INTERGLOBAL HEALTHCARE PLANS
• INDIVIDUAL APPLICATION FORM •

Please complete in BLOCK CAPITALS

A - YOUR PERSONAL DETAILS

Title:	☐ Mr	☐ Mrs	☐ Miss	☐ Ms	☐ Dr	Other:
Surname:				First Names:	
Address*:					
Country where you live:				How long have you lived there?:	
International Telephone Number:				Fax Number:	
Email:				Nationality on passport:	
Occupation:				Date of Birth (dd/mm/yy):	

* All correspondence will be sent to this address unless otherwise notified.

Please indicate your preferred communication channel	☐ Email	☐ Airmail	☐ Fax	☐ Telephone

B - DEPENDANTS TO BE COVERED

Surname:	First names:
Relationship to you:	Date of birth (dd/mm/yy):
Surname:	First names:
Relationship to you:	Date of birth (dd/mm/yy):
Surname:	First names:
Relationship to you:	Date of birth (dd/mm/yy):
Surname:	First names:
Relationship to you:	Date of birth (dd/mm/yy):

C - GEOGRAPHICAL AREA OF COVER YOU WOULD LIKE

☐ Area 1	Europe	☐ Area 2	Worldwide, not including the USA
☐ Area 3	Worldwide	☐ Area 4	Australia and New Zealand

D - ULTRACARE PLAN SELECTION

☐ Plus Plan	☐ Comprehensive Plan	☐ Select Plan	☐ Standard Plan

E - VOLUNTARY EXCESS: PLUS PLAN, COMPREHENSIVE PLAN AND SELECT PLAN

Standard excess on out-patient treatment claims is £25 for plans in GB pounds, $37.50 for plans in US dollars or €37.50 for plans in euros. Do you want to accept a voluntary excess on claims above the standard claim excess?

☐ Yes	☐ No

If 'Yes', please tick the level of voluntary excess you want to accept

☐ £50/$75/€75 excess = 5% premium discount

☐ £100/$150/€150 excess = 10% premium discount

☐ £250/$375/€375 excess = 20% premium discount

(Discount applies to HealthCare Plan premium only - not to optional add-on plan premiums.)

1 July 2003

F - NIL EXCESS: PLUS PLAN, COMPREHENSIVE PLAN AND SELECT PLAN

Do you want to delete the standard excess of £25/$37.50/€37.50	☐ Yes	☐ No
If 'yes', please tick your acceptance of 10% premium increase.	☐ I accept the premium increase	

G - VOLUNTARY EXCESS: STANDARD PLAN

☐ £500/$750/€750 excess = 10% premium discount

☐ £1,000/$1,500/€1,500 excess = 20% premium discount

(Discount applies to HealthCare Plan premium only - not to optional add-on plans.)

H - OPTIONAL ADD-ON BENEFITS

Do you want to add any of the following?

Personal Travel Plan	☐ Yes	☐ No	If Yes, please indicate type	☐ Single	☐ Couple	☐ Family	☐ Single Parent Family		
Full Maternity Benefit Plan	☐ Yes	☐ No	If Yes, please indicate level of co-insurance selected per person	☐ 10%	☐ 20%				
Personal Accident Plan*	☐ Yes	☐ No	If Yes, please indicate how many units selected	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	

*Please detail below the names of all persons named in this application who require Personal Accident benefit:

1	2	3
4	5	6

(The voluntary excess premium discount does not apply to these options.)

The Personal Accident Plan does not include accidents arising from manual or hazardous occupations, dangerous sports, pursuits, or activities. If your occupation is not purely office-based or you take part in any dangerous sports, pursuits or activities, please give full details on a separate sheet and include it with this Application Form. We will then advise what premium is necessary to cover the increased risk.

I - CURRENCY

In which currency do you want your plan to be issued?

☐ GB pounds (£) ☐ US dollars ($) ☐ Euros (€)

(The Plan currency you select also decides your premium currency.)

J - PAYMENTS

I want to pay

☐ Yearly ☐ Quarterly ☐ Monthly

(Quarterly and monthly premiums by credit card only: MasterCard, Visa or American Express*.)

*** Payment in euros will not be accepted by American Express.**

K - HOW TO PAY

I want to pay by

Yearly Only	☐ Bank transfer	☐ Bank draft	☐ Cheque
Yearly, Quarterly, Monthly	☐ Credit card		

£ GB pound or $ US dollar

Please make your cheque or draft payable to **InterGlobal Limited**
Please make your £ GB pound or $ US dollar bank transfer payable to
NatWest Bank plc, Farnham, Surrey, GU9 7NR United Kingdom

Bank sort code: **60.08.15** £ GB pound account reference: **90306996** $ US dollar account reference: **140/0006502873**

(Please make sure your name is clearly shown on the transfer.)

€ euro

Please make your cheque or draft payable to **InterGlobal Limited**
Please make your € euro bank transfer payable to
NatWest Bank plc, PO Box 1, 1 Stoke Road, Guildford, Surrey, GU1 4HN United Kingdom

Bank sort code: **60.08.15** € euro account reference: **08005192**

(Please make sure your name is clearly shown on the transfer.)

L - DATE ON WHICH YOU WOULD LIKE YOUR COVER TO START

☐ When we accept your application Other:

M - PLEASE PROVIDE DETAILS OF YOUR (FAMILY) DOCTOR(S) WHO HAS/HAVE TREATED

Name:	Name:
Phone number:	Phone number:
Fax number:	Fax number:
Address:	Address:

N - PRE-EXISTING MEDICAL CONDITIONS **(Please read this section carefully)**

We will not cover you or any of your dependants under this plan for treatment of any existing medical or related condition which you or your dependants first had symptoms of, knew about, or for which treatment was received in the two years before the start date of this plan. However, if after a period of two years has passed during which you or your dependants have had no treatment or medication, nor sought advice for the condition, then we may begin cover for that condition.

O - DECLARATION

I apply to be enrolled in the InterGlobal UltraCare Plan selected together with the people to be insured under this plan listed in this application. I confirm that as far as I know, the information given in this application is true and complete. I have read and understood and accept section N of this application relating to pre-existing medical conditions. I shall read the Plan Rules when received and I agree to be bound by them unless I cancel enrolment within 30 days of receiving the plan documents.

I authorise and request the doctors named in section M and/or any other medical establishment, including any other physician, general practitioner or health professional who has attended me and any of my dependants included under this plan for diagnosis, treatment, disease or ailment, to provide the insurer's medical co-ordinator with the information they may need in connection with treatment related to a claim under this plan.

I accept, if I do not provide the information required in section M that, in the event of a claim being made by me, or any of my dependants included under this plan, which is deemed as being treatment for a pre-existing medical or related condition (refer section N) by the Chief Medical Officer, such claim will be rejected.

Signature: Date (dd/mm/yy):

1 July 2003

CREDIT CARD AUTHORITY

To InterGlobal Limited

I hereby authorise the Card Account specified below may be debited with the current premium due, and all subsequent renewal premiums due as notified by InterGlobal until I give notice in writing that I wish to terminate this agreement. I understand that InterGlobal will give at least 4 weeks notice of renewal, and that the premiums may vary each year. I understand that InterGlobal cannot be held liable if my plan is lapsed should the credit card be declined and I do not respond to requests for alternative methods of payment.

Please complete in BLOCK CAPITALS

Name (as it appears on your card)

Please tick the appropriate

☐ MasterCard ☐ Visa ☐ American Express*

My Card Number is

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Issue Date Expiry Date

☐☐ ☐☐ ☐☐ ☐☐

My Card billing address is

Please charge the above card (please tick)

☐ Yearly ☐ Quarterly ☐ Monthly

☐ GB £ ☐ US $ ☐ euros €

Signature: Date (dd/mm/yy):

* American Express cards cannot be used for premiums payable in euros €. Only GB £ and US $ currencies are acceptable.

For use by InterGlobal only (reference)	Broker/Adviser Stamp
	Future Insurance Broker Services (L.L.C) Dubai, U.A.E

INTERGLOBAL

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1 July 2003