



GLOBALHEALTH EXPATRIATE INDIVIDUAL MEDICAL INSURANCE

INDIVIDUAL AND FAMILY APPLICATION FORM

POLICYHOLDER'S DETAILS

Name (last): _____

Name (first): _____

Name (middle): _____

ID/Passport No.: _____ Nationality: _____

Date of Birth (dd/mm/yy): ____/____/____ Height (cm): _____ Weight (kg): _____

Gender (M/F): M F Smoker: Yes No

Occupation (specify nature of duties): _____

Country of Residence: _____

CONTACT DETAILS

Email: _____

Telephone (Home): _____ (Work): _____

Mobile: _____ Fax: _____

Residential Address

(Line 1): _____

(Line 2): _____

(Line 3): _____ City: _____

State/Region: _____ Country: _____

Mailing Address (if different from residential address):

(Line 1): _____

(Line 2): _____

(Line 3): _____ City: _____

State/Region: _____ Country: _____

PLAN SELECTION

1. Level of Cover - Select your plan	<input type="checkbox"/> Advantage 100	<input type="checkbox"/> Advantage 200	<input type="checkbox"/> Advantage 300	<input type="checkbox"/> Advantage 400	<input type="checkbox"/> Advantage 500
	Hospital only cover with sub-limits	Hospital only cover with sub-limits and option to add out-patient	A comprehensive hospital plan with extensive pre- and post-hospitalization	Strong hospital and out-patient coverage	Strong hospital and out-patient coverage with Maternity cover
2. Deductible - Select your deductible (in US\$)	<input type="checkbox"/> 500 <input type="checkbox"/> 1,000 <input type="checkbox"/> 2,000 <input type="checkbox"/> 5,000	<input type="checkbox"/> NIL <input type="checkbox"/> 500 <input type="checkbox"/> 1,000 <input type="checkbox"/> 2,000 <input type="checkbox"/> 5,000	<input type="checkbox"/> NIL <input type="checkbox"/> 500 <input type="checkbox"/> 1,000 <input type="checkbox"/> 2,000 <input type="checkbox"/> 5,000	<input type="checkbox"/> NIL <input type="checkbox"/> 500 <input type="checkbox"/> 1,000 <input type="checkbox"/> 2,000 <input type="checkbox"/> 5,000	<input type="checkbox"/> NIL <input type="checkbox"/> 500 <input type="checkbox"/> 1,000 <input type="checkbox"/> 2,000 <input type="checkbox"/> 5,000
3. Area of Cover - Upgrade to a Worldwide plan	NA	NA	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

PLAN SELECTION (continued)

4. Other Options	<input type="checkbox"/> Dental	<input type="checkbox"/> Dental <input type="checkbox"/> Include out-patient cover	<input type="checkbox"/> Dental	<input type="checkbox"/> Dental	<input type="checkbox"/> Dental	
Personal Accident - Select your plan	<input type="checkbox"/> Classic		<input type="checkbox"/> Premier		<input type="checkbox"/> Supreme	
	Child Plan	Adult Plan	Child Plan	Adult Plan	Child Plan	Adult Plan
Accidental Death, Burns and Dismemberment (Maximum limit US\$)	15,000	75,000	15,000	150,000	15,000	300,000
Hospital Income (Up to 90 days per policy year)	NA	45	NA	80	NA	80

Annual Premium	Age	Classic	Premier	Supreme
Accidental Death, Burns and Dismemberment	Adult Plan	150	300	600
	Child Plan	35	35	35
Hospital Income	18-29	55	90	90
	30-39	85	140	140
	40-49	115	190	190
	50-65	160	265	265

Policy Dominated Currency (Claim settlement will match the policy currency at exchange rate: USD/RMB 6.4): U.S. Dollar RMB Yuan

Requested Policy Start Date (dd/mm/yyyy): _____/_____/_____

FAMILY MEMBERS TO BE INSURED

Details	Dependent 1	Dependent 2	Dependent 3	Dependent 4
Last Name				
First, Middle Name				
Relationship to Policyholder				
Marital Status				
Nationality				
Passport/ ID Number				
Date of Birth (dd/mm/yy)				
Gender	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F
Height (cm) & Weight (kg)				
Smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Occupation				

Yes Has any proposed minor under 18 years of age been currently insured under any death benefit offered by Chartis China and other insurance companies? (Note: if ticked, then Chartis China will not accept the application for such minor to be covered under the optional plan of Personal Accident & Hospital Income; if not ticked, then it shall be deemed that such minor has not been insured under any death benefit offered by Chartis China and other insurance companies.)

Important Note about filling in this form:

The answers you give to the questions contained in this Application will form the basis of any insurance policy issued, and will be incorporated into the contract. It is essential that you give accurate, truthful, and complete information for all persons to be insured, as inaccuracies may jeopardize coverage or invalidate a claim.

1. Does any of the persons to be Insured reside outside the Usual Country of Residence as shown above? If "Yes", please state which country. Yes No

2. Does the occupation of any of the persons to be Insured include any activities involving offshore, underwater, underground, or manual work, or work in a remote location? If "Yes", please give details. Yes No

3. Have any of the persons to be Insured previously applied for or held a GlobalHealth policy? If "Yes", provide policy number. Yes No

4. Do any of the persons to be Insured have health insurance with another company? If "Yes", please attach a copy of the policy and benefit schedules, and indicate if the other coverage will be continued if the GlobalHealth application is approved. Yes No

5. Have any of the persons to be Insured ever had a policy or application for life, sickness, accident disability, critical illness or medical insurance refused, postponed, declined, withdrawn, or had any special terms (including extra premium or exclusions) imposed? If "Yes", please provide full details. Yes No

6. Within the last five years, have any of the persons to be Insured experienced, been treated for, sought advice on, or had symptoms relating to any of the following conditions? Yes No

If the answer is "Yes" to any of the following, **please write** the medical condition and complete the relevant questionnaire where indicated. For other medical conditions, please provide details in the table on page 4.

- a) Cancer, leukemia, tumors, cysts or a growth of any kind? (If "Yes", please complete the Tumor/Cyst Questionnaire) Yes No

- b) Asthma, persistent cough, coughing of blood, pneumonia, chest or breathing complaints, chronic bronchitis, chronic sinusitis, allergies, deviated nasal septum, tuberculosis, or any disease or disorder of the lungs? (If "Yes", please complete the Respiratory Questionnaire) Yes No

- c) Chest pain, raised blood pressure, raised cholesterol, heart murmur or heart condition, breathlessness, abnormal heart rate, rheumatic fever, varicose veins, or circulatory disorder? (If "Yes", please complete the Cardiovascular Questionnaire) Yes No

- d) Indigestion, gastritis, gastric or duodenal ulcer, blood in stools, fistula, hernia, haemorrhoids or any disease or disorder of the bowel? Yes No

- e) Kidney stones, urinary tract infections or complaint, blood, protein or sugar in urine, or any disease or disorder of the kidney, bladder, prostate or genito-urinary tract? Yes No

- f) Jaundice, hepatitis of any form or any disease or disorder of the gall bladder, pancreas or liver? Yes No

- g) Diabetes, thyroid disorders or any other endocrine disorders? Yes No
-
- h) Anaemia, thalassaemia, haemophilia, or any other disease or disorder of the blood? Yes No
-
- i) Disease of the brain or nervous system, stroke, epilepsy, paralysis, weakness of a limb or prolonged headache? (If "Yes", please complete the Cerebrovascular/Nervous System Questionnaire) Yes No
-
- j) Mental health disorder, depression, anxiety, nervous condition, stress, post traumatic stress disorder, behavioural problem, alcohol or drug addiction? Yes No
-
- k) Back or neck pain or strain, spinal condition, sciatica, slipped disc, whiplash, gout, arthritis, bone fracture, joint injury e.g. knee, elbow, wrist, shoulder, hallux valgus (hammer toes) or any symptoms of a muscle disorder? (If "Yes", please complete the Musculo-Skeletal Questionnaire) Yes No
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- l) Malaria, dengue fever, typhoid or any other tropical disease? Yes No
-
- m) HIV, AIDS (Acquired Immuno Deficiency Syndrome), AIDS related condition or had any positive blood test for HIV (also called AIDS or HTLV-III) virus? Yes No
-
- n) Psoriasis, eczema, dermatitis, acne or any other skin condition? Yes No
-
- o) Ear discharge, nose bleeds, double vision, impaired sight, hearing or speech or any other disease or disorder of the ear, eye, nose or throat? Yes No
-
- p) **(Females only)** Pregnancy or any complications of pregnancy, abnormal smear test or any gynaecological disorder e.g. fibroid &/or cyst of the female reproductive system? If "Yes", please complete the Gynaecological Questionnaire) Yes No
-
- q) Any other ailment, impairment, injury, accident, condition(s), medical investigations, or hospital treatments not mentioned above? Yes No
-

If you answered "Yes" to any of the above questions that did not require a Medical Questionnaire , please give details of the condition in the table below.

Insured's concerned	Q.No.	Date of first consultation	Details of Medical condition, including nature of treatment, results and if you have fully recovered?	Name & Address of doctor, hospital or health professional consulted	Do you require any follow up treatment or consultation, if so when?

(Please use an extra sheet if more space is required)

7. Other than for those medical conditions mentioned above, has this person been admitted to hospital for treatment or observation or undergone any surgical procedure? If Yes, please provide full details, including the date, diagnosis and nature of treatment or surgical procedure. Yes No

8. Is this person taking any medication or receiving any form of treatment at the present time? If Yes, please provide the medical condition, name of medication and dosage, and/or treatment. Yes No

9. Has this person been advised to have or do they intend to seek any medical advice, test, investigation, surgical procedure, hospitalization, or treatment in the near future? If Yes, please provide the medical condition, attending physician and recommended treatment. Yes No

10. Please provide the following information about this person's current usual doctor/ personal physician/ medical centre or hospital:

Name: _____

Email: _____

Telephone (Work): _____ Fax: _____

Address

(Line 1): _____

(Line 2): _____ City: _____

State/Region: _____ Country: _____

How long has this person been under this physician's care: _____

Date of last attendance & reason: _____

IMPORTANT NOTICE:

- This Policy does not cover any medical expenses incurred in or arising from any accident or illness occurred in Cuba, Burma, Iran and Sudan.**
- This policy will not cover any terrorist or member of a terrorist organization, narcotics trafficker, or illegal purveyor of nuclear, chemical or biological weapons defined by any country or international organization.**
- In order to protect your own interests, before applying for the Policy, please read carefully the terms and conditions of this Policy, especially the exclusions. The policy wording is available from our salespersons or on our website at www.chartisinsurance.com.cn. Please call 8009880898 or contact our salespersons to enquire the terms and conditions of this Policy. Please make sure that you fully understand the explanations of our salespersons. With no enquiry, you are deemed to have fully understood the terms and conditions of this Policy.
- The Insurance Policy shall consist of policy wording, application form, quotation (if any), schedule, endorsements, remarks and any other relevant agreements.
- If the Company agrees to cover, the inception date of insurance shall be (1) expected inception date, provided that the Company receives the agreed premium in full before such date; or (2) the day following receipt of the agreed premium in full, provided that the Company receives the agreed premium in full on or after the expected inception date. If the Company rejects the application, the Company will refund the received premium in full without interest.

DECLARATION BY POLICYHOLDER / INSURED PERSON(S)

I/We hereby apply for a policy to be issued based on the statements contained herein and declare in the Application Form that all answers to the foregoing questions are correctly recorded, and that they are full, complete and true. Except as declared herein, all persons to be insured are currently in good health. I/We agree that if the health status of the above intended insured person changes after this application is signed and before Chartis Insurance Company China Limited ("the Company") issues a policy I/we shall immediately notify the Company of the change. I/We agree that the policy as issued including all schedules, endorsements, and this application shall form the whole contract and that no insurance shall be in force until and unless the application has been accepted, and the appropriate premium paid.

I/We acknowledge that before applying for the insurance, I/we have read carefully the terms and conditions of this Policy, especially the **exclusions**, and fully understand your explanations and reminder. We understand that all insurance coverage is subject to the terms and conditions of this Policy.

I/We hereby declare and agree that our information and any personal information regarding the insured persons collected or held by the Company (contained in this application form or otherwise obtained) may be held, used and disclosed by the Company to individuals or organizations associated with the Company (within or outside China) for the purposes of (i) processing this application and other insurance related matters, (ii) providing insurance services & (iii) communication with us or the insured persons.

I/We fully understand that any dispute arising from performance of this insurance contract shall be settled by litigation or arbitration to be chosen upon negotiation with the Company when such dispute occurs or when the contract is concluded.

I/We hereby understand that the special notice should be given to the Company where the death benefit offered by all the commercial insurance policies for any insured under 18 years old exceed the death benefit limit of RMB100,000 for person under 18 years old specified by China Insurance Regulatory Commission, otherwise, the Company may not be liable for any amount in excess of the regulatory limit.

Cashless Out-patient Facility (Applicable only to the following plans with nil deductible: Advantage 400 and Advantage 500):

I/We authorize Chartis China to release the names, dates of birth, sex, passport and/or identification number, any information provided on the Application and Employee & Family Enrolment Forms and any records Chartis China may have regarding the Insured person(s) shown on the Namelist to hospitals, clinics, laboratories, physicians, specialists, dentists, chiropractors, acupuncturists, physiotherapists, or other medical practitioners for the purpose of providing direct bill paying services for the Insured Person(s). By signing this Authority and Release Form, I/We also acknowledge the specific Policy term listed below:

Right of Recovery:

In the event of authorization of payment and/or payment is made by Chartis Insurance Company China Limited for a claim which is not covered under this Policy or when the limit of liability of this insurance is exceeded, Chartis China reserves the right to recover the said sum or excess from you. This recovery includes but is not limited to deducting the payments owed from other claims made by you during the Policy period. If the amount owed remains outstanding for more than 90 days, then Chartis China reserves the right to suspend the direct billing service to you without further notice.

Printed Name/Title

Signature

Date

For enquiries/applications, please contact us

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Email: Globalhealth.sh@chartisinsurance.com

Web: www.chartisinsurance.com.cn