



APPLICATION FORM

Please complete this form in block capitals. Payment must be submitted before any cover can be granted. You must disclose in this form, fully and faithfully, all material facts. A material fact is one that is likely to affect the assessment of this health insurance application. Failure to do so may result in you not receiving any benefit from your policy.

Company Name _____ Group Number: _____
If you are applying as an employee of a company, please insert the name of the company above. If you are applying as an individual or a family, please leave it blank. Please complete in block capitals.

1. YOUR PERSONAL DETAILS (MAIN APPLICANT)

Title: _____ First Names: _____
Family Name: _____
Gender (please circle): M/F _____ Nationality: _____ Date of Birth (dd mm yy): _____
Occupation: _____
Usual Country of Residence: _____ Passport/ID number: _____

2. CONTACT DETAILS

Residential address of the country where you spend more than 6 months per year:
Address: _____
Country: _____ Postal Code: _____
Email Address: _____
Country Code Area Code Number Country Code Area Code Number
Home Telephone: _____ Work Telephone: _____
Country Code Area Code Number Country Code Area Code Number
Fax Number: _____ Mobile Telephone: _____

3. ADDITIONAL MEMBERS TO BE COVERED

Title: _____ First Names: _____
Family Name: _____
Gender (please circle): M/F _____ Nationality: _____ Date of Birth (dd mm yy): _____
Occupation: _____
Usual Country of Residence: _____
Relationship to main applicant: _____

1st Child
Title: _____ First Names: _____
Family Name: _____
Gender (please circle): M/F _____ Nationality: _____ Date of Birth (dd mm yy): _____
Occupation: _____
Usual Country of Residence: _____

2nd Child
Title: _____ First Names: _____
Family Name: _____
Gender (please circle): M/F _____ Nationality: _____ Date of Birth (dd mm yy): _____
Occupation: _____
Usual Country of Residence: _____



3rd Child

Title: _____ First Names: _____
 Family Name: _____
 Gender (please circle): M/F _____ Nationality: _____ Date of Birth (dd mm yy): _____
 Occupation: _____
 Usual Country of Residence: _____

4. YOUR CHOICE OF MEDICAL COVER

Please tick one box only

Plan: Essential Comprehensive Supreme Do you wish to purchase the optional dental cover? Yes No

Area of Cover: Area 1 (Worldwide) Area 2 (Worldwide excluding USA) Other: _____

Deductible: (US \$500) (US \$1,000) (US \$2,000) Nil
 (£300) (£600) (£1,200)
 (€400) (€800) (€1,600)

5. METHOD OF PAYMENT AND CONTRACT DETAILS

Contract Details

Date you want cover to commence (dd/mm/yy): _____
 (Please note this date cannot be prior to the date we receive this application form)

Payment Details

Currency (please tick one box only): US \$ EURO GB £

Method (please tick one box only):
 Bank Cheque Bankers Draft Bank Transfer*

Amount: _____
 (Please make payable to Optimum Global Ltd.)

There are no payment surcharges for annual payments. However, you can choose the option of paying half yearly, for which there is a 3% surcharge , or quarterly for which there is a surcharge of 5% .

*Any charges made by the remitting bank and receiving bank in the course of submitting funds to Optimum Global Ltd must be borne by the applicants. This may mean that it is necessary to pay an amount in excess of the contribution due to the plan to cover these charges.

Please indicate your name and invoice number when remitting payment.
 Please remit the amount to the currency denominated bank account of Optimum Global Limited as shown below:

Currency	Bank branch & Identifier code	Swift code	Iban number	In favour of	Optimum Global Account number
US Dollar (\$)	HSBC, Horsham MIDLGB2114G	MIDLGB22	GB31MIDL40051567496486	OptimumGlobal	67496486
Euro (€)	HSBC, Horsham, MIDLGB2114G	MIDLGB22	GB94MIDL40051567518535	Optimum Global	67518535
GB Pound (£)	HSBC, Horsham MIDLGB2114G	MIDLGB22	GB13MIDL40243311578189	Optimum Global	11578189



6. CONFIDENTIAL MEDICAL HISTORY

	Main Applicant		Spouse/Partner		1st Child		2nd Child		3rd Child	
Name										
Height (cm)										
Weight (kg)										
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Smoker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Has any person named in this form been admitted to hospital or nursing home or had any medical tests done in the last 4 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has any specialist been consulted and/or provided prescriptions for any drugs or medication in the last 4 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has any application for life, accident, health or any other insurance been refused or had special terms applied?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does any person named in this form anticipate the need or has been recommended to undergo any medical tests or investigations in the foreseeable future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has any person named in this form ever suffered from or are suffering from any disease or condition stated below?

	Yes
Heart trouble or chest pains	<input type="checkbox"/>
Blood pressure problems or circulatory disorders	<input type="checkbox"/>
Fainting, blackouts, dizziness, seizures, fits	<input type="checkbox"/>
Strokes or paralysis	<input type="checkbox"/>
Asthma, persistent cough, breathlessness or other respiratory disorders	<input type="checkbox"/>
Stomach ulcer, liver, hepatitis, gall bladder, intestinal or bowel disorders	<input type="checkbox"/>
Kidney, bladder, prostate or genitor-urinary disorders	<input type="checkbox"/>
Gynaecological or hormone disorders or irregularity	<input type="checkbox"/>
Diabetes, cholesterol problems or diseases or disorders of the blood	<input type="checkbox"/>
Tumour growth, cancer or glandular diseases or abnormalities	<input type="checkbox"/>
Diseases or disorders of the eyes, ears, nose or throat	<input type="checkbox"/>
Diseases or disorders of the back, bones, joints, muscles or skin	<input type="checkbox"/>
Mental or nervous disorders	<input type="checkbox"/>
AIDS, HIV or venereal diseases	<input type="checkbox"/>
Any diseases, disorders or conditions which are long lasting or recurrent	<input type="checkbox"/>
Treatment for drug or alcohol addiction or abuse	<input type="checkbox"/>
Any other illnesses, disabilities or defects present that may require treatment that have not already been disclosed	<input type="checkbox"/>

If you have answered 'yes' to any of the above questions, please provide more details by indicating the question number, the condition, dates of consultation, the treatment received and the name and address of doctor. Use the enclosed Continuation Page. Please attach a copy of all medical reports if applicable. Attach these items to this form and indicate you have done so by ticking this box:



7. DECLARATION

Benefits may not be payable if you do not fully disclose any material facts which could influence our assessment and acceptance of this application and, if you are in any doubt as to whether any facts are material, you should disclose them.

I/We declare that all the information on this application form is true and complete. I am/We are unaware of the existence of any medical condition or circumstance foreseeably requiring my/our hospitalisation in the future, and understand that benefits will not apply to treatment or expense arising from medical conditions which originated or were known to exist or for which treatment, medication, advice or diagnosis was sought or received prior to my/our enrolment in the Policy unless such conditions are fully disclosed to and accepted by Optimum Global Ltd prior to the inception of the Policy. I/We consent to Optimum Global Ltd seeking information from any doctor who has attended to me/us and I/we authorise the giving of such information. I/We further authorise Optimum Global Ltd to give such information obtained or information contained herein for the purpose of obtaining insurance cover under this application to my insurance representative. I/We understand that Optimum Global Ltd may require further medical information from my doctor and I/we am/are aware that I am/we are responsible for obtaining and paying for such information should I/we wish to continue my/our application. I am/We are aware that I/we can seek advice from a qualified adviser before I/we sign this application form. Should I/we choose not to, I/we take sole responsibility to ensure that this product is appropriate to my/our financial needs and insurance objectives. I/We have received Optimum Global Policy Conditions and the product benefit table and they have been explained to my/our satisfaction.

I/We agree that any cover which I/we may purchase for the USA shall terminate upon informing Optimum Global Ltd that I/we have become a resident of the USA. I/We agree that this application shall be the basis of the contract of insurance between me/us and Optimum Global Ltd. I/We understand that the insurance shall not become effective until it is accepted and confirmed in writing by Optimum Global Ltd.

Signature of Main Applicant

Date

Signature of Spouse/Partner

Date

Broker/Distributor details:

Distributor Number: