For office use only	
Ref No.	Agency No.

Medical Expenses Protection Plan

Please complete this form in full and in English block letters.

1. Applicant Details (Please note that the applicant will be the policyholder)

You must notify us of any change of contact details so we can ensure that correspondence reaches you.

Title _____ Gender Male ☐ Female ☐

First Name _____

Family Name _____

Date of Birth _____

Nationality _____

Country of Residence _____

Height (cm) _____

Weight (kg) _____

Occupation _____

Phone No. (Primary) _____

(Secondary) _____

(Home) _____

Email address _____

Residential Address _____

Postcode _____

Correspondence Address (if different) or Agent's Address ☐

Postcode _____

2. Dependants to Be Covered Under the Contract

This includes your spouse/ partner and children financially dependent on applicant 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. Where the child is 18 years of age or older, please attach a letter from the college/ university confirming student status. The nationality of dependants will be deemed to be the same as the main applicant, unless otherwise stated.

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

3. Plan Options (This section does not need to be completed if you are applying as part of a group scheme)

Please note that the below chosen will apply to all policy members.

Level of Cover:	Pearl ☐	Sapphire ☐	Ruby ☐
Currency:	US Dollar $ ☒		
Area covered:	Area 1 (worldwide excluding USA, Canada and the Caribbean) ☒		
Optional Add-Ons:	Personal Accident Option for - Main applicant only ☐ All adult applicants (18yo and above) ☐ Dental and Optical for - Main applicant only ☐ All adult applicants ☐ All applicants ☐		

Voluntary In-patient Deductibles					
Deductible Amount:	US$ 250 ☐	US$ 500 ☐	US$ 1,000 ☐	US$ 2,000 ☐	US$ 5,000 ☐
Discount Rate:	10%	12.5%	20%	30%	40%

4. Commencement of Cover

Please indicate the date you require cover from: DD / MM / YYYY

Cover is conditional upon acceptance of your application, which is only confirmed when an Insurance Certificate is issued to you. Please note that your application is only valid for 30 days from the date of signature. If cover is not incepted by then, we reserve the right to ask you to complete a new application form again.

5. Health Declaration

Please answer the following questions on behalf of yourself and your dependants (if applicable). We cannot accept your application if this health declaration is incomplete. If someone else (for example your partner or financial adviser) completes this form for you, you must check that all details are correct before you sign the declaration.

1. Has any applicant named on this form ever suffered from, been in hospital with, or received treatment, tests or investigation for:
   a) Disorders of the eyes, nose or throat? Yes ☐ No ☐
   b) Neurological disorders, dizziness, fainting, convulsions, headache, speech defect paralysis or stroke, mental 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 ☐
   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 of the 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. Is any applicant named on this form receiving treatment(s) for any or all the above mentioned disorders or accidents, including prescriptions? Yes ☐ No ☐
3. Is any applicant named on this form has any deformity, lameness, amputation or any congenital or acquired physical defect? Yes ☐ No ☐
4. Within the past 5 years, has any applicant named on this form:
   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) Been advised to have a diagnostic test, hospitalisation or surgery which was not completed? Yes ☐ No ☐
5. Has any applicant named on this form been advised to have any counselling or investigations in connection with AIDS or Hepatitis B? Yes ☐ No ☐

Does any applicant named on this form:

6. Consume alcohol? Yes ☐ No ☐
   If YES, what is the average intake per week? _____Units
7. Smoke? Yes ☐ No ☐
   If YES: i) How long have you been smoking? _____Years
   ii) How many cigarettes per day? _____Total
8. Has any applicant named on this form ever had a proposal for life insurance being postponed, declined, or accepted on special terms? Yes ☐ No ☐
9. Family background: Has any applicant's parents, siblings brothers or sisters ever had type 1 diabetes, type 2 Diabetes, high blood pressure, heart or kidney disease, cancer or mental illness? Yes ☐ No ☐
   a) If YES, have you ever been tested for the illness above? Please provide test date and results in the table below.
10. Has any applicant named on this form have gynaecological disorder? Yes ☐ No ☐
11. Is any female applicant named on this form currently pregnant? Yes ☐ No ☐

If you answered 'yes' to any questions above, please provide full details of each condition in the below table. You can continue on a separate sheet if necessary. Please enclose supporting medical reports/ test results if possible.

eg. 1a	Name of the person affected by the condition	Diagnosis, test results or medication doses/ treatments	Date of onset; Date of last episode	Past or current treatment	Present State of Health

6. 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.

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 for 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.

7. 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 (1998).

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 team of my IPH plan, including any periods of cover following subsequent renewals, or for so long as allowed by law.

8. Signature

We can accept signed and scanned copies of the form attached to an email as a PDF.

We can also accept a digital version of this form, provided you have typed your name below, and your email contains the following copy: "I, [your name], have signed the form myself, and I am happy to be bound by the terms of the plan/agreement attached to this email." This needs to be sent from the same email address as stated on your form.

Signature of Applicant & Date:

D	D	M	M	Y	Y	Y	Y

PLEASE RETURN YOUR FULLY COMPLETED APPLICATION FORM BY:

Email to: info@iphinsurance.com

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

Fax: +44(0)2082072878

Tel: +44(0)2089052888

iphinsurance.com

PAYMENT FORM

Policyholder:
Risk Number:
Inception Date:
Annual Premium:

Tick/cross one of the following payment methods and fill in any relevant details.

Please ensure you sign and date the "Declaration" section, then return the form to us.

Please note, if paying by credit/debit card, US Dollar amounts will be converted to Pound Sterling and charged to the authorized card

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☐ **Credit or Debit Card**

Pay the annual premium in: ☐ One full payment ☐ Two semi-annual payments ☐ Four quarterly payments

Please note: an administrative surcharge applies for semi-annual (5%) and quarterly (10%) payments

Card Provider: ☐ Visa ☐ Mastercard / Maestro

Card Number: | | | | | | | | | | | | | | | |

Cardholder Name: _____

Expiry Date: | | | | | *Security Code: | | | | |

Card Payment Authorisation: *I authorise you, until further notice in writing, to charge to my Visa/MasterCard account unspecified amounts for my IPH policy, as and when these become due, until this instruction is countermanded by giving notice in writing to IPH Ltd.*

X Cardholder Signature: _____ **X** Date: _____

Name and Address of Cardholder (If different from above):

First Name/s: _____ Last Name: _____

Address: _____ Post/Zip Code: _____

***Where can I find my card's Security Code?**
Visa/MasterCard: Look at the signature box on the back of the card. Some numbers will be printed on it. The last 3 digits of this number is your Security Code.

☐ **Cheque**

Please make cheque to the sum of your full annual premium payable to **IPH Ltd** and return it with this form.

☐ **Bank Transfer**

Currency: US Dollars (US$) – please transfer full annual premium
Intermediary bank: N/A
Intermediary swift code: N/A
Beneficiary bank address: Santander UK plc, Bridle Road, Bootle, Merseyside, GIRO AA, UNITED KINGDOM
Beneficiary account name: International Private Healthcare Ltd
Beneficiary account number: 61048029
Beneficiary sort code: 09-18-10
Beneficiary SWIFT/BIC code: ABBYGB2LXXX
Beneficiary IBAN: GB48ABBY09181061048029

Declaration

I confirm that I have read the terms and conditions of my policy and agree to be bound by them.

Contact number: _____ Email: _____