Freedom Health Insurance

Worldwide

Individual Application Form

(Full Medical Underwriting)

Each of the following parts should be completed by you and the completed form returned to **Freedom Health Insurance, County Gates House, 300 Poole Road, Poole, BH12 1AZ. Please use BLOCK CAPITALS.**

Maximum age of entry is 70

About you

Title:

Forename(s):

Surname:

Country of residence:[1]

When did you move there? M M Y Y

Home country:

Nationality on passport:

Date of birth:
Maximum age of entry is 70 D D M M Y Y Y Y

Occupation:

Health and lifestyle: Größe: Height: cm Gewicht: Weight: kg Raucher:[2] Smoker: 2 Nein No ☐ Ja Yes ☐

Residential address:[3]

Postcode:

Telephone numbers (inc. area code): Daytime: Evening:

Mobile number:

Email address:

When would you like your cover to start? D D M M Y Y Y Y (We cannot backdate cover under any circumstances)

Correspondence address:
(if different from above)[2]

Postcode:

Telephone numbers (inc. area code): Daytime: Evening:

Mobile number:

Email address:

[1] Your country of residence will determine the value of Insurance Premium Tax that is added to your premium. Please speak to your adviser or contact us if you are unsure whether your premium will be affected.

[2] A smoker is someone who would answer "Yes" to the question, "Have you used or smoked tobacco or nicotine replacement products in the past 12 months?"

[3] All correspondence will be sent to this address unless you have completed the correspondence address details above. It is very important that you tell us immediately of any changes to your contact or personal details. A change in circumstances could affect your cover.

About your family

If you require further dependants to be covered please use a separate sheet. **Maximum age of entry is 70**

Forename(s):

Surname:

Date of birth:

Nationality on passport:

Country of residence:[1]

Relationship to you:

Occupation:

Health and lifestyle:

Größe: Height: cm

Gewicht: Weight: kg

Raucher:[2] Smoker: 2 Nein No ☐ Ja Yes ☐

Forename(s):

Surname:

Date of birth: D D M M Y Y Y Y

Nationality on passport:

Country of residence:[1]

Relationship to you:

Occupation:

Health and lifestyle:

Größe: Height: cm

Gewicht: Weight: kg

Raucher:[2] Smoker: 2 Nein No ☐ Ja Yes ☐

Forename(s):

Surname:

Date of birth: D D M M Y Y Y Y

Nationality on passport:

Country of residence:[1]

Relationship to you:

Occupation:

Health and lifestyle:

Größe: Height: cm

Gewicht: Weight: kg

Raucher:[2] Smoker: 2 Nein No ☐ Ja Yes ☐

Forename(s):

Surname:

Date of birth: D D M M Y Y Y Y

Nationality on passport:

Country of residence:[1]

Relationship to you:

Occupation:

Health and lifestyle: Größe: Height: cm Gewicht: Weight: kg Raucher:[2] Smoker: [2] Nein No ☐ Ja Yes ☐

Forename(s):

Surname:

Date of birth: D D M M Y Y Y Y

Nationality on passport:

Country of residence:[1]

Relationship to you:

Occupation:

Health and lifestyle: Größe: Height: cm Gewicht: Weight: kg Raucher:[2] Smoker: [2] Nein No ☐ Ja Yes ☐

Forename(s):

Surname:

Date of birth: D D M M Y Y Y Y

Nationality on passport:

Country of residence:[1]

Relationship to you:

Occupation:

Health and lifestyle: Größe: Height: cm Gewicht: Weight: kg Raucher:[2] Smoker: [2] Nein No ☐ Ja Yes ☐

The cover you require

Select the area of cover from the descriptions below based upon the location of your country of residence and your home country if you require the option of returning to your home country for treatment. Please see the eligibility section in the Policy Document for restrictions on US Citizens. You and your dependants must have the same area of cover.

☐ Area 1 - Europe ☐ Area 2 - Worldwide excluding USA ☐ Area 3 - Worldwide

Please indicate the plan type that you require. Please be sure that you have read the policy summary and details of cover before making your selection to ensure the product meets your requirements. Please contact us if you require copies of these documents.

		Please select
Freedom Diamond	2,000,000 (€/£/$) overall limit	
Freedom Platinum	1,000,000 (€/£/$) overall limit	
Freedom Gold	750,000 (€/£/$) overall limit	
Freedom Silver	500,000 (€/£/$) overall limit	
Freedom Bronze	500,000 (€/£/$) overall limit	

Excess

Do you require an excess? ☐ Yes ☐ No

If yes, please choose from the following:

Excess per year €/£/$	Premium reduction %	Please select
Nil excess	n/a	
50	5%	
100	10%	
250	15%	
500	20%	
1000	25%	
2500	30%	
5000	40%	

Note: An excess does not apply to the Dental Benefit.

Doctor's/Medical Practitioner's details

Please provide the contact details of your family doctor(s) or medical practitioner(s) who last treated you or your family in the last 2 years. Failure to provide this information may cause a delay in processing any claims submitted.

Name:

Hospital/Clinic/Practice:

Address:

Postcode:

Telephone number: Fax:

Email address:

Full medical underwriting questionnaire

Benefits will not be payable for the treatment of any disease, illness or injury (whether or not diagnosed) for which the member has received medication, advice or treatment or of which the member has experienced symptoms prior to the date of acceptance of this application, or any related condition, unless fully disclosed on this application and accepted by us. Failure to provide full information may lead to the cancellation of the policy at a later date.

Please complete the following questionnaire for **ALL** members:

A: In the previous five years have you been diagnosed with, treated for or require any ongoing medication or tests for the following conditions:

Cancer, tumours, lumps or growths?	☐ Yes	☐ No
Heart disease, rheumatic fever, chest pain or circulatory problems?	☐ Yes	☐ No
Blood disorders?	☐ Yes	☐ No
Respiratory disorders?	☐ Yes	☐ No
Abdominal/Digestive disorders?	☐ Yes	☐ No
Genito/urinary disorders?	☐ Yes	☐ No
Musculo-skeletal/nervous system disorders?	☐ Yes	☐ No
Gynaecological disorders?	☐ Yes	☐ No
Ear, nose & throat disorders?	☐ Yes	☐ No
Neurological or mental disorders?	☐ Yes	☐ No
Skin disorders?	☐ Yes	☐ No
Eye disorders?	☐ Yes	☐ No
Any operations, special investigations?	☐ Yes	☐ No

B: Have you ever been treated or been recommended for treatment for the use of alcohol or drugs? Been advised to stop/reduce the amount of alcohol intake or ever been convicted of any drug related offences?	☐ Yes	☐ No
C: In the previous five years have you been advised to obtain treatment in a hospital or a clinic for any tests, x-rays, treatment or procedures which are not covered within any other questions on this medical questionnaire?	☐ Yes	☐ No
D: Are you aware of any tests, treatment, or specialist consultations that may be necessary within the following two years?	☐ Yes	☐ No
E: Do you have any disorders, deformities or disabilities which you have not disclosed in answers for any other questions on this medical questionnaire?	☐ Yes	☐ No
F: Have you ever been declined for any life or health insurance products (including refusal of a renewal)?	☐ Yes	☐ No
G: Have you undergone a surgical procedure or have reason to believe that a surgical procedure will be required in the future?	☐ Yes	☐ No

If any member to be insured on this application form answers 'Yes' to any of the questions above please give full details. Please note: You should declare all medical conditions or symptoms even if they do not become apparent in the above questionnaire.

Applicant name:	
Describe the condition/symptoms, medication and/or treatment received. Please include dates:	
Initial symptom date:	
Details of ongoing tests, medication and treatment required:	
Please include dates:	

Applicant name:

Describe the condition/symptoms, medication and/or treatment received. Please include dates:

Initial symptom date:

Details of ongoing tests, medication and treatment required:

Please include dates:

Applicant name:

Describe the condition/symptoms, medication and/or treatment received. Please include dates:

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Details of ongoing tests, medication and treatment required:

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Initial symptom date:

Details of ongoing tests, medication and treatment required:

Please include dates:

Applicant name:

Describe the condition/symptoms, medication and/or treatment received. Please include dates:

Initial symptom date:

Details of ongoing tests, medication and treatment required:

Please include dates:

If you require additional space, please attach a separate sheet.

Declaration

I/We hereby apply to be covered under the selected Freedom Health Insurance Worldwide Policy together with the dependants listed in this application.

I/We declare that the statements made on this application form and any additional information supplied as part of this application is full and accurate. Failure to take reasonable care in answering any questions may result in claims being declined, your or any applicant's underwriting terms being changed or the cover being cancelled.

I/We shall read the Policy documents when I receive them and agree that I, and any other dependants included in this application, will be bound exclusively by the terms and conditions of the Policy. This agreement shall constitute the entire agreement between the parties.

I/We understand and accept the information provided in the underwriting section of the Worldwide brochure.

I/We understand that this application is subject to acceptance by Freedom Health Insurance and the medical information provided may result in a Policy endorsement(s) being applied or in some circumstances Freedom Health Insurance being unable to offer cover.

I authorise and request the doctor named in this application and/or any other medical establishment, including any other health professional who has attended me and any of my dependants included under this plan for treatment of a medical condition, to provide Freedom Health Insurance with the information they may need in connection with any claim made under this plan.

I accept, if I do not provide the information required in the medical practitioner section 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 medical condition by Freedom Health Insurance, such claim will be rejected.

Use of personal information

Personal information given on this application form will be used to administer your insurance policy. This includes underwriting your policy to decide what cover we can offer, administering your policy and handling claims, and helping to detect and prevent fraud.

Personal information may be shared with third parties that help us administer your policy. We may also share personal information with regulatory bodies, medical professionals involved in your treatment, and any broker acting on your behalf.

The way we use personal information is explained in our Privacy Policy which is on our website at **freedomhealthinsurance.co.uk/privacy-policy**. Alternatively you can ask us for a copy.

Marketing choices

☐ From time to time, we would like to tell you about products and services that may be of interest to you. If you would like to receive this information, please tick this box. You can unsubscribe at any time by contacting us at **dataprotection@freedomhealthinsurance.co.uk**.

Signature: _____ Date: D D M M Y Y Y Y

(For office use only)

Agent/Broker name: _____ Agent/Broker number: _____

Methods of payment

☐ Annual cheque
Please attach the annual cheque payment

☐ Credit card or debit card
Please complete section 1 below

☐ Direct Debit
Please complete section 2 below

☐ Euros (€)

☐ GB Pounds (£)

☐ US Dollars ($)

1. Credit card or debit card

Credit/debit card authorisation form

☐ Monthly ☐ Annually

Type of card: ☐ Mastercard ☐ Visa ☐ Debit

Name on card:

Card number:

Security number: Expiry date: M M Y Y Y Y

To Freedom Health Insurance

I authorise you, until further notice in writing, to charge my Mastercard/Visa account with unspecified amounts in respect of premiums as and when they become due.

Signed: Date: D D M M Y Y Y Y

2. Direct Debit (UK bank account holders only)

DIRECT Debit

Service User Number

9	1	3	0	3	9

☐ Monthly ☐ Annually

Instruction to your bank/building society to pay by Direct Debit to:

Freedom Health Insurance, County Gates House, 300 Poole Road, Poole, BH12 1AZ.

Please complete parts 1-5 to instruct your bank/building society to make payments directly from your account.

1. Name and full postal address of your branch

To: Bank/Building Society

Address:

Postcode:

2. Branch sort code: - -

3. Account number:

4. Name of account holder:

5. Instruction to your bank or building society

Please pay Freedom Health Insurance, Direct Debits from the account detailed in this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with Freedom Health Insurance and, if so, details will be passed electronically to my bank/building society.

Banks and building societies may not accept Direct Debit Instructions for some types of accounts.

Signed: Date: D D M M Y Y Y Y

The Direct Debit Guarantee

DIRECT Debit

Banks and building societies may not accept Direct Debit Instructions for some types of account.
This Guarantee should be detached and retained by the payer.

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits
- If there are any changes to the amount, date or frequency of your Direct Debit Freedom Health Insurance will notify you 5 working days in advance of your account being debited or as otherwise agreed. If you request Freedom Health Insurance to collect a payment, confirmation of the amount and date will be given to you at the time of the request
- If an error is made in the payment of your Direct Debit, by Freedom Health Insurance or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society
  – If you receive a refund you are not entitled to, you must pay it back when Freedom Health Insurance asks you to
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.