

Global Health Plans

Application Form for Individuals & Families (Full Medical 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.

Broker/intermediary details

If you were introduced to us through an intermediary or broker, please state their name and company.

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				

Start date required

When would you like your plan to start? On acceptance of your application Specific date:

Please note that your application is only valid for 28 days from the date we receive it. Cover cannot be backdated.

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:

Please select the cover you require

Please choose either a) an Elite plan or b) an Essential plan, then select the optional benefits you require.

If you have one, please state the quote illustration reference for the quote you wish to accept:

a) Elite plans

Plan: Excess required:

Gold	<input type="checkbox"/> Nil	<input type="checkbox"/> \$50/£33/€45 per claim	<input type="checkbox"/> \$800/£530/€750 per claim	<input type="checkbox"/> \$2,500/£1,660/€2,500 per annum
		<input type="checkbox"/> \$100/£67/€90 per claim	<input type="checkbox"/> \$1,000/£660/€1,000 per annum	<input type="checkbox"/> \$5,000/£3,330/€5,000 per annum
		<input type="checkbox"/> \$250/£167/€225 per annum	<input type="checkbox"/> \$1,600/£1,060/€1,500 per claim	<input type="checkbox"/> \$10,000/£6,600/€10,000 per annum
Silver	<input type="checkbox"/> Nil	<input type="checkbox"/> \$50/£33/€45 per claim	<input type="checkbox"/> \$800/£530/€750 per claim	<input type="checkbox"/> \$2,500/£1,660/€2,500 per annum
		<input type="checkbox"/> \$100/£67/€90 per claim	<input type="checkbox"/> \$1,000/£660/€1,000 per annum	<input type="checkbox"/> \$5,000/£3,330/€5,000 per annum
		<input type="checkbox"/> \$250/£167/€225 per annum	<input type="checkbox"/> \$1,600/£1,060/€1,500 per claim	<input type="checkbox"/> \$10,000/£6,600/€10,000 per annum
Bronze	<input type="checkbox"/> Nil	<input type="checkbox"/> \$250/£167/€225 per annum	<input type="checkbox"/> \$1,000/£660/€1,000 per annum	<input type="checkbox"/> \$2,500/£1,660/€2,500 per annum
		<input type="checkbox"/> \$800/£530/€750 per claim	<input type="checkbox"/> \$1,600/£1,060/€1,500 per claim	<input type="checkbox"/> \$5,000/£3,330/€5,000 per annum
				<input type="checkbox"/> \$10,000/£6,600/€10,000 per annum

Options available with the Elite plans

- Direct billing services** – only available with the Silver or Gold plans **and** if you have also selected a nil or \$50/£33/€45 per claim excess (please note that you must also submit an application for direct billing services)
- Medevac Plus**
- Enhanced well-being benefit** – only available with the Silver and Gold plans
- Dental Basic** – only available with the Silver plan
- Dental Plus** – only available with the Gold plan, and with the Silver plan **if** Dental Basic is also selected
- Semi-private room discount** – only available to residents of Hong Kong with the standard area of cover (this option is not available if you have also selected the ward discount)
- Ward discount** – only available to residents of Hong Kong with the standard area of cover (this option is not available if you have also selected the semi-private room discount)

Your Elite plan area of cover

The standard area of cover for the Elite plans is worldwide excluding the USA. If you require cover in the USA, or if you live in Indonesia, Africa or the Indian Subcontinent and you only require regional cover, please select **one** of the options below. Otherwise, we will assume that you require the standard area of cover.

USA cover options

- Add cover in the USA, limited to US\$100,000 per period of cover for temporary trips of not more than 45 days (this limit is increased to US\$250,000 for emergency treatment for conditions you have never suffered from before).
- Add cover in the USA limited to US\$250,000 per period of cover for temporary trips of not more than 90 days.

Restricted cover options*

If you live in Africa or the Indian Subcontinent:-

- Restrict cover to Africa & the Indian Subcontinent*

If you live in Indonesia:-

- Worldwide cover excluding the USA, with 20% co-insurance on eligible treatment costs in Singapore, Hong Kong, China, Japan, Macau, Taiwan, Switzerland, and hospitals within the London area
- Restrict cover to Indonesia, most of Southeast Asia (excl. Singapore), Central Asia, Africa, and the Indian Subcontinent*

*These options include up to US\$100,000 per period of cover for emergency treatment whilst you are on temporary trips of up to 90 days' duration outside the restricted cover region. No cover at all is provided in the USA, Canada, the Caribbean countries and islands, or hospitals within the London area.

b) Essential plans

Plan:	Excess required:		
Essential Care Plus	<input type="checkbox"/> Nil	<input type="checkbox"/> \$250 per annum	<input type="checkbox"/> \$5,000 per annum
	<input type="checkbox"/> \$50 per claim	<input type="checkbox"/> \$1,000 per annum	<input type="checkbox"/> \$10,000 per annum
	<input type="checkbox"/> \$100 per claim	<input type="checkbox"/> \$2,500 per annum	
Essential Care	<input type="checkbox"/> Nil	<input type="checkbox"/> \$1,000 per annum	<input type="checkbox"/> \$5,000 per annum
	<input type="checkbox"/> \$250 per annum	<input type="checkbox"/> \$2,500 per annum	<input type="checkbox"/> \$10,000 per annum

Your Essential plan area of cover

Cover is provided everywhere, except in the following restricted or excluded countries and regions. Cover is restricted to treatment for accidents or unforeseen illnesses only, and limited to \$50,000 per period of cover if you travel to any European country, Japan, Hong Kong, Macau, China, Taiwan, Singapore, Australia or New Zealand. No cover at all is provided in the USA, Canada, any Caribbean country or island, and any hospital in the London area.

Add-ons available with your health plan

Travel plan You Partner Children

Personal accident plan You Partner

Please select the level of personal accident benefit you require:

- \$75,000 or £50,000 or €75,000 \$150,000 or £100,000 or €150,000 \$225,000 or £150,000 or €225,000
- \$300,000 or £200,000 or €300,000 \$375,000 or £250,000 or €375,000

You only need to complete the next two questions if you have selected a personal accident plan.

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 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.

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.

Paying for your plan

Please select the currency in which you would like to pay your premiums. Your plan benefits and excess will be denominated in this currency. Please note that the Essential plans are only available in US Dollars.

- US Dollars GBP Sterling Euros

Paying for your plan (continued)

Please select your payment method and frequency:

- Credit/debit card Annually Half-yearly² Quarterly³ Monthly³
- Direct debit¹ Annually Half-yearly² Quarterly³ Monthly³
- Bank transfer Annually

¹ Direct debit payments are only available when you pay in Sterling from a UK bank account.

² Half-yearly premiums are subject to a 3% surcharge.

³ Quarterly or monthly premiums are subject to a 5% surcharge.

Health declaration

Your plan will be underwritten on a full medical underwriting basis. Please complete the following health declaration and provide us with full details of any medical conditions existing before the start date of your plan. Pre-existing medical conditions and related conditions will not be covered, unless you have told us about them and we have agreed to cover them. This includes conditions arising between the time you submit this application and the start date of your plan, so please contact us immediately if the information provided changes.

Please answer the following questions for each person named on this form fully, accurately, and to the best of your knowledge and belief. If you answer YES to any question, please supply full details in the spaces provided. If you require more space please continue on a separate sheet of paper. If you do not answer the questions fully and accurately, your plan may be cancelled, claims may be rejected, or special terms may be applied retroactively. If you are in any doubt as to whether you should tell us anything, please tell us anyway.

Please complete the following table 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 			

Medical questions for EACH person to be insured

① Has any person named on this form ever suffered from any of the following conditions?

- a) **Brain or nervous system conditions?** Yes No
 For example: stroke/transient ischemic attack (TIA), epilepsy, migraines or repeated headaches, multiple sclerosis, meningitis, shingles, nerve pain.
- b) **Cancer, tumours or growths?** Yes No
 For example: polyps, benign growths or cysts, lymphomas, any cancers or pre-cancerous conditions.
- c) **Heart or circulatory conditions?** Yes No
 For example: high blood pressure, angina/chest pains, heart attacks or failure, abnormal heartbeat, varicose veins, raised cholesterol, stroke, deep vein thrombosis.

Health declaration (continued)

- d) **Psychiatric, psychological conditions or sleep disorders?** Yes No
 For example: depression, anxiety, stress, anorexia nervosa, autism, bipolar disorder, insomnia, narcolepsy, sleep apnoea.
- e) **Joint replacements?** Yes No
- ② In the last five years, has any person named on this form seen a physician, or experienced any symptoms, or been admitted to a hospital or medical facility for an operation or procedure, or undergone any tests or investigations, for any of the following conditions:
- a) **Auto-immune disorders?** Yes No
 For example: HIV/AIDS, rheumatoid arthritis, systemic lupus erythematosus, scleroderma.
- b) **Back, joint, muscular or skeletal problems?** Yes No
 For example: back or joint pain, whiplash, sciatica, degenerative changes, osteoarthritis, osteoporosis, gout, bunions, fractures, cartilage or ligament problems.
- c) **Breathing or upper and lower respiratory conditions (including allergies)?** Yes No
 For example: asthma, chronic obstructive pulmonary disease (COPD), shortness of breath, chest infections, pneumonia, bronchitis, tuberculosis (TB), allergies to food substances and animals.
- d) **Diabetes, thyroid or any other endocrine disorder?** Yes No
 For example: diabetes type 1 or 2, overactive or underactive thyroid, pituitary or adrenal problems, obesity.
- e) **Eyes, ear, nose and throat or oral/dental conditions?** Yes No
 For example: glaucoma, cataracts, retinal detachment, macular degeneration, hearing difficulties, repeated ear infections, tonsillitis, sinusitis, dental problems, wisdom teeth problems, gingivitis.
- f) **Gynaecological or breast conditions?** Yes No
 For example: complications of pregnancy, heavy or irregular periods, fibroids, endometriosis, ovarian cysts, abnormal smear tests, miscarriage, pre- and post-natal complications, breast lumps/ cysts.
- g) **Skin conditions (including allergies)?** Yes No
 For example: eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed or allergic reactions.
- h) **Stomach, liver/gall bladder, or digestive system conditions?** Yes No
 For example: ulcers, irritable bowels, Crohn's disease, colitis, reflux/heartburn abdominal pain, anaemia, hepatitis, cirrhosis, gallstones, hernias, haemorrhoids/piles.
- i) **Urinary, kidney or prostate conditions?** Yes No
 For example: kidney infections, kidney stones, incontinence, prolapse, prostate problems, recurrent bladder or urine infections.
- j) **Any alcohol and/or drug dependency problems?** Yes No
- k) **Any physical defect, infirmity or congenital condition?** Yes No
- l) **Any other medical condition not mentioned above?** Yes No
- ③ Is any person named on this form currently taking any medication, prescribed or otherwise? Yes No
- ④ Has any person named on this form experienced any signs or symptoms of any medical condition in the last six months, whether or not a physician has been consulted? Yes No
- ⑤ Is any person named on this form currently undergoing any treatment or periodic reviews for a medical condition, physical impairment, disability or recurrent illness not already mentioned? Yes No
- ⑥ Is anyone named on this form currently pregnant? Yes No

Health declaration (continued)

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

Question no: Name of person affected:

Date(s) on which the injury or condition occurred:

Date symptoms were last suffered:

Please state what diagnosis was made, and what treatment was received:

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Is any future treatment required, including consultations with a physician or periodic tests or reviews?

Yes No If YES, please give details:

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Question no: Name of person affected:

Date(s) on which the injury or condition occurred:

Date symptoms were last suffered:

Please state what diagnosis was made, and what treatment was received:

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Is any future treatment required, including consultations with a physician or periodic tests or reviews?

Yes No If YES, please give details:

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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.

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. 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 the plan I am applying for does not cover medical conditions that existed before the proposed start date of the plan, unless I have provided full details of any such medical conditions to William Russell Ltd. and William Russell Ltd. has agreed to cover them. I also understand that my certificate of insurance will advise me of any medical conditions that are not covered by my plan, based on the information I have provided on this form.
- 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)

- I authorise William Russell Ltd. to send all insurance documents as PDF files to the email address I have provided on this form. If I have 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.
- I understand that, upon receipt of my insurance documents, if I am not entirely satisfied, I can cancel my application from inception and receive a full refund of the premium paid, provided I notify William Russell Ltd. within 30 days of the plan start date, and provided no claim has been made.

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:**

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