit card please provide the following information:

Type of credit card MasterCard ☐ VISA ☐

Card Number |_|_|_|_| — |_|_|_|_| — |_|_|_|_| — |_|_|_|_|

CVC Code* |_|_|_| Expiry date |m|m| |y|y|

Credit Card Authorisation

I authorise Allianz Worldwide Care to charge my credit card account unspecified amounts in respect of premiums for my healthcare cover as and when these become due, until the instruction is cancelled by my giving written notice to Allianz Worldwide Care. I understand I will be given one month 's notice of any premium increase.

Cardholder's Name |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Cardholder's Signature _____ Date |d|d| |m|m| |y|y|

**CVC Code: The last three digits after the card number on the back of the card or the last 3 digits in the signature field.*

Payment Charges and Details

Payments are subject to the following administration surcharges:
2% for half yearly payments,
3% for quarterly payments and
4% for monthly payments.
There are no administration charges for annual payments.

- All cheque payments must be made payable to Allianz Worldwide Care, with the policyholder's name and insurance number marked clearly on the back of the cheque
- All bank transfers must be clearly marked with the Policyholder's name and Insurance Number
- We will only accept payment by credit card via MasterCard or VISA
- Allianz Worldwide Care does not accept liability for any payment which does not clearly identify the policyholder
- Please note that Insurance Premium Tax and other Government Levies may apply. Where such taxes or levies apply, they will be detailed on your Invoice/Payment Details

6 Pre-existing Conditions.

Pre-existing Conditions are not covered unless they have been declared by you in the Health Declaration section and accepted by Allianz Worldwide Care. Conditions arising between signing the Application Form and confirmation of acceptance by the underwriting department of Allianz Worldwide Care will equally be deemed to be pre-existing. Therefore, it is necessary that you advise us of any material changes to the information provided, between submission of this application and acceptance by us.

You are hereby obliged on request to provide any further information that we might require.

Pre-existing Conditions are medical conditions or any related conditions, for which symptom(s) have been shown at some point during the five years prior to commencement of cover, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition about which you or your dependants know, knew or could reasonably have been assumed to have known, will be deemed to be pre-existing.

7 Health Declaration.

All information supplied will be treated in strict confidence. All material facts including those relating to these questions must be disclosed. Failure to do so may invalidate the Policy. A material fact is any information that would be likely to influence the insurer's assessment and acceptance of this Application Form. If you are in any doubt whether a fact is material then it should be disclosed.

	Policyholder	Dependant 1	Dependant 2	Dependant 3	Dependant 4
1. Height/Weight	cm ⌊_____⌋ kg ⌊_____⌋	cm ⌊_____⌋ kg ⌊_____⌋	cm ⌊_____⌋ kg ⌊_____⌋	cm ⌊_____⌋ kg ⌊_____⌋	cm ⌊_____⌋ kg ⌊_____⌋
2. Are you currently suffering from any complaints, illnesses, after-effects of an accident, mental or physical disabilities, psychiatric disorders and chronic/long term medical or dental conditions?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
3. Have you ever suffered from, been in hospital with, or received treatment, tests or investigations for:					
a) Rheumatism, gout, arthritis or disease of the muscles or joints including the back	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
b) Epilepsy or other neurological disorders	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
c) Any digestive disorder including stomach and/ or bowel problems	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
d) Anxiety, depression or psychiatric or mental illness	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
e) Gynaecological disorders	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
f) Any disorder of the kidneys, bladder or liver/ pancreas including diabetes	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
g) Any lump, cyst, mole or cancer	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
h) Any skin disorder	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
4. Have you ever been advised to consult a doctor for a recurrent complaint, or been advised to have any diagnostic test or treatment which has not been completed or that you still await the results of?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
5. Have you been tested for HIV-antibodies?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If yes, please state when:	dd /mm/ yy	dd /mm/ yy	dd /mm/ yy	dd /mm/ yy	dd /mm/ yy
Was the result HIV-positive?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6. Have you ever suffered from or been in hospital for any other disorder or as a result of an accident which required that you:					
a) Received more than 14 days treatment?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
b) Were off work for more than one week?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
c) Had specialised treatment?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
7. Are you pregnant?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Please state expected date of childbirth:	dd /mm/ yy	dd /mm/ yy	dd /mm/ yy	dd /mm/ yy	dd /mm/ yy
8. Have either of your parents or any of your brothers or sisters, living or deceased, suffered before the age of 65, from diabetes, heart disease, high blood pressure, cancer, kidney disease, raised cholesterol, nervous or brain disorders such as Alzheimer's, Parkinson's, or M.S., eye, hearing or speech disorders or any family disorder?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
9. Have you had cancer screenings or general check-ups within the last 5 years?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10. Have you smoked (or used any tobacco products or substances) within the last 12 months?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If yes, please confirm the following:					
Amount:					
Type:					
11. If you have consumed alcohol in the past 12 months please confirm the average amount of alcohol consumed per week.					

Health Declaration (continued).

Please state the name, address and telephone number of your family doctor or details of your last consultation:

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other First Name

Surname

Address

Telephone Number COUNTRY CODE — AREA CODE —

Date of last visit d d m m y y

Additional Information.

If you answered 'Yes' to any of the questions from 2 to 9, please give all necessary details in the box below (in BLOCK CAPITALS).
Failure to provide complete information may result in Allianz Worldwide Care seeking this information from your family doctor. This may in turn result in a delay in proceeding with any application. **If in doubt whether a fact or information is material then it must be disclosed.**

Name	Number of Question with 'Yes' answer	Where applicable, please provide date of 1st diagnosis/consultation, name and address of treating physician, frequency and severity of symptoms, date of last episode as well as details of any past, current and known future treatment.

If there is not sufficient space for your additional information, please use another Application Form.

8 Dental Declaration.

(Should only be completed if you are purchasing Dental cover).

	Policyholder	Dependant 1	Dependant 2	Dependant 3	Dependant 4
a) Are you currently undergoing, or have you been advised to undergo any treatment?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
b) Do you have missing teeth which have not been replaced (excluding wisdom teeth)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
c) Have you denture sets (crowns, inlays, implants, bridges, fillings etc.)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
d) Do you suffer from parodontosis?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
e) Have you had a dental check up within the last five 5 years?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If YES, when and what was the result: Date:	dd /mm/ yy	dd /mm/ yy	dd /mm/ yy	dd /mm/ yy	dd /mm/ yy
Outcome:					

If you answered 'Yes' to questions A to D, your family dentist will need to complete a dental questionnaire, which can be downloaded from our website www.allianzworldwidecare.com (under section called "Pdf Forms"). Alternatively, you can contact our Helpline or email client.services@allianzworldwidecare.com

Dental Declaration (continued).

Please state the name, address and telephone number of your family dentist:

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other | First Name

Surname

Address

Telephone COUNTRY CODE — AREA CODE —

9 Data Protection Legislation.

Allianz Worldwide Care would like to assure you that all personal information and medical data will be dealt with in strict confidence and in accordance with European Union Data Protection Legislation. Personal data may be given to hospitals and / or medical providers in relation to medical insurance claim services provided by us to you. You have a right to access the personal data that is held about you. You also have the right to amend or delete any information we hold about you if you believe that it is inaccurate or out of date. Allianz Worldwide Care, any of the Allianz Group companies or an organisation appointed by us, might contact you in the future in relation to other products/services that you might be interested in.

If you do not wish to receive information on other products or services from us, please tick ☑ this box. ☐

10 Declaration.

(a) I declare, that all information supplied above is true and complete, including those answers that are not in my own handwriting. I also declare that I have not suppressed, misrepresented or misstated any material fact. I understand that this application shall be the basis of the contract between Allianz Worldwide Care and I, and that any false, incorrect or misleading statement may render this insurance null and void.

(b) I undertake to inform Allianz Worldwide Care immediately in writing of any changes in my or my dependants' state of health occurring after the Application Form has been signed and before the Commencement Date.

(c) I understand that I can withdraw my application in writing by letter, email or fax, within 14 days from the policy commencement date and provided that I have not submitted a claim, I am entitled to a full refund of the premium.

(d) I accept that it is my responsibility to check the accuracy of the information contained within the Insurance Certificate once issued. If the content is not in accordance with the Application Form, the situation will be considered accepted if I enter no protest within 14 days following the issue date of the Insurance Certificate.

(e) I consent to the fact that Allianz Worldwide Care, if it considers it appropriate, will check statements concerning my health condition and will check with other health insurers all statements concerning previous, or existing contracts applied for. I authorize all such practitioners, physicians, dentists, members of medical professions, employees of hospitals and health authorities as well as medical facilities to release my medical records to Allianz Worldwide Care. I also make this statement for my co-insured children as well as for the co-insured persons for whom I am responsible, or those who cannot assess the meaning of this statement.

(f) I accept that this policy will be subject to the standard Policy Terms and Conditions effective at the time of policy commencement. I confirm that I have read and understand the full Definitions, Benefits, Exclusions and Conditions of this Policy including the exclusion relating to Pre-existing Conditions.

Applicant's Signature

Signature of all Adult Dependants

Date d d m m y y

For office use only - Agent details and stamp

PACIFIC PRIME INTERNATIONAL

Thank you for completing your membership Application Form. Please ensure that you have completed the following:

- ☐ Please ensure that your contact details are correct as we will use this to communicate with you in the future
- ☐ Information in section 7 - Health Declaration is complete and correct
- ☐ Payment method and details have been completed in full
- ☐ You have signed and dated the Declaration in section 10

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.