Employee Application Form

The Employee should complete the sections relevant to their application. Please note that it is vital that all relevant questions on this form are answered accurately and that all relevant information is disclosed.

SECTION A - Employer Details

Employer Name	
Employer Address	

SECTION B - Employer Details

Start Date		
Plan Selected	☐ GEH Plan	☐ Vital care
Optional Benefits	☐ Outpatient	☐ Dental
	☐ Personal Accident	Occupation (for P.A.):
	☐ Travel Insurance	☐ Travel Insurance +winter Sports
Personal Accident Benefit (where selected as an optional benefit)	$	

SECTION C - Employer Details

Title	☐ Mr	☐ Mrs	☐ Miss	Other:
Forename (s)				
Surname (Family name)				
Employee Address				
Country of Residence			Home Country	
Nationality			Passport Number	
Gender	☐ Male	☐ Female	Date of Birth (dd/mm/yyyy)	
Height (m)			Weight (kg)	
Home Telephone			Mobile	
E Mail				
Elected Country (for elective medical transfer. Must be in the same geographical area)				

SECTION D - Employee Dependent Details

Insert the names of your dependents that require cover at this time. If you have more than 3 dependents please use an additional copy of this page.

Dependent 1

Forename (s)		Surname	
Gender	☐ Male ☐ Female	Date of Birth (dd/mm/yyyy)	
Height (m)		Weight (kg)	
Place of Birth			
Relationship to Employee			
Personal Accident Benefit (where selected as an optional benefit)	$		

Dependent 2

Forename (s)		Surname	
Gender	☐ Male ☐ Female	Date of Birth (dd/mm/yyyy)	
Height (m)		Weight (kg)	
Place of Birth			
Relationship to Employee			
Personal Accident Benefit (where selected as an optional benefit)	$		

Dependent 3

Forename (s)		Surname	
Gender	☐ Male ☐ Female	Date of Birth (dd/mm/yyyy)	
Height (m)		Weight (kg)	
Place of Birth			
Relationship to Employee			
Personal Accident Benefit (where selected as an optional benefit)	$		

I confirm that all dependent children live in my household, are dependent solely upon me for support and if ageed 19 to 25, are in full time education.

Signature of Employee			
Name			
Date (dd/mm/yyyy)			

LAMP

SECTION E - Statement of Health for Individual Application

Please answer YES or NO. If Yes, please specify details in the space provided on the following page. All information supplied will be treated in strict confidence. All material facts including those relating to these questions must be disclosed. Failure to do so may invalidate the policy. A material fact is information that would be likely to influence the insurer's assessment and acceptance of this Application Form. If you are in any doubt whether a fact is material then it should be disclosed.

	Employee	Dependent 1	Dependent 2	Dependent 3
Is any individual Pregnant?	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Are any inpatient or outpatient medical/surgical or dental procedures or oral surgery (including diagnostic testing) recommended/contemplated?	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Does any individual use tobacco products?	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Is any individual currently taking medication?	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Has any individual been examined by or consulted with a physician / doctor or received any medical treatment in the last 5 years? (routine check ups,minor ailments (coughs / colds) of a non-chronic and non-recurring nature can be ignored.	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Has any individual ever been denied medical, dental, optical or disability coverage or been quoted anything other than standard terms for them?	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐

Within the last ten years has there been any disease/impairment of or any treatment for any of the following (ignore diagnostics with a negative outcome)? If Yes, please give the disease/impairment, year of onset, duration and treatment details in the space provided on the following page.

	Employee	Dependent 1	Dependent 2	Dependent 3
AIDS/HIV	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Alcoholism/Substance Abuse	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Arthritis	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Asthma	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Back/Neck/Spine	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Blood Vessels/Heart	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Bones	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Brain/Head	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Cancer	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Carpal Tunnel Syndrome	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Diabetes	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Ears/Eyes	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐

SECTION E - (continued)

	Employee	Dependent 1	Dependent 2	Dependent 3
Epilepsy	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Gastrointestinal Disorder/Intestines	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Hereditary Disorders	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Hernia	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Immune System Disorder	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Kidney/Bladder	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Liver	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Lungs	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Mental/Nervous Disorder	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Paralysis	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Reproductive System Disorder	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Rheumatic Fever	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Sexually Transmitted Infections	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Skin	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Stroke/Blood Pressure/Hypertension	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Surgical Operation	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Thyroid	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Tumour/Growth	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Ulcer	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐

Use this space to complete extra information required for Section D. Continue on a separate sheet of paper if there is insufficient space.

SECTION F - Statement of Oral Health

Please state if there is an oral / dental condition needing treatment by any individual requesting coverage. Only fill in this section if you require the Dental Care extension.

	Employee	Dependent 1	Dependent 2	Dependent 3
Routine dental examination in last year?	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Any fillings needed?	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Any crowns needed?	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Any denture/bridgework/implant needed?	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Missing teeth needing replacement?	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Damaged teeth needing replacement?	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Gum problem needing treatment?	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Root canal treatment needed?	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Any teeth needing extraction?	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Periodontal disease needing treatment?	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Orthodontic treatment needed?	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐

Use this space to complete extra information required for Section E. Continue on a separate sheet of paper if there is insufficient space.

SECTION G - Employee Banking Details - for Reimbursement of Claims

Currency of Account	☐ USD	☐ GBP	☐ Euro	Other:

Name of Bank			
Bank address			
Sort or SWIFT Code		Post Code	
Account Number		Country	
IBAN Number			

SECTION H - Data Protection

LAMP Insurance Company Limited assures you that all your personal and medical information will be held in strictest confidence and in accordance with applicable legislation. Personal data may be passed to other companies with the LAMP Group or given to third party providers in relation to services which we provide to you, and may be transferred by electronic or other means. You have a right to know what information is held about you, and to amend or delete any data we hold which is inaccurate or out-of-date.

SECTION I - Certification by Employee and Spouse (if Spouse coverage is required)

· I/We certify that these answers are complete and true to the best of my knowledge and belief. I will inform LAMP Insurance Company Limited of any changes to the information provided which happen between the time the form is completed and the time coverage becomes effective. I agree that this document shall form a part of my request for group coverage and I acknowledge that I have been given a copy of this document as completed by me.

· I/We understand that, to the extent permitted by law, false statements will result in the denial of claims or in my insurance coverage being void and the premium forfeit with no benefits payable. I understand that conditions which are disclosed on this form will be subject to all conditions of my employer's Plan, including specifically any pre-existing medical condition limitations and exclusions.

· I, the employee, and (if in employment) I, the spouse, certify that I am actively at work, meaning that I am employed and have not been absent from work through sickness, illness or injury for more than ten days in the last year and that, at the date of signing this certification, I have not been absent from work through sickness, illness or injury at all in the last month. I, the spouse, (if not in employment) certify that I have not been sick, ill or injured for more than ten days in the last year.

· AUTHORISATION: To all physicians/hospitals/healthcare institutions/insurers/medical or hospital service providers/employers: You are authorised to provide LAMP Insurance Company Limited information concerning healthcare, advice, treatment, supplies, absence (including those related to mental illness and/or AIDS/ARC/HIV) relating to me or any members of my family for whom coverage has been requested. This information will be used to determine eligibility for coverage. This authorisation will be valid for twenty four months from the date of signature of this form.

· I/We acknowledge that I/We will reinstate this authorisation after twenty four months have passed if so requested by LAMP Insurance Company Limited.

· I agree that a facsimile or scanned copy of this authorisation is as valid as the original.

I WISH/DO NOT WISH (delete as appropriate), at my expense, to see any copies of any reports obtained using this

Signature of Lead Applicant	
Name	
Date (dd/mm/yyyy)	

Please return this questionnaire to Global Expatriate Healthcare Limited

Email: insure@globalhealthonline.com

Underwritten by LAMP Insurance Company Limited, 260/262 Main Street, Gibraltar
Tel: +350 2005194

LAMP Insurance Company Limited is licensed by the Chief Executive of the Financial Services Commission of Gibraltar under the Insurance Companies Ordinance
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