Group Application Form

Please complete the sections relevant to your 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			
Registered Address			
Post Code		Registered number	
Nature of Business			
Telephone		Fax number	
Web Site			

SECTION B - Contact Person

Title	☐ Mr	☐ Mrs	☐ Miss	Other:
Forename (s)				
Surname (Family name)				
Job Title				
Telephone		Mobile		
E-mail				

SECTION C - Plan Selection

Underwriting Method

1. FMU (Full Medical Underwriting) – All the details of your employees medical history are required in the application form with this option. By choosing this option your employee will know exactly what they are covered for. If you employees or any of their dependents have a medical condition that is likely to recur or is ongoing, that condition (and anything related to it) may not be covered. Employees must complete underwriting options 'Section E' of the Employee Application Form. Pre-existing medical conditions will not be covered unless they are declared to and accepted by us in writing.

2. CPME (Continued Personal Medical Exclusions) - No details of employee medical history are required in the application form. If you or your employees have existing exclusions, these will be carried forward and continued. If no membership certificates are available from the previous insurer, employees will be underwritten as Moratorium. An additional premium may be payable and will be included in your quotation.

3. MHD (Medical History Disregarded) - This option is only available for employers with than 30 employees. No medical or underwriting information is required and no pre-existing exclusions will be applied to your employees. Employees do not need to complete the underwriting options 'Section E' of the Employee Application Form. An additional premium may be payable and will be included in your quotation.

SECTION C - Plan Selection - continued

Start Date				
Plan Selected	☐ GEH Plan	☐ Vital care		
Optional Benefits (GEH Plan Only)	☐ Outpatient	☐ Dental		
	☐ Personal Accident	Occupation (for P.A.):		
	☐ Travel Insurance	☐ Travel Insurance +winter Sports		
Geographical Cover*	☐ Area 1	☐ Area 2		
Excess / Deductible	☐ Nil	☐ $100	☐ $300	☐ $500
	☐ $1,000	☐ $3,000	☐ $5,000	
Underwriting Method	☐ FMU	☐ CPME	☐ MHD	

Number of Employees to be covered		Number of Dependents to be covered	

***Geographical Cover**

AREA 1 comprises all countries worldwide with the exception of the following: United States of America, Canada, Anguilla, Antigua & Barbuda, Aruba, Bahamas, Barbados, Bermuda, Cayman Islands, Cuba, Curaçao, Dominica, Dominican Republic, Dutch Antilles (including St. Maarten), Grenada, Guadeloupe, Haiti, Jamaica, Martinique, Puerto Rico, St. Kitts-Nevis, St. Lucia, St. Vincent, Trinidad & Tobago, Virgin Islands.

AREA 2 comprises all countries worldwide.

SECTION D - CPME (Continued Personal Medical Exclusions) & MHD (Medical History Disregarded) Declaration ONLY

If CPME/MHD has been selected in 'Section C', please sign the following declaration, if it is correct, on behalf of all employees.

I declare that to the best of my knowledge all applicants to be covered by this plan:
* are actively at work (in the case of employees)
* have not had any deterioration in health since being underwritten as a result of any major illness such as heart disease, stroke, cancer or mental illness.

(Please provide membership certificates from your current insurer or a fully completed employee application form - CPME applicants only).

Signed	
Name	
Date (dd/mm/yyyy)	

SECTION E - Payment Details

Currency	☐ USD	☐ GBP	☐ Euro	
Premium Payment	☐ Annual	☐ Semi-annual	☐ Quarterly	☐ Monthly

* a surcharge of 4% of the annual premium will apply to semii-annual payments.
* a surcharge of 6% of the annual premium will apply to quarterly payments.
* a surcharge of 8% of the annual premium will apply to monthly payments.

Premiums are fixed in US Dollars (USD), as quoted above. Premiums requested to be billed in GBP or Euro will be converted from USD on the day of billing, based on rates published by OANDA (www.oanda.com). Your application will be processed on receipt of payment.

Premiums are fixed in US Dollars (USD), as quoted in Section E. Premiums requested to be billed in GBP or Euro will be converted from USD on the day of billing, based on rates published by OANDA (www.oanda.com)

Please select required payment method [X] 1 or 2

1. Payment by Bank Transfer ☐

Please make your payment to the account in accordance with the currency you have selected.

US DOLLAR ($) Account

Beneficiary	LAMP Insurance Company Limited		
Account Number	60329686		
SWIFT Code	MIDLGB22	Sort Code	40-05-15
IBAN number	GB77 MIDL 4005 1560 3296 86		
Bank & Address	HSBC Bank, 45 Milsom Street, Bath, BA1 1DU, United Kingdom		

Euro (€) Account

Beneficiary	LAMP Insurance Company Limited		
Account Number	67184697		
SWIFT Code	MIDLGB22	Sort Code	40-05-15
IBAN number	GB92 MIDL 4005 1567 1846 97		
Bank & Address	HSBC Bank, 45 Milsom Street, Bath, BA1 1DU, United Kingdom		

Sterling/GBP (£) Account

Beneficiary	LAMP Insurance Company Limited		
Account Number	02272997		
SWIFT Code	MIDLGB2102G	Sort Code	40-09-19
IBAN number	GB35 MIDL 4009 1902 2729 97		
Bank & Address	HSBC Bank, 45 Milsom Street, Bath, BA1 1DU, United Kingdom		

Please ensure that your name is clearly stated on the bank transfer as the originator.

2. Payment by Credit Card ☐

For security reasons, we do not gather credit card data on this application form. If you wish to pay premiums by credit card, please advise us and we will make separate arrangements to collect credit card details.

SECTION F - 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 G - Declaration

• I confirm the correctness of the statements and information contained in this application and confirm the correctness of all other documents submitted now or in the future concerning this application. This clause will constitute a condition precedent to the payment of the benefits provided for in the terms of the Plan. We accept that LAMP Insurance Company Limited will be relying on such statements and information when agreeing to accept this application. LAMP Insurance Company Limited reserves the right to investigate where uncertainty exists about the validity of information provided.

• I, the applicant and the listed dependents, agree to being called upon to submit such medical examinations and tests as LAMP Insurance Company Limited deems necessary.

• I acknowledge that LAMP Insurance Company Limited reserves the right to cancel the membership of this Plan if any amount due is not paid by or on the due date concerned.

• I agree to give LAMP Insurance Company Limited immediate written notice should any changes material to the assessment of this application occur before the date upon which LAMP Insurance Company Ltd grants written acceptance. This will give LAMP Insurance Company Limited the opportunity to reconsider the terms of acceptance.

• 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

Signed	
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
Registered Address: 260/262 Main Street, Gibraltar
Company Number: 93562
Email: info@lampinsurance.com
Web: www.lampinsurance.com