Pacific Prime International

MULTINATIONALS

ENROLMENT FORM

FOR INDIVIDUAL SCHEME FOR EXPATRIATES

INSURED (S):

I, the undersigned (Last name, first name) ____________________

Born on ____________________ *in* ____________________

Citizenship (s) ____________________

Mailing Address ____________________

____

Occupation ____________________

Telephone ____________________ *Email* ____________________

Country of Expatriation ____________________

I wish cover to begin | 01 | MM | YY |

and request that it is extended to my family members as listed below:

RELATIONSHIP	LAST NAME	FIRST NAME	DATE OF BIRTH
SPOUSE			
CHILDREN			

SUBSCRIBER'S DETAILS (if different from the Insured's) :

Name ____________________

Mailing Address ____________________

____

Telephone ____________________ *Email* ____________________

I hereby declare that I reside and work in a country other than my home country.

I have duly noted that enrolment in this plan shall be effective subject to

- Approval by the GMC Medical Board, based on a review of the health declaration duly filled out by each member and enclosed in a sealed envelope attached to this application for enrolment;
- The payment of an initial premium for six months of coverage (unless arrangements are made for Visa/Mastercard payment).

la garantie médicale et chirurgicale

Having taken note of the summarized general conditions, the scope of benefits and the terms of coverage and the corresponding premiums, I hereby apply for enrolment in the individual insurance plan for expatriate employees (please check the appropriate boxes).

☒ **MEDICAL EXPENSES + ASSISTANCE (Mandatory Basic Coverage)**

Zone:

❑ 1 ❑ 2 ❑ 3

Coverage level:

Mandatory Cover:

❑ ★ ❑ ★ ★

Optional Modules

❑ ★ ❑ module 1 ❑ module 2 ❑ module 3

❑ ★ ★ ❑ module 1 ❑ module 2 ❑ module 3

Persons to cover:		PREMIUMS
☒ Member		
❑ Spouse		
❑ Children under 21	______ x ______	
❑ Children 21 to 28	______ x ______	
TOTAL ANNUAL PREMIUM		

After the initial premium payment, I wish to be billed :

❑ Quarterly ❑ Every six months ❑ Annually

I wish to pay premiums:

❑ By cheque ❑ By bank transfer ❑ By Visa/Mastercard

Signed in (city, country) :

on (date) :

Signature of the member, preceded by the words “read and approved”

02/2003 - Réf. : 12187/2

MULTINATIONALS
HEALTH DECLARATION

Please complete this medical form for yourself, your spouse and your children.
Check the boxes corresponding to your answers

	INSURED	SPOUSE	FIRST CHILD	SECOND CHILD	THIRD CHILD	FOURTH AND SUBSEQUENT CHILDREN
Last name: *First name:* *Date of birth:* *Gender:* *Height:* *Weight:* *Blood pressure:*						
Are you currently on sick leave?	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
Over the past 5 years, have you ever been on sick leave for more than 15 consecutive days due to illness or accident?	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
Are you currently undergoing medical treatment or are you on a diet or under any kind of health monitoring, or has this been the case over the past five years?	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
Over the past 5 years, have you ever been hospitalised (in a hospital, health clinic, treatment facility, psychiatric institution, etc.)?	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
Have you ever undergone surgery or are you scheduled to do so?	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
Do you suffer from a handicap, disability or chronic illness?	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO
*If you answered "yes" to any of the above, please specify at what time the event occurred and the after-effects, if any, or any illness or accident**						

I hereby certify that the above declarations are true and accurate and undertake to provide to the GMC Medical Board any information or medical data required. Any misstatement or omission shall render the policy null and void.

Signed in (city, country) ______________________ on (date) ______________

Signature

signature(s) of the member and his/her spouse, if applicable, preceded by the words "read and approved"

02/2003 - Réf. : 12188/3

(*) Use a separate sheet of paper if necessary, and attach it to this form

Please return this questionnaire, in an envelope marked "Confidential", to the Medical Board,
GMC International Department - 10 Rue Henner - 75 459 Paris Cedex 09 France

HOW TO PURCHASE COVERAGE

Please make sure you send us a complete application if you wish coverage to take effect as soon as possible

1 - Carefully fill out the enrolment application form and the medical questionnaire, including specifics where necessary (if you answer "yes" to any question).

2 - Enclose a bank account identification form for reimbursements to be effected.

3 - Enclose your previous insurance certificate in order to waive waiting periods.

4 - Calculate the amount of the premium for yourself and your dependants, if any.

5 - Include premium payment for the first six months, unless Visa/Mastercard payment has been arranged (please note that the enrolment will only be made after the initial premium has been paid).

6 - Mail all of the above documents to the Medical Board, at GMC International Department, 10 Rue Henner, 75459 Paris Cedex 09, France

VISA/MASTERCARD PAYMENT

❏ **VISA** ❏ **EUROCARD/MASTERCARD**

Card Holder's Name: ____

Card Number

Expiry Date

Signature: