Individual Plan

MediCare INTERNATIONAL

Broker's stamp	Policy number Effective date *(Cover may not be backdated)*

Return completed form to your Financial Advisor or Broker or to:
MediCare International
One Hundred Whitechapel
London E1 1JG, England
Telephone: +44 (0)20 7816 2033
Facsimile: +44 (0)20 7816 2188
E-mail: medicare@medicare.co.uk
Website: www.medicare.co.uk

Individual Application Form

PLEASE COMPLETE IN BLOCK CAPITALS AND TICK RELEVANT BOXES

Your personal details

Applicant's full name:

Mailing address:

Postcode: Country:

Telephone: Facsimile: Email:

Occupation: Nationality:

(Which will be used to establish the Home Country of the Applicant and Dependants)

Cover required

International Plan ☐
International Plus Plan ☐
Executive International Plan ☐
Waive Outpatient Excess ☐

Area 1 Worldwide ex USA, Canada & Caribbean ☐
Area 2 Worldwide ☐

Persons to be insured – If you are aged 65 years or over, you will need to complete and return the medical questionnaire overleaf as special terms may apply to your cover.

Surname	First Names	Date of Birth	Sex	Country of Residence†	Area of Cover Required
Applicant:					
Spouse/Partner:					
*Child:**					
*Child:**					
*Child:**					
*Child:**					

**Up to the age of 18 or 24 if still in full-time education. Evidence will be required. †Restrictions may apply to certain countries considered to be war zones by underwriters.*

Please provide details of your regular treating physician or any physician with whom you have consulted in the last 2 years.
Physician:

Premium payment

I enclose my cheque for: £ ☐ € ☐
(NB: Cheques drawn on banks based outside the UK are not acceptable.
Payment in US$ or £STG may be made by direct transfer to our bank account.)

I authorise you to charge my Visa*/Mastercard*/Amex* account the sum of £ ☐

I hereby authorise that the Card Account specified above may be debited with the current premium due, and all subsequent instalment premiums due as notified by MediCare International until I give notice in writing that I wish to terminate this agreement. I understand that MediCare will give at least one month's notice of renewal, and that premiums may vary each year. I understand that MediCare International cannot be held liable if my Plan is lapsed should the credit/charge card be declined and I do not respond to requests for alternative methods of payment.

Card No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiry date ☐☐☐☐☐☐ Security Code (last 3 digits on back of card) ☐☐☐

Name of cardholder:

Address where bills are sent:

Data Protection Act

The information you have provided will become part of the personal data held by MediCare International and will be used for the provision and administration of insurance products and services. MediCare International may disclose your personal data to insurance companies and to their agents for underwriting, claims handling and fraud prevention services. In addition, it may seek information from insurance companies to check the answers you have provided. Full details of MediCare International's processing of personal data appear in the register maintained by the Information Commissioner.

Declaration

I hereby apply to be enrolled in the Plan together with the persons to be insured listed above. I declare to the best of my knowledge and belief that the information given in this application is true and complete. I have read and understood the Rules attached to this application particularly in relation to new born children and I understand them to be part of any contract of Insurance issued as a result of this application and agree they will be binding on me and all eligible dependants included in my membership. I acknowledge on behalf of all the persons to be insured that benefits will not apply to treatment arising from any Pre-Existing conditions as more fully defined in the rules of which I am in receipt. It is agreed that this declaration and the information given in this application shall form the basis of the contract(s) between the Insured Person(s) and the Insurer.

Signature of applicant: Date:

(On behalf of all persons to be insured)

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Medical Questionnaire (for 65 years and over only)

If you or your spouse are 65 years or older you must complete this form

PLEASE COMPLETE FULLY IN BLOCK CAPITALS AND TICK RELEVANT BOXES

Your personal details

Applicant's full name:

Spouse full name (if over 65):

Have you or any of the proposed Insured's who are 65 years or over had any surgical operation, been confined or treated in a hospital, sanatorium, nursing home or other medical institution within the last five (5) years or is any treatment currently being performed or any operation/hospital confinement scheduled?

Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No

Have you or any of the proposed Insured's who are 65 years or over had any treatment or tests performed by a general practitioner or specialist including the prescription of drugs within the last five (5) years?

Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No

Are you currently suffering from any medical condition or disability, or experiencing symptoms of any kind which might reasonably be considered to need medical treatment in the future?

Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No

If the answer to any of the above questions is 'YES' please give full details including dates, nature of ailment, medical procedure(s) or tests performed and drugs prescribed. Please state name and address of physician and/or medical facility where tests or treatment have been carried out.

Applicant:

Spouse:

Please give name and address of your normal attending (family) physician. If none, so state:

Applicant:

Spouse (if different to applicant):

SHOULD THE INFORMATION YOU PROVIDE ON YOUR APPLICATION FORM RAISE FURTHER QUESTIONS CONCERNING YOUR OR ANY OF THE PROPOSED INSURED'S STATE OF HEALTH, A 'COMPREHENSIVE HEALTH DECLARATION FORM' (NO MEDICAL EXAMINATION REQUIRED) WILL BE SENT TO YOU FOR COMPLETION AND FURTHER EVALUATION UPON RETURN.

Declaration

I declare that the answers to the above details are accurately represented and are to the best of my knowledge and belief, full, complete and true, and that I do not have any knowledge of any circumstance that could affect the results of the evaluation by the Insurer related to my application for insurance.

I authorise any physician or practitioner who has observed me or any of the proposed Insured's for diagnosis, treatment, disease or ailment, to give to the Insurer full particulars of these, including any prior medical history. I waive in my name, and that of any other person who shall have or claim an interest in any policy issued as a result of the answers, all provisions of law forbidding such action.

The refusal to submit medical information by any Insured or doctor, clinic, hospital or institution, shall be considered as a waiver of benefits by such Insured and/or supplier of services and the Insurer shall have no further obligation towards such persons or entity.

I consent to the processing by MediCare International of any of the personal data I provide or which is provided to Medicare International about me by any other person.

Signature of applicant:

Signature of spouse:

Date: