

EMPLOYEE APPLICATION FORM (MORATORIUM)

Please complete this form in block capitals using black ink



GLOBAL HEALTH[®]
Health Insurance for Expatriates

SECTION 1: TO BE COMPLETED BY THE EMPLOYER

Employer: _____ Group No: _____
Employee name: _____ Mr/Dr/Mrs/Ms/Miss _____ Date of employment: _____

GLOBAL HEALTH PLAN REQUIRED

Please complete this section if the employee named above requires different cover to that stated on your Corporate Application Form.

Global Health Essential

Essential Care Essential Care Plus

Global Health Elite

Bronze Silver Gold Platinum Bespoke (50+ employees)

Area of cover required for Global Health Elite plan:

- Standard** – Area 1 World-wide cover excluding the USA.
 World-wide – Area 2 World-wide with cover in the USA limited to temporary trips of up to 45 days and a benefit limit of US \$100,000.
 World-wide Plus – Area 3 World-wide with cover in the USA limited to temporary trips of up to 90 days and a benefit limit of US \$250,000.
 Semi-private room discount: Only available to residents of Hong Kong and Singapore.
 Direct billing in Hong Kong and China: Available to residents of Hong Kong with a nil excess. Available to residents of China with a nil or \$50 / £30 / €45 excess. A 7.5% premium surcharge will apply in China.

Required excess

The standard excess is Nil for Essential Care and Bronze, and \$50/£30/€45 for Essential Care Plus, Silver, Gold and Platinum (\$15 / AED 55 in UAE).

- Nil
 \$50/£30/€45 (\$15 / AED 55 in UAE per consultation) n/a for Essential Care or Bronze
 \$100/£60/€90 (\$30 / AED 110 in UAE per consultation) (n/a for Essential plans or Bronze)
 Other, please state: _____

OPTIONAL GLOBAL TRAVEL PLAN REQUIREMENTS

Employee Employee and partner Employee, partner and dependants

OPTIONAL GLOBAL PERSONAL ACCIDENT PLAN REQUIREMENTS

Employee Employee and partner

Exclusions apply in respect of hazardous occupations and hazardous sports. When Personal Accident Benefit cover is required for an employee whose occupation is not 100% office based, or who participates in hazardous activities of any kind, a detailed job description and / or details of their hazardous activities must be submitted to us. Cover for hazardous occupations / activities may be subject to a premium loading.

SECTION 2: TO BE COMPLETED BY THE EMPLOYEE

PERSONAL DETAILS

Have you previously been insured, or are you currently insured, with William Russell? Yes No

Previous/current policy number: _____ Date of expiry of previous policy: _____

Have you previously been insured, or are you currently insured, with another health insurer? Yes No

Name of Insurer: _____

Your first name: _____ Surname: _____ Mr/Dr/Mrs/Ms/Miss _____

Address: _____

Telephone No (for correspondence): _____ Telephone No (other): _____ Fax No: _____

Email (home): _____ Email (other): _____

Date of birth: _____ Nationality: _____ Male Female

Country of residence: _____ Occupation: _____

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

If YES, please give full details _____

FAMILY MEMBERS TO BE INCLUDED IN THE PLAN

Please enter the names and details of all dependants for whom cover is required. You may include your partner and children, up to age 18 or up to age 25 if in full-time education – proof will be required. Children aged 18 or over who are not in full-time education must make their own application for cover.

First name(s)	Surname	Date of birth dd/mm/yy	Relationship to applicant	Country of residence	Occupation/ Full-time education
Partner					
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No
Child					<input type="checkbox"/> Yes <input type="checkbox"/> No

GENERAL DECLARATION OF GOOD HEALTH

1. Your height (cms): _____ Your weight (kgs): _____ Your partner's height (cms): _____ Your partner's weight (kgs): _____

2. Have any persons named in this application ever:

- A. Suffered from, been diagnosed with, treated or prescribed drugs for any form of cancer, or heart disease, or any other serious or chronic illness that requires regular medication and/or monitoring? Yes No
- B. Been tested HIV and/or Hepatitis C positive? Yes No
- C. Had an application for insurance turned down or accepted at special terms? Yes No

If you answered YES to any question, please state the names(s) of the person(s) and details: _____

PRE-EXISTING MEDICAL CONDITIONS AND RELATED CONDITIONS

The Global Health plans do not cover the treatment of pre-existing medical conditions and related conditions. A pre-existing medical condition means any disease, illness or injury for which you have received medication, advice or treatment, or for which you have experienced symptoms, whether the condition has been diagnosed or not, during the 24 month period preceding the commencement of your Global Health plan.

After two years of continuous cover, some pre-existing medical conditions will become eligible for benefit, subject to the terms and conditions of your plan, provided you have not consulted any doctor or medical practitioner for medical treatment or advice (including check-ups), or taken medication, (including injections), or been advised to follow a special diet, or suffered symptoms for that medical condition, or for any related condition, for a continuous period of two years.

Examples of pre-existing conditions that will never be covered include diabetes, hypertension (raised blood pressure), hyperlipidaemia (raised cholesterol levels), ischemic heart disease, cancer, thyroid disease, and auto-immune disorders. If you have suffered from any of these conditions, or any other condition for which it is generally accepted medical advice that it be monitored in any way, then that condition – and any related conditions – will never be covered. Examples of related conditions are raised cholesterol levels and heart disease and stroke. If you have suffered from high cholesterol before your date of entry to the plan you will never be covered for cardiac problems or strokes.

DOCTOR'S CONTACT DETAILS

1. Please give details of the doctor who is most familiar with your medical history and the medical history of your family members.

Name: _____ Practice name: _____
Address: _____
Telephone No: _____ Fax No: _____ Email: _____
Length of time you have known this doctor: _____ If less than two years, please complete question 3.

2. If this doctor does not treat all persons named in this application, please supply additional information.

Name: _____ Practice name: _____
Address: _____
Telephone No: _____ Fax No: _____ Email: _____
Who does this doctor treat? _____ Length of time the patient has known this doctor: _____

3. If you or your family member(s) have known the doctor(s) above for less than two years, please provide details of the previous doctor(s).

Name: _____ Practice name: _____
Address: _____
Telephone No: _____ Fax No: _____ Email: _____
Who did this doctor treat? _____ Length of time the patient has known this doctor: _____
Date of last consultation: _____

THE INSURER

If you are resident in the United Arab Emirates (UAE), the insurer of your Global Health plan will be Dubai Insurance Company psc.
If you a resident outside the UAE, the insurer of your Global Health plan will be Hauteville Insurance Company Limited.

DECLARATION AND AUTHORISATION

I hereby apply for cover on behalf of all the persons named in this application form under my employer's Global Health plan as specified above. I declare that all the persons named in this application form are in good health, and not aware of any symptoms or pre-existing medical conditions that may give rise to a claim under the Global Health plan.

I declare that I have read and understood the plan agreement of the Global Health plan as specified above and that I am aware that cover shall be provided in accordance with the agreement. I fully understand that pre-existing conditions as defined in the Global Health plan agreement shall not be covered by the insurance plan. I authorise any doctor who has ever treated or advised any of the persons named in this application to provide William Russell Limited with any information they may require in connection with treatment related to any claim under this plan. I declare that the information given in this application is true and complete.

If my employer has applied for a travel insurance plan, I declare that at the time of purchasing this insurance or at the time of booking any future trip(s), I am aware of no reason why any journey or trip should be cancelled or curtailed or expense be incurred.

Signature of employee:

Date:

Signed on behalf of the employer:

Date:

Position in Company:

IMPORTANT: Please ensure you have given an answer to every question. An incomplete form will delay your application.



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