InterGlobal

Top Up and Top Up Plus

Individual And Family Application Form

Cover under the plan will commence immediately or on a future date, subject to our acceptance and receipt of premium.

Preferred Cover Start Date (dd/mm/yyyy): / /

Please complete clearly in BLOCK CAPITALS.

A. Your Personal Details

Surname:	First Name:
☐ Male ☐ Female	Date of Birth (dd/mm/yyyy): / /
Country of residence:	How long have you lived there:
Home Country:	Nationality on passport:
Telephone:	Fax:
Mobile:	Email:

B. Dependants to be enrolled:

Surname:	First Name:
☐ Male ☐ Female	Date of Birth (dd/mm/yyyy): / /
Surname:	First Name:
☐ Male ☐ Female	Date of Birth (dd/mm/yyyy): / /
Surname:	First Name:
☐ Male ☐ Female	Date of Birth (dd/mm/yyyy): / /
Surname:	First Name:
☐ Male ☐ Female	Date of Birth (dd/mm/yyyy): / /

If there are additional dependents to be enrolled, please provide their information on a separate sheet.

C. Your Cover Options: Plan Type / Optional Benefits

1. Plan Type			
☐ Top Up Plus With Dental USD$ 410	☐ Top Up Plus Without Dental USD$ 300	☐ Top Up With Dental USD$ 360	☐ Top Up Without Dental USD$ 250

2. Optional Benefits			
Would you like to add the Personal Travel Plan?		☐ Yes	☐ No
If Yes, please indicate type below:			
☐ Single $195	☐ Couple $390	☐ Family $487.50	☐ Single Parent Family $292.50

Would you like to add the Personal Accident Plan USD$160 per annum per person?			☐ Yes	☐ No
If Yes, please check who will require the Personal Accident Plan on this Application:				
☐ Main Plan Holder	☐ Dependent 1	☐ Dependent 2	☐ Dependent 3	☐ Dependent 4

D. Pre-existing Medical Conditions

Please carefully read Benefit Exclusion 1, which can be found in the Plan Guide accompanying this application form, before you agree to enrollment of you and your dependants under this plan.
In short - we will not pay benefits for costs arising from medical conditions or related medical conditions for which you have received medical treatment, had symptoms of, sought advice for or to the best of your knowledge existed in the one (1) year prior to your application. These conditions may become eligible for benefit after one (1) year continuous cover provided that during that time no treatment or advice was given and no symptoms or reoccurrence were apparent in respect of these conditions.
If after enrollment you are not happy with this plan, you are entitled to cancel your cover within 30 days from receipt of your plan documents.

E. Details of your Family Doctor (if known)

Doctor's Name:		
Address:		
	Phone:	Fax:

F. Declaration

I hereby apply to be covered under the selected InterGlobal Top Up Plan together with the dependants listed in this application. I am aware that best of my knowledge and belief the information given in this application is true and complete. I have read, understood and agree to be bound by enrolled after the commencement date of the plan. It is agreed that this declaration and information supplied in this application shall form the attended me and any of my dependants included under this plan for treatment of a medical condition, to provide InterGlobal Insurance Company under this plan, which is deemed as being treatment for a pre-existing medical or related medical condition by InterGlobal Insurance Company the purpose of i) assessing this application and providing on-going insurance cover, customer service and the processing of claims, ii) processing products and services and those of its associated companies.

Signature: ______________________________	Date: (dd/mm/yyyy) ______/______/______
Broker / Advisor Details	

Moratorium Underwriting Clause

It is important that you read, understand and accept all of the paragraphs in the following declaration for your InterGlobal application to be underwritten under this Moratorium Underwriting Clause.

This declaration applies equally to you and to any eligible dependant(s) you have included on the application form.

Moratorium means a waiting period of twelve (12) months from the date of joining, or the date specified on the special terms section of your Certificate of Insurance, that must have elapsed before claims for pre-existing medical conditions may be eligible for cover under the policy/plan.

Pre-existing means any medical or related medical condition which has one or more of the following characteristics:

-Was foreseeable,
-Manifested itself,
-The person had signs or symptoms of,
-The person sought advice for,
-The person received treatment for, or,
-To the best of the person's knowledge, was aware existed.

After a period of twelve (12) months continuous cover under the policy/plan, pre-existing medical conditions may become eligible for benefit, if the person concerned has not:

- Experienced symptoms,
- Sought advice,
- Required treatment, medication, or special diet, or,
- Received treatment, medication, or special diet.

If the person concerned has experienced any of the above, he/she will be required to wait a further twelve (12) months from the last date of treatment and must meet the above criteria, before being eligible to claim benefit for the pre-existing medical condition in question. This constitutes the rolling part of the moratorium.

Declaration

I confirm that I have read, understood and accept this Moratorium Underwriting Clause relating to pre-existing medical conditions and that it applies equally to any eligible dependant(s) included within the application form.

Signature: ______________________________ **Date** **(day/month/year):** ______/________/______

InterGlobal

CREDIT CARD CHARGE AUTHORISATION

For Top Up and Top Up Plus Plan

Policyholder Name:

Plan ID Number:
(If known)

Member Number:
(If known)

As confirmation that you would like to pay for your premium by Credit Card, please complete the following:

Card Type: ❑ Visa ❑ MasterCard ❑ American Express

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

Credit Card Number:

Expiry Date: m m / y y

Card Security Code:

For your safety and security, we require that you enter your card's security code.

For Visa and MasterCard, the security code is a three-digit number printed on the back of your card. It appears to the right of your card number.

For American Express card holders, the security code is a four-digit printed on the front of your card. It appears above and to the right of your card number.

Once your payments have been initiated this number will be destroyed.

My card billing address is:

Authorisation:

I hereby authorise InterGlobal Insurance Company Limited to charge my credit card account for my individual/group healthcare insurance premium. I understand that InterGlobal cannot be held liable if my plan lapses should the credit card be declined and I do not respond to requests for alternative methods of payments.

x

Cardholder's Signature

Today's Date

InterGlobal Insurance Company Limited
The Woolmead, Farnham,
Surrey, GU9 7TT
United Kingdom
T +44 1252 745 910
F +44 1252 745 920
E info@interglobalpmi.com

InterGlobal Japan Co., Ltd.
Koike Koraibashi Bldg 3F,
1-3-4 Koraibashi, Chuo-ku,
Osaka 541-0043 Japan
Tel: +81 6 4706 7701
Fax: +81 6 4706 7702
Email: igj@interglobal.co.jp