MediCare INTERNATIONAL

Broker's stamp

jbi Insurance Brokers
Agent No: 1096

Policy number

Effective date
(Cover may not be backdated)

Return completed form to your Financial Advisor or Broker or to:
MediCare International
The Matrix, 9 Aldgate High Street
London EC3N 1AH, England
Telephone: +44 (0)20 7204 3700
Facsimile: +44 (0)20 7204 3746
E-mail: medicare@medicare.co.uk
Website: www.medicare.co.uk

Individual Application Form

PLEASE COMPLETE IN BLOCK CAPITALS AND TICK RELEVANT BOXES

Your personal details

Applicant's full name:

Mailing address:

Postcode: Country:

Telephone: Facsimile: Email:

Occupation: Nationality:

(Which will be used to establish the Home Country of the Applicant and Dependants)

Cover required (please tick)

International Plan ☐
International Plus Plan ☐
Executive Plan ☐
Executive Plus Plan ☐
Waive Outpatient Excess* ☐
*applicable to the Executive Plus Plan only

Area 1 Worldwide ex USA, Canada & Caribbean ☐
Area 2 Worldwide ☐

Voluntary Excess Option
£500/$850/€650 ☐
£1,000/$1,700/€1,300 ☐
£5,000/$8,500/€6,500 ☐
£10,000/$17,000/€13,000 ☐

Required start date

On Acceptance ☐ Other (please specify) ☐

Persons to be insured

Surname	First Names	Date of Birth	Sex	Country of Residence	Area of Cover Required
Applicant:					
Spouse/Partner:					
Child:†					
Child:†					
Child:†					
Child:†					

†*Up to the age of 18, or 24 if still in full-time education. Evidence will be required.*

Your Doctor's contact details

Please give details of the doctor(s) who is(are) most familiar with your/your dependants medical history

Doctor's Name: Doctor's Name:

Address: Address:

Telephone No: Telephone No:

Declaration

I hereby apply to be enrolled in the Plan together with the persons to be insured listed above. I declare to the best of my knowledge and belief that the information given in this Application is true and complete. For my benefit and protection, I have read the Plan Rules carefully, (including the Rules relating to newborn children) and requested further information on any points I do not understand. I understand the Rules to be part of any contract of insurance issued as a result of this Application. I agree that they will be binding on me and all eligible dependants included in my membership. I acknowledge on behalf of all the persons to be insured that benefits will not apply to treatment arising from any pre-existing conditions as more fully defined in the Plan Rules. It is agreed that this declaration and the information given in this Application shall form the basis of the contract(s) between the Insured Person(s) and the Insurer.

Signature of applicant: Date:

(On behalf of all persons to be insured)

PLEASE COMPLETE THE METHOD OF PAYMENT FORM AND RETURN IT WITH YOUR APPLICATION FORM TO MEDICARE INTERNATIONAL

Data Protection Act

The information you have provided will become part of the personal data held by MediCare International and will be used for the provision and administration of insurance products and services. MediCare International may disclose your personal data to insurance companies and to their agents for underwriting, claims handling and fraud prevention services. In addition, it may seek information from insurance companies to check the answers you have provided. Full details of MediCare International's processing of personal data appear in the register maintained by the Information Commissioner.

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Medical Questionnaire (for 65 years and over only)

If you or your spouse/partner are 65 years or older you must complete this form

PLEASE COMPLETE FULLY IN BLOCK CAPITALS AND TICK ALL RELEVANT BOXES

Personal details

Applicant's full name: _____ Spouse/Partner's full name: _____

Height (cms): _____ Weight (kgs): _____ Height (cms): _____ Weight (kgs): _____

Please provide details of the Doctor(s) who is (are) most familiar with your/your spouse/partner's medical history

Doctor's name: _____ Doctor's name: _____

Address: _____ Address: _____

_____ _____

Telephone No: _____ Telephone No: _____

1. Have you had any surgical procedure, been confined or treated in a hospital, clinic, sanatorium, nursing home or other medical institution within the last five years, or is any treatment or tests currently being performed or any operation/hospital confinement scheduled?

   Applicant: ☐ Yes ☐ No Spouse/Partner: ☐ Yes ☐ No

2. Have you ever had any treatment, tests or medical examinations performed by a General Practitioner or Consultant, including Prescription Drugs, within the last five years?

   Applicant: ☐ Yes ☐ No Spouse/Partner: ☐ Yes ☐ No

3. Are you currently suffering from any medical condition or disability or experiencing symptoms of any kind which might reasonably be considered to require medical treatment in the future?

   Applicant: ☐ Yes ☐ No Spouse/Partner: ☐ Yes ☐ No

Important

If the answer to any of the above questions is "Yes", please give full details, including dates, nature of ailment or disability, medical procedure or tests performed and details of any drugs prescribed. Please state the name and address of the treating physician/consultant and/or medical facility where tests or treatment took place.

Applicant: _____

_____

_____

Spouse/Partner: _____

_____

_____

Declaration

I declare that the answers to the above questions are accurately represented and are to the best of my knowledge and belief, full, complete and true, and that I do not have any knowledge of any circumstance that could affect the results of the evaluation by the Insurer related to my application for insurance. I authorise any physician or practitioner who has observed me or my spouse/partner for diagnosis, treatment, disease or ailment, to give to the Insurer full particulars of these, including any prior medical history. I waive in my name, and that of any other person who shall have or claim an interest in any policy issued as a result of the answers, all provisions of law forbidding such action. The refusal to submit medical information by any Insured or doctor, clinic, hospital or institution shall be considered as a waiver of benefit by such Insured and/or supplier of services and the Insurer shall have no further obligation towards such persons or entity. I consent to the processing by MediCare International of any of the personal data I provide or which is provided to MediCare International about me by any other person.

Signature of Applicant: _____ Date: _____

Signature of Spouse/Partner: _____ Date: _____

Cover will not commence until you have been advised by MediCare International of any special terms that may apply and you have confirmed acceptance of such terms and paid the premium due.