

UltraCare Plan

Individual & Family Application Form

If you have any questions or need any assistance in completing this form, please contact your adviser or us.

Please complete clearly in BLOCK CAPITALS.

If you have received a quotation from us, please write the quote number here:

Please note: If any of the details that you provide on this form are different from the details that you gave when you received your quotation, your premium may be different.

A Your personal details

Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Other:	
Family Name:	First Names:	
Country of Residence: ¹	How long have you lived there?:	
Home country:	Nationality on Passport:	
Occupation:	Date of Birth (dd/mm/yyyy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F

¹ Your country of residence will determine the value of Insurance Premium Tax that is added to your premium. Please speak to your adviser or contact us if you are unsure whether your premium will be affected.

Residential Address ²

Address:	
Town:	City:
Postal Code:	Country:
Telephone:	Fax:
Email:	

² All correspondence will be sent to this address unless you have completed the correspondence address details below.

It is very important that you tell us immediately of any changes to your contact or personal details. A change in circumstances could affect your cover.

Correspondence Address – if different from residential address above

Address:	
Town:	City:
Postal Code:	Country:
Telephone:	Fax:
Email:	

B Dependants to be Covered

Dependant 1

Family Name:	First Names:
Date of Birth (dd/mm/yyyy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Country of Residence:	Nationality on Passport:
Occupation:	Relationship to you:

B Dependants to be Covered (continued)

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Dependant 2

Family Name:	First Names:
Date of Birth (dd/mm/yyyy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Country of Residence:	Nationality on Passport:
Occupation:	Relationship to you:

Dependant 3

Family Name:	First Names:
Date of Birth (dd/mm/yyyy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Country of Residence:	Nationality on Passport:
Occupation:	Relationship to you:

Dependant 4

Family Name:	First Names:
Date of Birth (dd/mm/yyyy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Country of Residence:	Nationality on Passport:
Occupation:	Relationship to you:

If you have any further dependants to be covered please provide details on a separate sheet of paper and submit it along with this application.

C Cover Start Date

Your cover will commence on the date when, subject to eligibility and the full completion of this form, we accept your application in writing. If you wish your cover to start at a later date please indicate this below. This date can be no more than 30 days after the date you complete this form. We cannot backdate cover under any circumstances.

Preferred Cover Start Date (dd/mm/yyyy):
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D Your Cover Options

Area of Cover

Select the area of cover from the descriptions below based upon the location of your country of residence and your home country if you require the option of returning to your home country for treatment. Please see eligibility section in the Plan Guide for restrictions on US Citizens. You and your dependants must have the same area of cover

- Area 1** Europe
 Area 2 Worldwide, not including the USA
 Area 3 Worldwide

Level of Cover / Plan Type

Please indicate the UltraCare plan type that you require. Please be sure that you have read the policy summary and table of benefits before making your selection to ensure the product meets your needs and demands. Please contact us if you require copies of these documents.

Plus <input type="checkbox"/>	Comprehensive <input type="checkbox"/>	Select <input type="checkbox"/>	Standard <input type="checkbox"/>
All the benefits of the Comprehensive Plan, but with higher limits.	As the Select Plan but with higher limits and cover for dental and wellness benefits.	Full in-patient and daycare treatment with limited cover for specialist out-patient treatment, including primary consultations. Includes evacuation.	Full in-patient and daycare treatment. Includes evacuation.

Excess Options

If you wish to change the excess from the standard excess shown, please tick the appropriate box below.

	Plus	Comprehensive	Select	Standard
Nil Excess	<input type="checkbox"/> 10% Premium Loading	<input type="checkbox"/> 10% Premium Loading	<input type="checkbox"/> 10% Premium Loading	N/A
£25 / \$42.50 / €37.50	<input type="checkbox"/> Standard	<input type="checkbox"/> Standard	<input type="checkbox"/> Standard	<input type="checkbox"/> Standard
£50 / \$85 / €75	<input type="checkbox"/> 5% Premium Discount	<input type="checkbox"/> 5% Premium Discount	<input type="checkbox"/> 5% Premium Discount	N/A
£100 / \$170 / €150	<input type="checkbox"/> 10% Premium Discount	<input type="checkbox"/> 10% Premium Discount	<input type="checkbox"/> 10% Premium Discount	N/A
£250 / \$425 / €375	<input type="checkbox"/> 15% Premium Discount	<input type="checkbox"/> 15% Premium Discount	<input type="checkbox"/> 15% Premium Discount	N/A
£500 / \$850 / €750	<input type="checkbox"/> 20% Premium Discount	<input type="checkbox"/> 20% Premium Discount	<input type="checkbox"/> 20% Premium Discount	<input type="checkbox"/> 10% Premium Discount
£1,000 / \$1,700 / €1,500	<input type="checkbox"/> 25% Premium Discount	<input type="checkbox"/> 25% Premium Discount	<input type="checkbox"/> 25% Premium Discount	<input type="checkbox"/> 20% Premium Discount
£2,500 / \$4,250 / €3,750	<input type="checkbox"/> 30% Premium Discount	<input type="checkbox"/> 30% Premium Discount	<input type="checkbox"/> 30% Premium Discount	<input type="checkbox"/> 30% Premium Discount
£5,000 / \$8,500 / €7,500	<input type="checkbox"/> 40% Premium Discount	<input type="checkbox"/> 40% Premium Discount	<input type="checkbox"/> 40% Premium Discount	<input type="checkbox"/> 40% Premium Discount

The standard excess on medical out-patient treatment claims applies per medical condition per plan year.

If you have chosen a voluntary excess to reduce your premium this will be applied to **all** (In-patient, Daycare and Out-patient) medical treatment. The Plus and Comprehensive plans also have a 25% co-insurance on out-patient dental treatment. This co-insurance cannot be removed.

Discounts apply to main UltraCare Plan premiums only - not to optional add-on plan premiums.

E Optional Add-on Plans and Benefits

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Do you want to add any of the following?

Personal Travel Plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If Yes, please indicate type	<input type="checkbox"/> Single	<input type="checkbox"/> Couple	<input type="checkbox"/> Family	<input type="checkbox"/> Single Parent Family
Maternity Plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If Yes, please indicate level of co-insurance selected per person	<input type="checkbox"/> Nil	<input type="checkbox"/> 10%	<input type="checkbox"/> 20%	

The maternity plan is only available for female members who are aged between 18 and 44. Cover only becomes available for treatment received 12 months after the inception date of this optional add-on plan.

Personal Accident Plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, please circle the number of personal accident units required for each person on this application:		
Main Planholder: 1 2 3 4 5	Dependant 1: 1 2 3 4 5	Dependant 2: 1 2 3 4 5
	Dependant 3: 1 2 3 4 5	Dependant 4: 1 2 3 4 5

The Personal Accident Plan does not include accidents arising from manual or hazardous occupations, dangerous or winter sports, pursuits, or activities. If your occupation is not purely office-based or you take part in any dangerous or winter sports, pursuits or activities, please give full details on a separate sheet and include it with this Application Form. We will then be able to advise if we are able to cover the increased risk.

F Paying Your Premiums

It is important that you keep your premiums up to date and notify us immediately of any changes to your payment details. Full payment details and information on unpaid or late payments are found in the UltraCare Plan Guide. Please Note: Whilst premiums are outstanding all claims settlements will be suspended.

Currency

In which currency do you wish to pay your premiums?

<input type="checkbox"/> GB Pounds (£)	<input type="checkbox"/> US Dollars (\$)	<input type="checkbox"/> Euros (€)
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This selection will also determine the currency of your benefit limits and excess.

Payment plans

UltraCare Plan

Please select the frequency in which you wish to pay your premiums. Due to increased administration costs the annual total of any monthly or quarterly premium payments will be higher than the cost of paying yearly.

	Cheque or Bank Draft	Bank Transfer	Credit Card	Direct Debit
Yearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quarterly	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>
Monthly	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>

Optional Add-on plans and benefits

If you have selected the Optional Maternity Add-on Plan, please select the frequency in which you wish to pay your Maternity Plan premiums. Due to administration costs the annual total of any monthly or quarterly premium payments will be higher than the cost of paying yearly.

Yearly <input type="checkbox"/>	Same as UltraCare plan (if monthly or quarterly) <input type="checkbox"/>
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Please note: Premiums for the Optional Travel Add-on Plan and Optional Personal Accident Add-on Plan are payable yearly in advance.

G Doctor's / Medical Practitioner's Details

Please provide the contact details of your family doctor(s) or medical practitioner(s) who last treated you or your family in the last 2 years. Failure to provide this information may cause a delay in processing any claims submitted.

Name:	Name:
Hospital/Clinic/Practice:	Hospital/Clinic/Practice:
Telephone:	Telephone:
Fax:	Fax:
Email:	Email:
Address:	Address:
Postcode:	Postcode:

H Pre-existing Medical Conditions

Please carefully read Benefit Exclusion 1, which can be found in the Plan Guide and below, before you agree to enrolment of you and your dependants under this plan.

You must sign this section to show that you understand and accept our 24 month moratorium. We will not process your application unless this section is signed as well as the Declaration on this application form.

If after enrolment you are not happy with this plan, you are entitled to cancel your cover within 30 days from receipt of your plan documents.

If you do not have a copy of the Plan Guide, please contact us to receive one.

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

Continued on next page. Please turn over.

Payment Details

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Please follow instructions for your chosen payment method

Cheque or Bank Draft

Please make all cheques and bank drafts payable to "InterGlobal". Please ensure that your quote number, family name and date of birth are clearly shown on the reverse in case your payment becomes separated from this form.

Bank Transfers

Please ensure that your family name is clearly shown on any bank transfer and that the transfer is in the correct currency and sent to the correct details below:

GB Pound (£) Account	US Dollar (\$) Account	Euro (€) Account
Bank: HSBC Bank plc Address: 8 Canada Square London E14 5HQ United Kingdom	Bank: HSBC Bank plc Address: 8 Canada Square London E14 5HQ United Kingdom	Bank: HSBC Bank plc Address: 8 Canada Square London E14 5HQ United Kingdom
Account No: 41611593 Sort Code: 40-21-05 Swift Code: MIDLGB2112U IBAN No: GB84 MIDL 402105 41611593	Account No: 67348768 Sort Code: 40-05-15 Swift Code: MIDL GB22 IBAN No: GB68 MIDL 4005156 7348768	Account No: 67348776 Sort Code: 40-05-15 Swift Code: MIDL GB22 IBAN No: GB46 MIDL 400515 67348776

Credit Card

We can accept payments using the following Credit Cards – Visa, MasterCard and American Express. If your card is not listed, please check with us as we may still be able to accept it. Please complete the Credit Card Authority Form attached to this application. Please ensure that your credit card is valid for at least 3 months from the start date of your plan to the expiry date of your credit card.

Direct Debit

We can only accept payments by Direct Debit if you have a UK Bank Account and have elected to pay your premiums in GB Pounds (£). Please complete the Direct Debit Form attached to this application.

Credit Card Authority

To InterGlobal

Please complete in BLOCK CAPITALS.

Quote number:	Name (as it appears on your card):
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My Card billing address is:

Postcode:

Please tick the appropriate:

<input type="checkbox"/> MasterCard	<input type="checkbox"/> Visa	<input type="checkbox"/> American Express	My Card Number is:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Issue Date:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Expiry Date:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Card Security Code:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>					

For your safety and security, we require that you enter your card's verification number (card security code). For Visa and Mastercard cardholders the verification number is a three-digit number printed on the back of your card. It appears to the right of your card number.

For American Express cardholders, the security code is a four-digit number 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 by us.

Please charge the above card (please tick)

<input type="checkbox"/> Yearly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Monthly
<input type="checkbox"/> GB Pounds (£)	<input type="checkbox"/> US Dollars (\$)	<input type="checkbox"/> Euros (€)

I hereby authorise the Card Account specified above may be debited with the current premium due, and all subsequent renewal premiums due as notified by InterGlobal until I give notice in writing that I wish to terminate this agreement. I understand that InterGlobal will give at least 4 weeks notice of renewal, and that the premiums may vary each year. I understand that InterGlobal cannot be held liable if my plan is lapsed should the credit card be declined and I do not respond to requests for alternative methods of payment.

Cardholder's Signature(s):	Date (dd/mm/yyyy):
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Direct Debit

Instruction to your Bank OR Building Society to pay by DIRECT DEBIT

Please complete in BLOCK CAPITALS and send to:
InterGlobal
Woolmead House East
The Woolmead
Farnham
Surrey GU9 7TT



Originator's Identification:

2 4 2 5 8 4

Quote number:

Name(s) of Account Holder(s):

Bank/Building Society Account number:

Branch Sort Code:

Name and full postal address of your Bank or Building Society

To: The Manager Bank/Building Society

Address:

Postcode:

Reference Number (for InterGlobal use only)

Instruction to your Bank/Building Society

Please pay InterGlobal Direct Debits from the account detailed in this instruction subject to the safeguards assured by The Direct Debit Guarantee. I understand that this instruction may remain with InterGlobal and if so details will be passed electronically to my Bank/Building Society.

Signature(s): Date (dd/mm/yyyy):

Banks and Building Societies may not accept Direct Debit Instructions for some types of accounts.

We offer Direct Debit as an alternative form of payment to all planholders who take out a GB£ plan and currently hold a UK Bank or Building Society account. If you would like to take advantage of this facility for your regular payments please complete the following form.

Please note: We must receive the original of this form in order to set up your Direct Debit payments as banks will not accept copies.

The Direct Debit Guarantee



This guarantee should be detached and retained by the Payer

- This Guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by your own Bank or Building Society.
- If the amounts to be paid or the payment dates change InterGlobal will notify you 10 working days in advance of your account being debited or as otherwise agreed.
- If an error is made by InterGlobal or your Bank or Building Society you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us.

H Pre-existing Medical Conditions (continued)

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

Moratorium means a waiting period of twenty-four (24) 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 twenty-four (24) 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 twenty-four (24) 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.

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 (dd/mm/yyyy):
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I Declaration

I hereby apply to be covered under the selected UltraCare Plan(s) together with the dependants listed in this application. I declare that to the 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 the terms and conditions detailed in the Plan Guide, along with all eligible dependants included in this application or any subsequent dependants enrolled after the commencement date of the plan. It is agreed that this declaration and information supplied in this application shall form the basis of the contract between me, my dependants and the insurance company. After reading all the terms & conditions and documents provided to me I am satisfied that the product selected meets my requirements at this time.

I authorise and request the doctor named in section G and/or any other medical establishment, including any other health professional who has attended me and any of my dependants included under this plan for treatment of a medical condition, to provide the insurance company with the information they may need in connection to any claim made under this plan.

I accept, if I do not provide the information required in section G that, in the event of a claim being made by me, or any of my dependants included under this plan, which is deemed as being treatment for a pre-existing medical or related medical condition by the insurance company, such claim will be rejected.

I confirm and agree that any personal information collected or held by the insurance company, whether contained in this application or otherwise obtained may be used by the insurance company, or disclosed to or transferred to any organisation for the purpose of i) assessing this application and providing on-going insurance cover, customer service and the processing of claims, ii) processing and effecting premium payments, iii) providing marketing communications in respect of the insurance company, its related products and services and those of its associated companies. (If you do not wish us to use your details in this way, please let us know in writing to the address below).

The insurance company may use organisations who may be located in the EEA or elsewhere. Where an organisation is located outside the EEA, the insurance company will take all necessary steps to ensure the organisation provides appropriate guarantees in respect of the technical and organisational security measures and the transfer and processing complies with all relevant data protection and privacy laws.

I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998, (on behalf of myself and any family members specified in this form) for the insurance company to process our personal information with respect to our membership and I confirm that I have brought the Data Protection Notice to the attention of these family members.

Please note: For your own benefit and protection, you should read the terms and conditions detailed in the Plan Guide carefully before signing this Declaration. If you do not understand any point, please ask for further information.

Signature:	Date (dd/mm/yyyy):
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Our full terms and conditions and details of our privacy policy can be provided on request.

Broker/Adviser Details: