Elite Medical Expenses Protection Plan

Application Form

Elite Plans are only available to residents of Asia

iphinsurance.com

Please complete the form in full and in English block letters and return it to us.

1. Applicant's Details

Title: _____ Family Name: _____

First Name: _____

Male: ☐ Female: ☐ Date of Birth: D D / M M / Y Y Y Y

Height in cm: _____ Weight in kg: _____

Occupation: _____

Nationality: _____

Country of Residence: _____

Full Address: _____

_____

_____

_____ Postcode: _____

Telephone: _____

Fax: _____

Email: _____

2. Dependants' Details

This includes your spouse and children who are aged not less than 15 days and not more than 18 years at the date of enrolment, or under 24 years if in full-time education – evidence will be required. The nationality of dependants will be deemed to be the same as the main applicant.

	Family Name	First Name	Gender (M/F)	Date of Birth	Height in cm	Weight in kg	Occupation	Relationship with main Applicant
1								
2								
3								
4								
5								

3. Plan Options

Type of Plan (please select one): Pearl ☐ Sapphire ☐ Ruby ☐

Currency: US Dollar $ ☑

Area covered: Area 1 (worldwide excluding USA, Canada and the Caribbean) ☑

Optional Benefits: Personal Accident Option ☐ (tick if required)

4. Medical History and General Questions

Please complete the following health declaration **on behalf of yourself and all those named within the application form**. Give full details about each condition by answering the questions in the following health declaration accurately and in as much detail as possible. Please continue on a separate sheet if necessary. We cannot accept your application if this health declaration is incomplete. If someone else completes this form for you (for example your partner or financial adviser) you must check that all the details are correct before you sign the declaration.

1. Have you ever been diagnosed and/or treated for:

a. Disorders of the eyes, nose, throat? Yes ☐ No ☐

b. Neurological disorders, dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke, mental or nervous disorders? Yes ☐ No ☐

c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? Yes ☐ No ☐

d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels? Yes ☐ No ☐

3. Do you have any deformity, lameness, amputation or any congenital or acquired physical defect? Yes ☐ No ☐

4. Other than the above, have you within the past 5 years:

a. Had any mental or physical disorder not listed above? Yes ☐ No ☐

b. Had a check-up, consultations, illness, injury or surgery? Yes ☐ No ☐

c. Been a patient in a hospital, clinic, sanatorium or other medical facility? Yes ☐ No ☐

d. Had an electrocardiogram, X-ray or other diagnostic test? Yes ☐ No ☐

e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, haemorrhoids, recurrent indigestion or other disorder of the stomach, intestines, liver or gall bladder? Yes ☐ No ☐

f. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate or reproductive organs? Yes ☐ No ☐

g. Diabetes, thyroid or other endocrine disorders? Yes ☐ No ☐

h. Neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones, including the spine and back joints? Yes ☐ No ☐

i. Disorder of skin, lymph glands or any kind of cysts? Yes ☐ No ☐

j. Tumour or cancer? Yes ☐ No ☐

k. Allergies, anaemia or disorders of the blood? Yes ☐ No ☐

2. Are you receiving treatment for any or all the above mentioned disorders or accidents including prescriptions? Yes ☐ No ☐

e. Been advised to have a diagnostic test, hospitalisation or surgery which was not completed? Yes ☐ No ☐

5. Have you had or been advised to have any counselling or investigations in connection with AIDS or Hepatitis B? Yes ☐ No ☐

6. What is your average intake of alcohol per week? _____ Units

7. Do you smoke? Yes ☐ No ☐

If YES:

i. How long have you been smoking and _____ Years

ii. How many cigarettes do you smoke per day? _____ Total

8. Has a proposal for your life insurance ever been postponed, declined, or accepted on special terms? Yes ☐ No ☐

9. Family Background: Have your parents, brothers or sisters ever had diabetes, high blood pressure, heart or kidney disease, cancer or mental illness? Yes ☐ No ☐

10. Females only:

Do you have any gynaecological disorder? Yes ☐ No ☐

Medical History and General Details

Please specify which corresponding questions from above you are responding to: eg. '1a' If you are diagnosed with a disorder in the eyes nose or throat.

eg.1a	Full Name	Nature of illness / disability and treatment	Date	Duration	Present state of health

5. Important notes

PRE-EXISTING MEDICAL CONDITIONS AND RELATED CONDITIONS

Underwriters shall not be liable for expenses incurred for any medical condition which originated prior to the date of acceptance of your membership or which was foreseeable at the time of application or any condition caused by the aforesaid medical conditions unless such medical conditions have been declared to and accepted by the Insurers. We rely on the information that you give us in this form when we decide whether or not to accept your application, and whether or not we need to apply special terms. Special terms are exclusions or conditions that we may apply to your cover. If you submit a claim for the treatment of any pre-existing condition or related condition which you omitted to tell us about here or you omit to tell us everything about, we will refuse to pay that claim. We also have the right to declare your IPH plan void, or we may impose special terms on your plan which will apply retrospectively. Please therefore take the greatest care to ensure that this application form is completed fully and accurately. If you are uncertain about whether any particular fact needs to be disclosed, you should include it. If you consider that the answer to any question in the proposal form requires expert knowledge which you do not have, you should indicate this in your answer.

CONTINUING DUTY OF DISCLOSURE

If after completing, signing and dating your application form any changes occur in the facts you have given us, such as a change in your state of health, you must tell us in writing about the change, and we reserve the right to decline to accept your application or to accept your application with special terms.

DATA PROTECTION DECLARATION

We will collect certain information about you in the course of considering your application and, if we issue a policy to you, conducting our relationship with you. This information will be processed for the purposes of underwriting your insurance coverage, managing any policy issued and administering claims. We may pass your information to underwriters, medical practitioners, medical assistance companies and claims administrators for these purposes. This may involve the transfer of your information to countries that do not have data protection laws. You may have a right of access to, and correction of, information that we hold about you. Please contact International Private Healthcare if you would like to exercise either of these rights. Some of the information we collect about you may be classified as 'sensitive' - that is, information about racial or ethnic origin, and physical or mental health. Data protection laws impose specific conditions in relation to sensitive information, including in some circumstances the need to obtain your explicit consent before we process the information. By signing this proposal form you consent to the processing and transfer of information including sensitive information described in this notice. Without this consent we would not be able to consider your application.

EXCLUSIONS

No benefit or reimbursement shall be paid by the insurers in respect of claims arising from:-

1. any medical, physical or mental condition (including chronic or recurring conditions), not disclosed on your Application Form for cover, in respect of which you had suffered or sought treatment or advice at any time prior to your original inception date or, if later, the date you joined your plan,
2. any medical, physical or mental condition or treatment or service which is specifically excluded on your Certificate of Insurance. After 12 months any excluded medical or related condition may be eligible for cover provided the condition(s) has not recurred, you have not received or needed treatment or medication or sought advice for such condition(s), your original inception date or, if later, the date you joined your plan,
3. suicide or self-inflicted injury,
4. alcohol or drug abuse,
5. illness or injury whilst performing duties as a serving member of a military or police force or unit,
6. routine medical examination (including vaccinations, the issue of medical certificates and attestations, and examinations as to suitability for employment or travel) and routine eye and ear examinations (including the cost of spectacles, contact lenses and hearing aids),
7. treatment relating to birth defects and congenital illnesses. Birth defects are deemed to include hereditary conditions,
8. all dental treatment which is not emergency dental treatment as described herein,
9. tests and treatment relating to infertility and in vitro fertilisation,
10. any abortion (and its consequences) unless it has been confirmed by a physician to be medically or surgically necessary,
11. prostheses, corrective devices and medical appliances which are not required intra-operatively, except as provided on your Certificate of Insurance,
12. cryopreservation or introduction or re-introduction of living cells,
13. treatment of mental illness, stress, psychiatric or psychological disorders, except in-patient psychiatric treatment as provided on your Certificate of Insurance,
14. elective and/or cosmetic surgery,
15. any sexually transmitted diseases,
16. Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex Syndrome (ARCS) and all diseases caused by and/or related to the virus HIV positive, except as provided on your Certificate of Insurance,
17. the performance of professional and/or hazardous sports and all kind of racing other than on foot,
18. treatment by a family member and any autotherapy including prescription of drugs or any treatment that is not scientifically recognised,
19. the acquisition and implantation of artificial heart and mono or bi-ventricular devices,
20. flying other than as a passenger on a scheduled regular carrier (this applies only to the optional Personal Accident Benefits),
21. any criminal act,
22. war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, act of terrorism,
23. any losses directly or indirectly arising out of contamination due to an act of terrorism, regardless of any contributory causes (If the insurer alleges that by reason of this exclusion any loss is not covered by this insurance the burden of proving the contrary shall be upon the insured),
24. ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
25. travelling specifically to obtain medical treatment unless agreed by underwriters.

IPH RESERVE THE RIGHT TO DECLINE ANY APPLICATION.

This insurance is not available to permanent residents of the United States of America, or Canada, of whatever nationality. Purchase of this insurance by permanent residents of the United States or Canada will render the policy void. Your application can be processed when the full premium and the completed application form is registered with International Private Healthcare Limited.

DEDUCTIBLE: You will be responsible for the first $100 of each and every ailment/diagnosed medical condition for which a claim, in respect of out-patient services, is made within any one policy year.

To be read in conjunction with IPH terms and conditions. Information correct at time of print.

6. Declaration

I hereby apply for cover on behalf of all the persons named in this application form for an IPH plan as specified above. I have made a full and complete disclosure about the medical history of each person included in this application and I fully understand that pre-existing conditions as defined in the IPH plan rules shall not be covered by the insurance plan. I understand that upon receipt of my IPH plan documents, if I am not entirely satisfied, I can cancel my application from inception and receive a full refund of the premium I have paid, provided I return the documents to IPH Limited within 30 days of the start of the policy, and provided I make no claim.

I agree that IPH Limited or the insurer may rescind the policy and release themselves from any liability whatsoever if it is proved that I have omitted to declare any relevant information, or have given any incorrect, incomplete or misleading information.

I also understand that I must notify IPH Limited of any changes in the facts contained in this application form, such as a change in the state of health of any person named in it. I authorise any doctor who has ever treated or advised any of the persons named in this application to provide IPH Limited with any information they may require in connection with treatment related to any claim under this plan. I declare that the information given in this application is true and complete.

I, and all those named in this application, understand that in order to assess my claim, IPH Limited may need to obtain details of my medical history. I, and all those named in this application, hereby authorise any physician, healthcare professional, hospital, clinic and other healthcare institution to disclose to IPH Limited, to the extent allowed by applicable law, any information concerning the medical history, services, supplies, or treatment provided to anyone listed on this application, including those services involving dental, substance abuse and HIV/AIDS. I understand that IPH Limited may rely on this information to administer my policy and claims and to determine policy coverage according to applicable laws and regulations.

If I have indicated that I wish to pay by credit or debit card, I agree that IPH Limited may debit my account with the appropriate premiums on or before their due dates, and all subsequent renewal premiums due as invoiced by IPH Limited until I give written notice that I wish to terminate this agreement. I understand that my cover will terminate in accordance with the terms of the IPH Health plan agreement if IPH Limited are unable to collect my premium – for whatever reason – and I do not provide IPH Limited with an alternate method of payment immediately.

I hereby give IPH Limited authorisation to send my insurance documents in pdf format by email to the email address I have stated in this application. If I have applied through an intermediary, I hereby give IPH Limited authorisation to send my insurance documents in pdf format by email to my intermediary.

I understand that my personal data will be processed in accordance with the Data Protection Act (1988) and the EU Data Protection Directive 95/46/EC.

I understand that IPH Limited will hold and process my personal data for the purposes of processing my IPH Health plan, processing any claims submitted under my IPH Health plan and providing other related services, which may include sharing my personal data with the insurers of my plan, doctors and other medical professionals involved in my treatment or care (or the treatment or care of other persons insured under my IPH Health plan), IPH Limited's emergency assistance providers and other agents. I understand that this may include the transfer of personal data to countries outside the European Union and in signing this form I consent to such transfer and use.

I also understand that my personal data may be disclosed to any regulatory body that may require IPH Limited to disclose it and that, in the event of fraud or suspected fraud, my personal data may be disclosed to other parties, including but not limited to, the appropriate law enforcement agencies.

I consent to IPH Limited processing personal and sensitive data about me and other persons included on this application form. I understand that all personal data I supply must be accurate and confirm that I have the specific consent of all other persons included on this application to disclose their personal data.

I understand that telephone calls to IPH Limited may be recorded and monitored.

I understand that I may ask to review my personal or healthcare information and request amendments, to the extent allowed by law, and that I may revoke this authorisation at any time.

This authorisation shall remain valid for the term of my IPH plan, including any periods of cover following subsequent renewals, or for so long as allowed by law.

7. Sign and return completed form

Signature of Applicant

Date: D D / M M / Y Y Y Y

Post: IPH, IPH House, Stirling Way, Borehamwood, WD6 2BT United Kingdom

Email: info@iphinsurance.com

Fax: +44 (0)20 8207 2878

Tel: +44 (0)20 8905 2888

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