CONTINUOUS PERSONAL MEDICAL EXCLUSIONS (CPME)

Application for coverage

Instructions

Please read through the following before completing this application.

1. You are responsible for completing this Application and are solely responsible for its accuracy and completeness. It is important that you answer all the questions in this application form fully, truthfully and accurately.
2. All questions and declarations must be completed in full; all signatures and dates must be included where noted.
3. Acceptance of coverage is not guaranteed and GBG reserves the right to accept or reject this Application based upon the information received or developed during the course of Underwriting
4. Continuation of Personal Medical Exclusions (CPME) means that, if approved by Underwriting, any medical underwriting terms for medical conditions you had on your previous policy will be transferred to your new policy. New exclusions may be added depending upon risk, at Underwriting discretion. Your policy will be subject to our general terms including the exclusions and benefit limitations, which you will find in the Policy Wording.
5. You will only be eligible for CPME consideration if you are switching from a CPME or FMU (Fully Medically Underwritten) policy.
6. A copy of the previous provider's medical insurance certificate is required as a part of the application process, as well as confirmation that individuals are currently insured under the previous insurance provider.
7. Please contact us straight away if any of the information on this form changes before the policy starts.
8. All information supplied will be treated in strict confidence.

1: Member details

Policy start date (DD-MM-YYYY):	

2a: Main member details

Title:	First name:	Middle name:	Last name:	Date of birth (DD-MM-YYYY):	Gender:

Height in cm:	Weight in kg:	Email address:	Mobile number:	Country of residence:

Residence address:	City:	Postal code:	Country:
Permanent address:	City:	Postal code:	Country:

Have you or any dependent to be insured ever been covered by GBG/TieCare before for any type of insurance coverage?	Yes ◯	No ◯
If yes, please provide policy number:		

2b: Dependent details

Complete below if enrolling spouse or civil/domestic partner, and or children under age 25.

Title:	First name:	Middle name:	Last name:	Date of birth (DD-MM-YYYY):	Gender:
Country of Residence:		Height in cm:	Weight in kg:	Relationship to primary applicant:	
Title:	First name:	Middle name:	Last name:	Date of birth (DD-MM-YYYY):	Gender:
Country of Residence:		Height in cm:	Weight in kg:	Relationship to primary applicant:	
Title:	First name:	Middle name:	Last name:	Date of birth (DD-MM-YYYY):	Gender:
Country of Residence:		Height in cm:	Weight in kg:	Relationship to primary applicant:	
Title:	First name:	Middle name:	Last name:	Date of birth (DD-MM-YYYY):	Gender:
Country of Residence:		Height in cm:	Weight in kg:	Relationship to primary applicant:	

Underwriting Questionnaire

3. Insurance and medical details

If the answer is Yes to any of the following questions, please provide full details.

Do you or any dependent to be insured currently have health insurance with another company?
If Yes, please provide details and attach all existing insurance certificates, schedules and endorsements relating to you and your dependents to be insured. CPME is only available to persons currently covered by an equivalent international medical insurance policy.

	Yes ◯	No ◯

Have you or any of your dependents to be insured been suffering from Chronic conditions such as: cancer, heart or vascular conditions, diabetes, emphysema/chronic bronchitis or pulmonary fibrosis, stroke, autoimmune diseases (lupus, rheumatoid arthritis, colitis, multiple sclerosis, etc), spinal issues, joint replacement, HIV, kidney failure, chronic hepatitis, cirrhosis or pancreatitis, severe mental illness, neurologic, blood or congenital disorders? Are you or any of your dependents a recipient of or candidate for any Organ Transplant or for Orthopedic Prosthesis?
Please inform name of applicant, condition(s)/diagnosis, treatment(s), treatment dates (from/to), ongoing or date of recovery, current status and any additional detail.

	Yes ◯	No ◯

Have you or any of your dependents to be insured had a change in health status within the last 12 months, such as: new medical condition, new treatment, hospitalization or symptoms for which a medical practitioner has or has not been consulted, or are there any pending surgeries, medical evaluations or tests, or any exams pending results?
Please inform name of applicant, condition(s)/diagnosis, treatment(s), treatment dates (from/to), ongoing or date of recovery, current status and any additional detail.

	Yes ◯	No ◯

Is anyone to be covered on this plan **currently pregnant**?

	Yes ◯	No ◯

Please enter the following details about the usual/family doctor for each person to be insured. If you do not have a usual/family doctor, please provide the names, addresses and contact information of medical providers you and your family members to be insured have seen in the last 3 years. Use a separate sheet if necessary. If you have never seen a doctor in the past 3 years, please indicate that below.

Name:			
Address:			
Telephone:		Fax:	
Email:			

Please provide more details on a separate sheet if required.

Additional space for further remarks

You may use this space for any further comments about any medical conditions you or your dependents to be insured have suffered from. Please remember to enclose any supporting documents with your application.

4. Use of personal information

Please note this is a summary of how we will use the personal information you provide in this application form. You should refer to the Notice on Privacy Practices section of your member guide for more details, including who we share personal information with, your rights and how to exercise them. Full details on GBG's Privacy policy can be found on our website: https://www.gbg.com/#/AboutGBG/PrivacyPolicy We'll use the personal information you give us to:

- Process and underwrite this application
- Decide if we can offer cover and on what terms
- Administer your policy and handle claims
- Help prevent and detect fraud
- Meet legal and regulatory requirements applicable to us
- Conduct research to keep our products and services competitive and suitable for our customers' needs

We will share your information with the insurer(s) named in your employers' group quotation(s), and will provide you with additional information regarding their privacy practices when required to do so. Other companies in the GBG Group or third parties, who provide services to us, in any country (including Austria, Netherlands and those from outside the European Economic Area such as the USA, UK, Serbia, Philippines, South Africa and India) could also use this information in this way. In the event this happens we'll ensure that they agree to treat the information with the same level of protection we use.

I confirm that I give explicit consent on behalf of myself and any Dependants specified in this form, for GBG to process our personal information with respect to our application and I confirm that I have brought the Use of Personal Information notice to the attention of these Dependants.

5. Declaration

I declare that to the best of my knowledge and belief the information given in this Application is accurate and complete. I acknowledge that if I do not answer all questions accurately and completely this may result in the insurer rescinding coverage or rejecting claims. The duty to answer questions accurately, honestly and completely applies in respect of each person who is named on this form.

I have carefully read, understood and agree to abide by the Insurer's policy conditions and Schedule of Benefits as they form part of my contract of insurance.

If any person insured under this policy become a resident of the United States, the insurer must be informed within 30 days of such residency and coverage will terminate at the end of the policy period.

By submitting this application form for health insurance coverage, I acknowledge and confirm my awareness that any health insurance policy issued by the insurer is not a substitute for any form of compulsory national health insurance in any country in which I or my Dependents may reside.

Any Changes that occur to your medical history, or that of your Dependents, prior to the issue of the policy must immediately be reported to the insurer.

Applicant's signature	**Date:**

Please email the completed application to enroll.europe@gbg.com