Individual Application Form

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

Whilst instalment terms are available, it should be noted that this application is for a **12-month policy** and may not be cancelled until the renewal date.

On acceptance of your application we will forward a second form to collect premium payment and reimbursement details from you.

SECTION A - Lead Applicant's Details

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

SECTION B - Plan Section

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

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)	$			
Geographical Cover*	☐ Area 1	☐ Area 2		
Excess / Deductible	☐ Nil	☐ $100	☐ $300	☐ $500
	☐ $1,000	☐ $3,000	☐ $5,000	

* 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 C - Dependent Applicant 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)	
Home Country			
Relationship to Applicant			
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)	
Home Country			
Relationship to Applicant			
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)	
Home Country			
Relationship to Applicant			
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 aged 19 to 25, are in full time education.

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

LAMP

SECTION D - 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.

	Lead Applicant	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.

	Lead Applicant	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 D - (continued)

	Lead Applicant		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 E - 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.

	Lead Applicant	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 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 hereby apply for membership to the Global Expatriate Healthcare Plan.

• I accept the benefits terms conditions and limits provided for in the terms of the insurance policy and I agree to be bound by such terms.

• I understand that this Application is subject to written acceptance by LAMP Insurance Company Limited.

• 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 eligibility for coverage. This authorisation will be valid for twenty four months from the date of signature of this form.

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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