OPTIMUM GLOBAL
INTERNATIONAL HEALTH INSURANCE

HEALTH 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: ____________________ COMPANY POLICY 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.

1. YOUR PERSONAL DETAILS

Title: ____________ First Names: ____________

Marital Status: ____________ Family Name: ____________

Gender (please circle): M / F Nationality: ____________ Date of Birth (dd mm yy): ____________

Occupation: ____________

Usual Country of Residence: ____________ Passport/ID number: ____________

2. YOUR CONTACT DETAILS

Residential address of the country where you spend more than 6 months per year:

____

Country: ____________ Postal Code: ____________

Email Address: ____________

Home Telephone: Country Code ____ Area Code ____ Number ____ Work Telephone: Country Code ____ Area Code ____ Number ____

Fax Number: Country Code ____ Area Code ____ Number ____

3. ADDITIONAL PERSONS TO BE COVERED

Title: ____________ First Names: ____________

Marital Status: ____________ Family Name: ____________

Gender (please circle): M / F Nationality: ____________ Date of Birth (dd mm yy): ____________

Occupation: ____________

Usual Country of Residence: ____________

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 & Canada) ☐ Other: ____________________

Please indicate who you wish to purchase the optional dental cover for:

Main Applicant ☐ Spouse/Partner/Employee ☐ 1st Child ☐ 2nd Child ☐ 3rd Child ☐

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

5. PREMIUMS

	Core Premium	Optional Premium
Main Applicant		
Spouse/Partner/Employee	________	________
1st Child	________	________
2nd Child	________	________
3rd Child	________	________
Total Premiums	________	________

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Premiums checked:

Intermediary	Optimum Global

6. 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 ☐ ________ Amount (Please make payable to Optimum Global Ltd.): ________

Bankers Draft ☐ Telegraphic Transfer* ☐

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% ☐, or the monthly option for which there is an 8% surcharge ☐.

Please note that the monthly premium option is only available for credit card payments.

*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 policy number.. Please remit the amount to the currency denominated bank account of Optimum Global Limited as shown below:

Currency	Bank	Swift Address	For account of	In favour of	DBS Optimum Global Account number
US Dollar ($)	Bank of New York, New York	IRVTUS3N	DBS Bank Ltd, Singapore (Chips UID 034675)	Optimum Global Ltd	0003-001556-01-4
Euro (€)	Barclays Bank Plc, London	BARCGB22	DBS Bank Ltd, Singapore	Optimum Global Ltd	0003-001556-02-4
GB Pound (£)	Lloyds TSB Plc London	LOYDGB2L	DBS Bank Ltd, Singapore	Optimum Global Ltd	0003-001556-03-4

Card Payment Authorisation (Please complete this section if you opt for credit card payment)

I authorise Optimum Global Ltd, until further notice in writing, to charge my card account, the premiums in respect of the Optimum Global International Health Plan as and when these become due. I will advise you in writing immediately if the card becomes stolen or if I wish to close my card account or cancel the authorisation.

Cardholder's Name (as it appears on credit card): ____________________

Visa ☐ Mastercard ☐ Card No: ____________________

Bank: ____________________

Expiry Date (mm yy): ________ Cardholder's Signature: ____________________ Date: ________

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7. CONFIDENTIAL MEDICAL HISTORY

	Main Applicant		Spouse/Partner Employee		1st Child		2nd Child		3rd Child	
Name										
Height (cm)										
Weight (kg)										
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Smoker	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Has any specialist been consulted and/or provided prescriptions for any drugs or medication in the last 4 years?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Has any application for life, accident, health or any other insurance been refused or had special terms applied?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Has any person named in this form ever suffered from or are suffering from any disease stated in note 1 below?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Note 1: Heart trouble, chest pain, blood pressure problems or circulatory disorders; Fainting, blackouts, dizziness, seizures, fits, strokes or paralysis; Asthma, persistent cough, breathlessness or other respiratory disorders; Stomach ulcer, liver, hepatitis, gall bladder, intestinal or bowel disorders; Kidney, bladder, prostrate or genitor-urinary disorders; Gynaecological or hormone disorders or irregularity; Diabetes, cholesterol problems or diseases or disorders of the blood; Tumour growth, cancer or glandular diseases or abnormalities; Diseases or disorders of the eyes, ears, nose or throat; Diseases or disorders of the back, bones, joints, muscles or skin; Mental or nervous disorders; AIDS, HIV or venereal diseases; Any diseases, disorders or conditions which are long lasting or recurrent; Treatment for drug or alcohol addiction or abuse; Any other illnesses, disabilities or defects present that may require treatment that have not already been disclosed.

If you have answered 'yes' to any of the above questions, please provide more details below by indicating the question number, the condition, dates of consultation, the treatment received and the name and address of doctor. Please attach a copy of all medical reports if applicable. If you need to use a separate sheet of paper, attach it to this form and indicate you have done so by ticking this box: ☐

8. 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 & Canada shall terminate upon informing Optimum Global Ltd that I/we have become a resident of the USA/ Canada. 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