Long-Term

International Health Plan

FULL MEDICAL UNDERWRITING – APPLICATION FORM

For Office Use: Inception Date: dd / mm / yyyy Policy Number: Broker Code:

1. HOW TO APPLY

1. Please complete sections 2–10 in full, they are mandatory.
2. Sign the declaration, ensuring you have understood all aspects of the application.
3. Complete the Method of Payment details.
4. Submit the application form to APRIL International UK.
5. We will review your application and advise you if it will be accepted with or without specific exclusions. If specific exclusions will apply to your plan, we will advise you in writing and you will need to let us have written confirmation that you accept these specific exclusions before the plan can start. We may refuse your application at our sole discretion. Any pre-existing medical conditions not declared on your application form will not be covered by the plan.

Insurance Premium Tax will be added to the premium if you and/or your dependants are resident in a country where we are required to charge tax.

All correspondence from us (your Certificate of Insurance, Policy Guide, Claims Reimbursements etc.) will be sent via email. Your Insurance Identification Card will be sent to you by post.

You must take care in answering all the following questions which are relevant to us in providing this insurance and setting the terms and premium. Please contact us if you do not understand the question or the nature of the information required or please seek guidance from your broker. Failure to provide information or the provision of incomplete or inaccurate information may result in the loss of cover.

PLEASE COMPLETE IN CAPITAL LETTERS

2. YOUR PERSONAL DETAILS

Title: ◯ Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Other .....

Surname: ..... First Name(s): .....

What is your country of Nationality/home country citizenship? .....

(You are required to declare your country of residence for the purposes of this insurance contract. Your choice of country will determine any insurance premium taxes that may be payable. This forms part of the pre-contractual representations you make to the Insurer. This will be used to establish the Home Country of the Applicant and Dependants)

Please provide your principal country of residence .....

(This is the country where you will be living most of the time once your insurance cover is incepted, usually for a period of at least six months during your insurance policy year)

Will you maintain permanent residency status in your Country of Nationality/Home country citizenship? ◯ Yes ◯ No

If yes, please provide your address in your country of Nationality/home country citizenship
If no, please provide your address in your principal country of residence

Address: .....

.....

City: ..... State/Region/County: .....

Postcode: Country: .....

Telephone: Email: .....

Occupation: .....

3. COVER REQUIRED (please tick)

Plans

◯ International Plan
◯ International Plus Plan
◯ Executive Plan
◯ Executive Plus Plan

Area of Cover

◯ Area 1: Worldwide excluding USA & Caribbean
◯ Area 2: Worldwide

Outpatient Service Benefit

◯ Nil excess option

Not applicable to the International Plan

Voluntary Excess Options

◯ None
◯ £100/$200/€150
◯ £250/$500/€375
◯ £500/$1,000/€750
◯ £1,000/$2,000/€1,500
◯ £2,500/$5,000/€3,750
◯ £5,000/$10,000/€7,500
◯ £10,000/$20,000/€15,000

4. REQUIRED START DATE (please tick)

○ On Acceptance ○ Other (please specify) d d / m m / y y y y

5. PERSONS TO BE INSURED

Please give details of all the persons to be covered under the plan

	Surname	First Names	Date of Birth	Gender	Country of residence	Area of cover
Applicant						
Spouse/Partner						
Child†						
Child†						
Child†						
Child†						

†Up to the age of 18, or 24 if still in full-time education. Evidence will be required.

6. DOCTOR DETAILS

Please give details of the doctor(s) who is(are) most familiar with your/your dependant(s) medical history

Doctor's Name: .....
Address: .....
.....
City: .....
State/Region/County: .....
Postcode: .....
Country: .....
Telephone: .....

Doctor's Name: .....
Address: .....
.....
City: .....
State/Region/County: .....
Postcode: .....
Country: .....
Telephone: .....

7. HOW TO COMPLETE THE MEDICAL QUESTIONNAIRE

The following sections must be completed for each person included in the application and asks for past and current health and medical details.

The main applicant should answer on behalf of themselves and any children under the age of 16. The spouse/partner and any children over the age of 16 should answer on their own behalf. Every question must be answered and if the answer is yes, please provide further information. If you run out of space, please use extra sheets of paper and make it clear which question you are answering.

In order to assess your application and administer your policy, we will need to process sensitive information about you, and anyone included in this application. Are you happy to confirm your/their consent to this?

Please initial here to confirm your consent:
(Please note that if you do not provide your consent, we may not be able to process your application)

8. PLEASE ALSO PROVIDE THE FOLLOWING INFORMATION

	Applicant	Spouse/Partner	Child 1	Child 2	Child 3	Child 4
Height (in cm)						
Weight (in kg)						

Has there been any significant weight change in the last year (± 6.5kg)? ○ Yes ○ No

If YES, please give details:

9. MEDICAL QUESTIONNAIRE

Have any persons named in this application ever been investigated, diagnosed or treated for any of the following including any consultations or medications (whether prescribed or not):

	Applicant	Spouse	Child
Cancer, leukaemia, Hodgkin's disease, lymphoma or any malignant condition?	○Y ○N	○Y ○N	○Y ○N
A mole or freckle that has bled, caused pain or changed in appearance or any lump or growth?	○Y ○N	○Y ○N	○Y ○N
Heart disease (including heart attack, angina, valve defect, heart defects from birth or heart surgery)?	○Y ○N	○Y ○N	○Y ○N
Chest pain, irregular heartbeat, raised blood pressure or raised cholesterol?	○Y ○N	○Y ○N	○Y ○N
Any other chest complaint?	○Y ○N	○Y ○N	○Y ○N
Disease or disorder of the arteries (including in the legs or of the aorta)?	○Y ○N	○Y ○N	○Y ○N
Stroke, transischaemic attack (TIA), brain haemorrhage or injury?	○Y ○N	○Y ○N	○Y ○N
Asthma, bronchitis, lung or any other respiratory infection?	○Y ○N	○Y ○N	○Y ○N
Multiple sclerosis, optic or retrobulbar neuritis, Parkinson's disease, paralysis, epilepsy, Alzheimer's disease, dementia, Bell's palsy or cerebral palsy?	○Y ○N	○Y ○N	○Y ○N
Any other disorder of the central nervous system not already mentioned?	○Y ○N	○Y ○N	○Y ○N
Numbness, loss of feeling or tingling of the limbs or face, loss of balance or coordination?	○Y ○N	○Y ○N	○Y ○N
Seizures, fits, fainting, unexplained loss of consciousness or blackouts?	○Y ○N	○Y ○N	○Y ○N
Mental illness or psychological problems that have required any kind of medical attention, time off work, hospital treatment or referral to a psychiatrist?	○Y ○N	○Y ○N	○Y ○N
Depression, anxiety, stress, insomnia, fatigue (including chronic fatigue syndrome [CFS]/ Myalgic encephalopathy [ME]) or nervous breakdown?	○Y ○N	○Y ○N	○Y ○N
Any disorder of the eyes or ears including blurred or double vision, or impaired hearing?	○Y ○N	○Y ○N	○Y ○N
Gout, arthritis, back pain, sciatica, neck, knee or wrist pain?	○Y ○N	○Y ○N	○Y ○N
Any other disorder of the joints, bones or muscles (including repetitive strain injury)?	○Y ○N	○Y ○N	○Y ○N
Diabetes, abnormal glucose tolerance or sugar in the urine?	○Y ○N	○Y ○N	○Y ○N
Disorder of the kidneys, bladder, or the genitourinary system (including blood or protein in the urine and urinary tract infections)?	○Y ○N	○Y ○N	○Y ○N
Any disorder of the digestive system, gallbladder, liver, stomach, spleen, pancreas, bowel, including ulcers, hepatitis, colitis or Crohn's disease or any other form of bowel disease?	○Y ○N	○Y ○N	○Y ○N
Any blood disorder or anaemia?	○Y ○N	○Y ○N	○Y ○N
Thyroid or glandular disorder?	○Y ○N	○Y ○N	○Y ○N
Any gynaecological, menstrual or breast problems (eg breast lumps)? (female applicants only)	○Y ○N	○Y ○N	○Y ○N
Any disease which was transmitted sexually?	○Y ○N	○Y ○N	○Y ○N

IMPORTANT If you have answered YES to any of the above, please provide further information regarding the condition, including consultations, treatment (whether proposed or received), medication (whether proposed or received including prescribed and non-prescribed medication) and prognosis in SUPPLEMENTARY INFORMATION

Are you aware of any symptoms or complaints for which you have not consulted a doctor or received treatment? ○ Yes ○ No

If YES, please give details (when, current, symptoms, complaint):

.....

.....

Have you ever been advised by your doctor or another medical practitioner to drink less alcohol? ○ Yes ○ No

If YES, please give details:

.....

.....

Have you used any form of tobacco or nicotine products in the last 12 months? ○ Yes ○ No

If YES, please give details of frequency/how many per day:

.....

.....

MEDICAL QUESTIONNAIRE (CONTINUED)

Have you ever tested positive for HIV, Hepatitis B or C or are you awaiting the results of such a test? If YES, please give details (date of test, medication, treatment):	◯ Yes ◯ No
Are you currently taking any form of medication, prescribed or otherwise or following any special diet or treatment or have you taken any form of medication for longer than 21 days? If YES, please give details:	◯ Yes ◯ No
Do you have any further disclosures to make with regard to any medical investigation, test or consultation, advice, counselling, operation, medication (whether prescribed or not) or treatment that you have had or been advised to have or are currently having, but have not already mentioned? If YES, please give details:	◯ Yes ◯ No

10. SUPPLEMENTARY INFORMATION

Please complete this section providing the following information for any questions that you have answered 'Yes' to in Section 9:

Date of occurrence (If more than one episode, please provide all dates): .....

.....

Diagnosis:

Treatment and/or medication (whether prescribed or not) received:

Further treatment required, including consultations and/or medication (whether prescribed or not):

Has a full recovery been made with no residual problems?

11. CHOICE OF JURISDICTION AND LANGUAGE OF CONTRACT

The insurance contract that is available to you is subject to the law and jurisdiction of the courts of England and Wales and documented in English language. Please tick below to confirm your acceptance:

I agree and accept the law and jurisdiction of England and Wales ◯

I agree and accept the insurance contract presented in English language ◯

(Please note that if you do not provide your acceptance, we may not be able to process your application)

12. DECLARATION

I/we declare that the information disclosed in this application form, is to the best of my/our knowledge and belief both accurate and complete. I/we have taken care not to make any misrepresentation in the disclosure of this information and understand that all information provided is relevant to the acceptance and assessment of this insurance, the terms on which it is accepted and the premium charged. For my benefit and protection, I have read the Policy Guide carefully and requested further information on any points I do not understand. I understand the Policy Guide to be part of any contract of insurance issued as a result of this Application. I agree that they will be binding on me and all eligible dependants included in my membership. I acknowledge on behalf of all the persons to be insured that benefits will not apply to treatment arising from any pre-existing conditions as more fully defined in the Policy Guide unless specifically agreed prior to your start date.

By signing the declaration below you are confirming that you understand the English language and the terms of cover where they have been provided to you in English. If you are unsure of any terms conditions or exclusions please seek assistance from your insurance adviser before you sign.

Applicant's Signature

Date: dd / mm / yyyy

(On behalf of all persons to be insured)

Signing this application form does not bind you to enter into this insurance. No cover is in force until this application form is accepted by the insurer and the premium is paid. The insurer reserves the right to decline any insurance application or to offer different premium and terms from those quoted dependent on the information you have provided.

You must tell us as soon as possible about any changes to the information you have provided to us which happens before or during any period of insurance. We will tell you if such change affects your insurance and if so, whether the change will result in revised terms and/or premium being applied to your policy. If you do not inform us about a change it may affect any claim you make or could result in your insurance being invalid.

13. METHOD OF PAYMENT

You will be advised of any special terms that will apply to your plan before any premium is collected.

Frequency of payment: ◯ Annual ◯ Quarterly (Credit Card payment only) ◯ Monthly (Credit Card payment only)

Premium amount: ☐☐☐☐☐.☐☐

Currency: ◯ £GBP ◯ $USD ◯ €EUR

Method of payment: ◯ Bank Transfer (Annual payment only) ◯ Credit/Debit Card

BANK TRANSFER

Please make bank transfers to the following accounts, instructing your bank to ensure that the transfer identifies you as the source

Account Name: APRIL International UK | **Bank:** Barclays | **Address:** 1 Churchill Place, London E14 5HP

Currency	Sort Code	Account No.	IBAN	SWIFT
£GBP	20-00-00	53869067	GB03BARC20000053869067	BARCGB22
$USD	20-00-00	76383566	GB61BARC20000076383566	BARCGB22
€EUR	20-00-00	44928922	GB97BARC20000044928922	BARCGB22

CREDIT CARD DETAILS

Credit/Debit Card: ◯ Visa ◯ Mastercard ◯ Amex

I authorise APRIL International UK Limited to debit the following credit/debit card for the premium amount indicated:

Card No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expiry Date: ☐☐ / ☐☐ Security Code: ☐☐☐☐ (Last 3 digits on back of card or if AMEX 4 digits on front of card)

Name of Cardholder: .....

Card Billing Address: .....

.....

City: ..... State/Region/County: .....

Postcode: ☐☐☐☐☐☐☐ Country: .....

Signature of Cardholder

Date: dd / mm / yyyy

14. BANK DETAILS FOR CLAIMS REIMBURSEMENT

Please provide us with your bank details for claims reimbursements. Your account details will be stored securely and used for future reimbursements unless we are notified.

This section is not mandatory - you will be able to provide us with your details when you submit your claim to us.

Name of bank: .....

Bank address: .....

.....

City: ..... State/Region/County: .....

Postcode: ☐☐☐☐☐☐☐ Country: .....

Account holder name: .....

Account number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Sort Code (UK only): ☐☐☐☐☐☐

BIC/Swift Code: ☐☐☐☐☐☐☐☐☐☐☐

IBAN No: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account Currency:

15. SUBMITTING YOUR APPLICATION

By Post: APRIL International UK,
Walsingham House, 35 Seething Lane,
London EC3n 4AH, United Kingdom

By Email: info@april-international.co.uk

16. IMPORTANT INFORMATION

Data Privacy
For full information about how we process and protect your personal information please refer to our Privacy Policy which can be viewed by clicking on the site terms and conditions on our website **www.april-international.co.uk**.

How We Use Your Information
The personal information, provided by you (or anyone acting on your behalf), is collected by or on our behalf and may be used by us, our employees, agents and service providers acting under our instruction for the purposes of insurance administration, underwriting, claims handling, insurance mediation, research or for statistical purposes.

We may process your information for a number of different purposes. For each purpose we must have a legal ground for such processing. When the information that we process is classed as 'special category data, we must have a specific additional legal ground for such processing.

Generally, we will rely on the following legal grounds:

- It is necessary for us to process your personal information to provide this policy and services related to it. We will rely on this for activities such as providing you with information about your quote, assessing your application, managing your policy, handling claims and providing other services to you.
- We have an appropriate business need to process your personal information and such business need does not cause harm to you. We will rely on this for activities such as maintaining our business records, developing, improving our products and services, and providing information about our products and services to you.
- We have a legal or regulatory obligation to usew such personal information.
- We need to use such personal information to establish, exercise or defend our legal rights.
- You have provided your consent to our use of your personal information, including special category data.

How we share your information
In order to sell, manage and provide our products and services, prevent fraud and comply with legal and regulatory requirements, we may need to share your information with the following types of third parties:

- Insurers, Reinsurers, Regulators and Authorised/Statutory Bodies
- Fraud prevention agencies
- Crime prevention agencies, including the police
- Suppliers carrying out a service on our behalf
- Other insurers, business partners and agents
- Other companies within the APRIL Group

As we operate as part of a global business, we may transfer your personal information outside the European Economic Area (EEA) for these purposes where adequate protection is in place.

Marketing
We will not use your information or pass it on to any other person for the purposes of marketing further products or services to you unless you have consented to this.

Fraud Prevention and Detection
In order to prevent or detect fraud and money laundering we may check your details with fraud prevention agencies and sanction websites, who may record a search. Searches may also be made against other insurers' databases. If fraud is suspected, information will be shared with those insurers. Other users of the fraud prevention agencies may use this information in their own decision making processes.

We may also conduct credit reference checks in certain circumstances. You can find further details in our full Privacy Policy explaining how the information held by fraud prevention agencies may be used.

Automated Decisions
We may use automated tools with decision making to assess your application for insurance and for claims handling processes. If you object to an automated decision, we may not be able to offer you an insurance quotation.

Contact Us
Please contact us if you have any questions about our privacy policy or the information we hold about you.

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