William Russell
Global protection for international living

Global Health Plans

Employee Application Form (Moratorium)

Please complete this form in **BLOCK CAPITALS** using black ink, and return it to us by email, fax or post. You can find our contact details at the end of this form.

Your employment details

Employer: …… Group plan number: ……

Date you started working for your employer: ……

Your personal details

First name: …… Surname: …… Title: ……

Address: ……

……

Telephone number: …… Mobile number: ……

Email: …… Occupation: ……

Date of birth: …… Nationality: …… ☐ Male ☐ Female

Country where you will be living/working: …… How long have you lived here? …… years

Dependants to be included

Please enter details of all dependants to be included in the plan. You may include your spouse or partner, provided they are under age 70 at their date of entry, and your unmarried children (i.e. your son, daughter, step-son, step-daughter, adopted children and children subject to legal guardianship) provided the unmarried children are aged less than 18 years old, or less than 25 years old if in continuous full-time education. Children aged 18 and over, and not in full-time education, must complete their own application form.

	Spouse/partner	Child 1	Child 2	Child 3
First name				
Surname				
Date of birth				
Gender				
Relationship to you				
Country where they will be living				
Occupation/full-time education				

Is your occupation and the occupation of your partner/spouse 100% office-based? ☐ Yes ☐ No

If NO, please provide a job description, or full details of any non-office-based activities and how often they are participated in:

……

Do you or your partner/spouse participate in any hazardous activities? ☐ Yes ☐ No

If YES, please provide full details of any hazardous activities and how often they are participated in:

……

If your employer's plan includes the personal accident optional benefit, this does not cover accidents as a result of hazardous activities/occupations. Cover for hazardous activities/occupations may be subject to a premium loading, special terms, or we may decline to offer cover.

Hazardous activities include off-piste skiing, scuba diving to a depth of more than 30 metres (or any unsupervised scuba diving), rock climbing or mountaineering, pot-holing, hang-gliding, parachuting (including tandem), bungee jumping, kite surfing/

windsurfing, hunting on horseback, driving or riding in any kind of race or competition, flying other than as a passenger in a commercial aircraft, riding a motorcycle (or riding pillion), motor scooter, moped or quad bike, or any other activity that places you in a similar degree of danger as any of those mentioned here.

Previous/current insurance

Have you, or any persons named on this form, ever:

1. **Applied for a plan or been insured with William Russell?** ☐ Yes ☐ No

If YES, please state the plan number: ..... Date of expiry of plan: .....

2. **Had an application for insurance declined or accepted with special terms, or had an insurance policy cancelled by any insurance provider?** ☐ Yes ☐ No

If YES, please provide details: .....

.....

3. **Are you currently insured with another health insurer?** ☐ Yes ☐ No

If YES, please provide details: ..... Date of expiry of plan: .....

Health declaration

Your Global Health plan will be underwritten on a moratorium basis. This means that medical conditions that existed within 2 years before the start date of your plan, and conditions related to these pre-existing medical conditions, will not be covered by your plan.

However, after two years of continuous cover from the start date of your plan, pre-existing medical conditions and any related conditions may be eligible for benefit, subject to the terms and conditions of the plan.

This only applies if, when you first receive treatment, you have not consulted any physician or medical professional for medical treatment or advice (including check-ups), or taken medication (including drugs, medicines, special diets, or injections), for that medical condition or any directly related condition for two continuous years after your policy start date.

It will not be necessary for you to complete a detailed health questionnaire. However, we will need you to provide some brief information about your health by answering the following questions. In some cases we may not be able to accept your application on a moratorium basis and we may ask you to complete a more detailed health questionnaire.

Please complete the following table for yourself, your spouse/partner, and any dependants over age 18 only:

	You	Spouse/partner	Dependants over age 18
Height (cm)			
Weight (kg)			
If you smoke, how many cigarettes/cigars do you smoke daily?			
If you consume alcohol, how many of the following do you consume each week? • *Pints of regular-strength beer or cider* • *Pints of strong beer or cider* • *175ml glasses of wine* • *250ml glasses of wine* • *35ml measures of spirits*			

Medical questions for EACH person to be insured

① **Has any person named on this form been admitted to a medical facility as an in-patient or day-patient in the last five years?** ☐ Yes ☐ No

② **Has any person named on this form undergone any tests or investigations (including x-rays, biopsies or blood tests) or been prescribed with a course of medication or treatment that has lasted more than 7 days, in the last 2 years?** ☐ Yes ☐ No

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③ **Does any person named on this form suffer from any serious health problems (e.g. cancer, diabetes), or a recurrent or chronic illness which requires regular medication or monitoring?** ☐ Yes ☐ No

④ **Is any person named on this form aware of the need for any medical treatment, medication or advice, or does any person have any treatment planned?** ☐ Yes ☐ No

⑤ **Is any person named on this form pregnant?** ☐ Yes ☐ No

Please note, if you have answered YES to any of the these questions we may be unable to offer you moratorium underwriting, and you will need to submit an application for a Global Health plan with full medical underwriting. We also reserve the right to decline an application based upon the medical history disclosed.

If you have answered YES to any of the above questions, please give full details

Question #: ..... Name of person affected by the illness/injury/condition: .....

Date(s) on which the illness/injury/condition occurred: ..... Date symptoms were last suffered: .....

What diagnosis was made and what treatment was received: .....

.....

.....

Is any future treatment required, including consultations with a physician and/or periodic tests or reviews? ☐ Yes ☐ No

If YES, please give details: .....

Please provide the name and address of the treating physician: .....

Question #: ..... Name of person affected by the illness/injury/condition: .....

Date(s) on which the illness/injury/condition occurred: ..... Date symptoms were last suffered: .....

What diagnosis was made and what treatment was received: .....

.....

.....

Is any future treatment required, including consultations with a physician and/or periodic tests or reviews? ☐ Yes ☐ No

If YES, please give details: .....

Please provide the name and address of the treating physician: .....

If you require more space, please continue on a separate sheet of paper. If you are attaching any supporting medical documents, please note that we can only accept them in English.

Physician's details

Please provide details of the physician who is most familiar with the medical history of all those named on this form. If any dependants regularly see a different physician, please provide this information on a separate piece of paper.

Name of physician: .....

Address: .....

Telephone number: ..... Email: .....

How long have you been known to this physician? .....

How we use your information

By submitting this application, you consent to William Russell Limited processing the personal data of each person named in this application, including sensitive medical information. We will use this data strictly within the provisions of the Data Protection Act 1998, and for the purposes of underwriting, administering your plan, and processing claims only.

In certain cases, it may be necessary to pass your data to the insurers and reinsurers of your plan, cost control agents, banks, your employer's appointed intermediary (if any), and our emergency assistance service providers. If you require emergency assistance or treatment outside the European Economic Area (EEA), we may pass your data to parties outside the EEA. If required, we will pass your data to legal or regulatory bodies, and to relevant parties in the interests of fraud prevention.

We may share your data (but not sensitive personal data) with external feedback service providers, to enable you to provide feedback about our services to an independent organisation.

Declaration for your Global Health plan

Please read this section carefully and sign below.

I understand that this application is subject to written acceptance by William Russell Limited. I declare that I have taken reasonable care to answer all questions for each person named on this form fully, accurately, and to the best of my knowledge and belief. I confirm that I have checked with each person that the information I have provided is a true representation of the facts.

I understand that misrepresentation could result in claims being rejected or not fully paid, and/or membership to my plan being cancelled. I also understand that this plan does not cover medical conditions existing before the start date of the plan, unless I have provided full details to William Russell Limited and they have agreed to cover it. I also understand that my Certificate of Insurance will advise me of any medical conditions excluded from cover based on the information provided on this form.

I understand that if I leave my current employment my eligibility to this group plan will no longer be valid, therefore my cover on the plan will cease with immediate effect. I understand that if I wish to take out an individual plan with William Russell Limited, I may need to reapply, and new terms may be issued.

I understand that I must inform William Russell Limited, in writing, of any changes in the facts provided in this application, including any change in health of any persons named on this form occurring before the start date of my plan.

I give consent on behalf of myself and each person named on this form for William Russell Limited to process our personal data within the provisions of the Data Protection Act 1998. I confirm that I have brought the data protection notice above to the attention of each person named on this form.

I understand that, to process my claims, William Russell Limited may need to obtain details of my medical history or of persons named on this form.

I authorise William Russell Limited to send all insurance documents as PDF files to the email address I have provided on this form. If my employer has appointed a broker or intermediary, I give consent for these documents to be sent via email to that broker or intermediary.

I understand that telephone calls to and from William Russell Limited may be recorded and monitored.

Important notes

- Your completed application form is valid for 28 days from the date you signed the form. If cover is not commenced within 28 days, we reserve the right to request that you complete a new application form.
- If the health of any person named on this form changes after you submit this form, but before your plan starts, you must let us know immediately.
- We are unable to accept electronic signatures below.

Name of applicant: .....

Signature of applicant: ..... **Date:** .....

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