EMPLOYEE APPLICATION FORM (UNDERWRITTEN)

Please complete this form in block capitals using black ink

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					☐ **Yes** ☐ **No**
Child					☐ **Yes** ☐ **No**
Child					☐ **Yes** ☐ **No**
Child					☐ **Yes** ☐ **No**

HEALTH DECLARATION

IMPORTANT

The Global Health plans do not cover the treatment of pre-existing conditions and related conditions. A pre-existing condition means any disease, illness or injury for which you have received medication, advice or treatment, or you have experienced symptoms, whether the condition has been diagnosed or not, at any time before the start of your cover. A related condition is any disease, illness or injury that is caused by a pre-existing condition or results from the same underlying cause as a pre-existing condition.

We rely on the information that you give us in this form when we decide whether or not to accept your application, and whether or not we need to apply special terms. Special terms are exclusions or conditions that we may apply to your cover. If you submit a claim for the treatment of any pre-existing condition or related condition which you omitted to tell us about here or you omit to tell us everything about, we will refuse to pay that claim. We also have the right to declare your Global Health plan void, or we may impose special terms on your plan which will apply retrospectively. Please therefore take the greatest care to ensure that this application form is completed fully and accurately.

If, after completing your application form, any changes occur in the facts contained in the form, such as a change in your state of health or the state of health of any of your dependants, you must tell us in writing about the change, and we reserve the right to decline or accept your application or to accept your application form with special terms.

Please give full details about each condition by answering the questions in the following health declaration accurately and in as much detail as possible. Please continue on a separate sheet if necessary. We cannot accept your application if this health declaration is incomplete.

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. Undergone a surgical operation (including any cosmetic surgery or any refractive laser eye surgery)?........ ☐ **Yes** ☐ **No**
B. Been a patient in a hospital clinic or sanatorium?........ ☐ **Yes** ☐ **No**
C. Been advised to have any medical tests or investigations?........ ☐ **Yes** ☐ **No**
D. Been tested HIV and /or Hepatitis C positive?........ ☐ **Yes** ☐ **No**
D. Had an application for insurance turned down or accepted at special terms?........ ☐ **Yes** ☐ **No**

3. Are any of the persons named in this application aware of any symptoms present now which may give rise to a claim? ☐ **Yes** ☐ **No**

4. Are any persons named in this application currently taking any drugs or medication?........ ☐ **Yes** ☐ **No**

5. Have any persons named in this application ever suffered from, been diagnosed with, treated or prescribed drugs for:

A. Conditions of the eyes, ears, nose or throat?........ ☐ **Yes** ☐ **No**
B. Fainting, blackouts or fits?........ ☐ **Yes** ☐ **No**
C. Any high blood pressure, heart or circulatory conditions?........ ☐ **Yes** ☐ **No**
D. Diabetes?........ ☐ **Yes** ☐ **No**
E. Any rheumatic or arthritic conditions?........ ☐ **Yes** ☐ **No**
F. Any spine, bone, muscle or joint conditions?........ ☐ **Yes** ☐ **No**
G. Asthma, respiratory, pulmonary or allergic conditions?........ ☐ **Yes** ☐ **No**
H. Genito-urinary or renal conditions?........ ☐ **Yes** ☐ **No**
I. Stomach, liver or bowel conditions?........ ☐ **Yes** ☐ **No**
J. Cysts, tumour or cancer?........ ☐ **Yes** ☐ **No**
K. Any skin conditions?........ ☐ **Yes** ☐ **No**
L. Any gynaecological or breast conditions?........ ☐ **Yes** ☐ **No**
M. Any physical defect, infirmity or congenital illness?........ ☐ **Yes** ☐ **No**
N. Any nervous, mental or psychiatric condition?........ ☐ **Yes** ☐ **No**
O. Any alcohol and/or drug dependency problem?........ ☐ **Yes** ☐ **No**
P. A higher than normal cholesterol level?........ ☐ **Yes** ☐ **No**
Q. Any neurological conditions, including migraine and/or headaches?........ ☐ **Yes** ☐ **No**
R. Any other type of disease, injury or medical condition?........ ☐ **Yes** ☐ **No**

6. Has any person named in this application ever suffered from any pre or post natal complications, complications of childbirth or suffered any miscarriage?........ ☐ **Yes** ☐ **No**

If you have answered YES to any question, please give full details on the following page. Please continue on a separate sheet if necessary.

Question No: Name of person who suffered the illness/injury:
Date(s) on which the illness/injury occurred:
Diagnosis:
Treatment/tests performed and results:

Date you last suffered symptoms or received treatment relating to this condition:
Name and address of treating physician:

Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: Name of person who suffered the illness/injury:
Date(s) on which the illness/injury occurred:
Diagnosis:
Treatment/tests performed and results:

Date you last suffered symptoms or received treatment relating to this condition:
Name and address of treating physician:

Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: Name of person who suffered the illness/injury:
Date(s) on which the illness/injury occurred:
Diagnosis:
Treatment/tests performed and results:

Date you last suffered symptoms or received treatment relating to this condition:
Name and address of treating physician:

Give details of any foreseeable need for further consultation or treatment for this condition:

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:

Please continue on a separate sheet if necessary.

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 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 have made a full and complete disclosure about the medical history of each person included in this application and I fully understand that pre-existing conditions as defined in the Global Health plan agreement shall not be covered by the insurance plan. I also understand that I must notify William Russell Ltd of any changes in the facts contained in this application form, such as a change in the state of health of any person named in it. 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. If after completing, signing and dating your application form any changes occur in the facts you have given us, such as a change in your state of health or in the state of health of any of your dependants, you must tell us in writing about the change, and we reserve the right to decline to accept your application or to accept your application with special terms.

WILLIAM RUSSELL
Peace of mind wherever you are

William Russell Limited
William Russell House,
The Square, Lightwater,
Surrey, GU18 5SS, UK.
T + 44 1276 486455
F + 44 1276 486466
sales@william-russell.com

William Russell (Asia Pacific) Limited
Marketing Office, Suite 7-3, 7th Floor,
Wisma UOA II, 21 Jalan Pinang,
50450 Kuala Lumpur, Malaysia.
T + 6 03 2171 2071
F + 6 03 2171 2072
kloffice@william-russell.com

Dubai Insurance Company
PO Box 3027, Dubai, UAE.
T + 971 4 2693030 (Ext 102)
F + 971 4 2693727
sales@globalplans.ae
www.globalplans.ae

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