

Global Health Plans

Application Form for Employees (Moratorium Underwriting)

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

Your employment details

Employer: Business plan number:
 Date you started working for your employer:

Your personal details

First name: Surname: Title:
 Address:

 Mobile number: Home 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 for all dependants to be covered. You may include your partner provided they are under age 70, and your children provided they 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.

	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				

1. Is your occupation and the occupation of your partner 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:

2. Do you or your partner participate in any hazardous activities? Yes No
 If YES, please provide full details of any hazardous activities and how often they are participated in:

The personal accident plan (if selected by your employer) does not cover accidents as a result of hazardous activities/occupations. Cover for hazardous activities and occupations may be subject to a premium loading, special terms, or we may decline to offer cover.

Dependants to be included (continued)

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

1. Has anyone named on this form ever 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. Has anyone named on this form ever 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. Does anyone named on this form currently have any other health insurance? Yes No

If YES, please state the name of insurer:

Policy number: Policy expiry date:

Health declaration

Your plan will be underwritten on a moratorium basis. This means that medical conditions and related conditions that existed up to 2 years before the start date of your plan will not be covered by your plan. However such pre-existing medical conditions and related conditions may become eligible for cover subject to the terms and conditions of your plan, provided that you have not experienced symptoms, 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 those pre-existing medical conditions and related conditions for 2 continuous years after your plan start date.

Please provide the following information for yourself, your partner, and any dependants over age 18.

	You	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? <ul style="list-style-type: none"> • Pints of regular-strength beer/cider • Pints of strong beer or cider • 175ml glasses of wine • 250ml glasses of wine • 35ml measures of spirits 			

Your 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 of your dependants regularly see a different physician, please provide this information on a separate piece of paper.

Name of physician: Title:

Address:

Telephone number: Email:

How long have you been known to this physician?

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How we use your information

Please read this section carefully.

- We will use the information that you have given us on this application form for the purposes of administering your plan, processing your claims, identifying and preventing fraud, complying with our legal and regulatory obligations, and carrying out research and statistical analysis to help us improve our services. We will not retain your information for longer than is necessary.
- We may share your information with other organisations in relation to the above purposes, e.g. the insurer of your plan, payment service providers, and our emergency medical assistance service providers. This may involve transferring your information to countries outside the European Union.
- Telephone calls to and from William Russell Ltd. may be recorded for training and monitoring purposes.
- By submitting this application form, you consent to us processing the personal information of each person named on this form, including sensitive information such as details about your health, in accordance with our privacy policy.
- Our privacy policy also contains information about who to contact if you have any questions about how we use your information, or if you would like to request a copy of the information we hold about you. For full details of our privacy policy, please visit william-russell.com/privacy or consult your plan agreement.

Declaration for your plan

Please read this section carefully and sign below.

- I understand that my application for a health plan is subject to written acceptance by William Russell Ltd.
- I declare that I have taken reasonable care to answer every question for all persons named on this form fully, accurately, and to the best of my knowledge and belief. I also 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 my plan being cancelled.
- I understand that I must inform William Russell Ltd., in writing, of any changes in the facts provided in my application, including any change in health of any persons named on this form, occurring before the start date of my plan.
- In order to process my claims, I understand that William Russell Ltd. may need to obtain details of my medical history and the medical histories of all persons named on this form.

Declaration for your plan (continued)

- If I leave my current employment, I understand that I will no longer be valid for cover under this business health plan and that my cover will cease with immediate effect. I also understand that, if I wish to take out an individual plan with William Russell Ltd., I may need to re-apply and that new insurance terms may be issued.
- I authorise William Russell Ltd. to send all insurance documents as PDF files to the email address I have provided on this form. If my employer has applied through a broker or intermediary, I give consent for these documents to be sent via email to that broker or intermediary.
- I give my consent and consent on behalf of all persons named on this form for William Russell Ltd. to use our personal information, including sensitive personal information, in accordance with the privacy policy of William Russell Ltd. I confirm that I have read and understood the privacy policy, and that I have brought it to the attention of all persons named on this form.

Some important notes

Please make sure that this form and all supplementary documents are legible. Your completed application form is valid for 28 days from the date you signed the form. If cover has not commenced within 28 days, you may have to complete a new form. If the health of any person named on this forms changes after you submit this form but before your plan starts, you must let us know immediately.

Please return this form to us using the contact details below by post or email.

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.

Name of applicant:

Signature of applicant: **Date:**