A member of the BUPA group

# APPLICATION FORM A

International Health Insurance danmark a/s

(PLEASE USE BLOCK LETTERS)

PACIFIC PRIME INTERNATIONAL - INTERNATIONAL HEALTH AND HOSPITAL PLAN

## FOR ADMINISTRATION USE

Ref. _____ Policy Number

Date _____ _____ – _____

# 361600000

## COMMENCEMENT DATE

I / we request that the policy commences from 0 1 day ____ month ____ year

## POLICYHOLDER

First name(s) _____ Date of birth (day/month/year) _____

Family name(s) _____ Sex (M/F) ____

Address _____

Address _____ Postal Code _____

City _____ Telephone _____

Country _____ Fax _____

E–mail _____

## ONLINE CUSTOMER SIGN UP

❍ I hereby sign up as an online customer with International Health Insurance danmark a/s. As an online customer, I will receive all documents and correspondence from IHI via my personal site myPage on www.ihi.com.

## INTERMEDIARY'S ACCESS TO DOCUMENTS

☒ In the event that I am represented by an intermediary, I hereby accept that my intermediary will get access to my documents online on his/her personal and secure IHI website.

## REIMBURSEMENT VIA BANK TRANSFER

If you would like us to transfer future reimbursements to your bank account, please state:

Account holder's name(s) _____

Name of bank _____

Bank address _____

Postal Code _____ City _____ Country _____

❍ Transfer to Danish account: ❍ Transfer to foreign account:

Reg. No. _____ Account No./IBAN No. _____

Account No. _____ SWIFT No. _____

## DEPENDANTS

First name(s) _____ Date of birth (day/month/year) _____

Family name(s) _____ Sex (M/F) ____

First name(s) _____ Date of birth (day/month/year) _____

Family name(s) _____ Sex (M/F) ____

First name(s) _____ Date of birth (day/month/year) _____

Family name(s) _____ Sex (M/F) ____

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## COVER – *PLEASE CHOOSE MODULES, CURRENCY AND DEDUCTIBLE BY TICKING THE RELEVANT BOXES*

| CHOICE OF MODULES | CHOICE OF DEDUCTIBLE / CURRENCY | | |
|---|---|---|---|
| ☒ Hospital Plan | ❍ Nil | ❍ Nil | ❍ Nil |
| ❍ Module 1 - Non-Hospitalisation Benefits | ❍ EUR 350 | ❍ GBP 250 | ❍ USD 400 |
| ❍ Module 2 - Medicine & Appliances | ❍ EUR 1,050 | ❍ GBP 750 | ❍ USD 1,600 |
| ❍ Module 3 - Medical Evacuation & Repatriation | ❍ EUR 4,000 | ❍ GBP 2,750 | ❍ USD 5,000 |
| ❍ Module 4A - Dental & Optical | ❍ EUR 8,000 | ❍ GBP 5,500 | ❍ USD 10,000 |
| ❍ Module 4B - Dental & Optical | **Please note that the chosen currency is binding.** | | |

## PREMIUM PAYMENT

❍ Annual ❍ Semi-annual ❍ Quarterly

## REQUEST FOR PAYMENT FROM A BANK OR ANOTHER ADDRESS *(IF DIFFERENT FROM RESIDENTIAL ADDRESS)*

Name(s)

Address — Account No. (if bank)

Address — Postal Code

City — Country

## REQUEST FOR PAYMENT BY INTERNATIONAL CREDIT CARD

I / we wish to pay the premium via credit card. International Health Insurance danmark a/s will charge the credit card company directly.

❍ American Express ❍ VISA ❍ Eurocard / MasterCard

❍ JCB ❍ Diners

Card no. — Expiry date (m/y) — CVC code* (except American Express)

* CVC code: The last three digits after the card number on the back of the card or the last three digits in the signature field.

**Cardholder's data if cardholder and policyholder are not the same person:**

Name(s)

Address

Address — Postal Code

City — Country

❍ I also authorise International Health Insurance danmark a/s, until further notice in writing, to charge my credit card account with unspecified amounts in respect of my premium payments as and when these become due. The Company will inform me in advance of any premium adjustments.

**Please note that the Company will need the original, signed form to be able to charge the credit card.**

Cardholder's signature _____ Date _____

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INTERNATIONAL HEALTH AND HOSPITAL PLAN

# MEDICAL QUESTIONNAIRE B

International Health Insurance danmark a/s

(PLEASE USE BLOCK LETTERS)

PACIFIC PRIME INTERNATIONAL

*A Medical Questionnaire B must be completed for each person aged 10 years or over applying for cover, and also for any adopted children or any child under the age of 10 with a pre-existing condition or who is not in good health. All the Medical Questionnaires should be sent together with the Application Form A to the insurer.*

## FOR ADMINISTRATION USE

Ref. Policy Number # 3616 00000

Date

## APPLICANT *(PLEASE UNDERLINE THE NAMES YOU WISH TO BE INDICATED ON YOUR INSURANCE CARD, MAX. 29 FIELDS)*

First name(s) Occupation

Family name(s)

Date of birth (day/month/year) Nationality

Age Sex (M/F) Height (cm) Weight (kg) / Height (inches) Weight (pounds)

## OTHER INSURANCE

Do you have a health insurance with another company? NO ❍ YES ❍

Company name Policy Number

Do you intend to continue being insured with the other company? NO ❍ YES ❍

Have you ever had an application for health or life insurance declined or accepted subject to exclusions or at a premium above the insurer's standard rates? NO ❍ YES ❍ If yes, please enclose complete information.

## MEDICAL HISTORY

If you have or previously have had any of the following illnesses / disorders, please tick the appropriate box and provide details. If you have any additional comments, please state details under "Further remarks" (question 8). All questions must be answered.

**a)** Tumours: Benign ❍ Malignant ❍ NO ❍
Details

**b)** Migraine ❍ Neurological Disorders ❍
Epilepsy ❍ NO ❍
Details

**c)** Mental Illnesses ❍ NO ❍
Details

**d)** Eye Diseases ❍ NO ❍
Details

**e)** Asthma ❍ Allergies ❍
Pulmonary Diseases ❍ NO ❍
Details

**f)** Cardiovascular Diseases ❍
Arterial Hypertension ❍ NO ❍
Details

**g)** Liver Diseases ❍ Pancreas Diseases ❍
Stomach Diseases ❍ Intestinal Diseases ❍ NO ❍
Details

**h)** Diabetes ❍ Other Hormone Diseases ❍ NO ❍
Details

**i)** Urinary Tract and Kidney Diseases ❍
Diseases of the Sexual Organs ❍ NO ❍
Details

**j)** Rheumatism ❍
Muscle, Joint or Bone Diseases ❍ NO ❍
Details

**k)** Back Problems ❍ NO ❍
Details

**l)** Skin Diseases ❍ NO ❍
Details

**m)** Cosmetic Operations ❍ NO ❍
Details

**n)** Any other diseases, disorders, illnesses ❍ NO ❍
Details

**o)** Have you ever had any fertility treatment? YES ❍ NO ❍
Details

**p)** Have you ever been tested for HIV-antibodies?
YES ❍ NO ❍
If YES, what was the result:
HIV-Positive ❍ HIV-Negative ❍

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1. **Do you take or have you taken any kind of medicine on a regular basis?** YES ❍ NO ❍

   If YES, please state type and daily dosage

   Diagnosis Expense per month

2. **Have you ever been hospitalised or received treatment for any illness?** YES ❍ NO ❍

   If YES, please state name of hospital / clinic / doctor. (You can use Further Remarks (question 8) if you have more info.)

   Name

   Address

   Telephone Fax

   E-mail

   Diagnosis Date

3. **Do you suffer from any side effects or consequences of the above conditions?** YES ❍ NO ❍

   If YES, please enclose complete information.

4. **Do you use spectacles or contact lenses – if so please indicate strength**

5. **For women only: are you currently pregnant?** YES ❍ NO ❍

6. **Family Doctor**

   Name

   Address

   Telephone Fax

   E-mail

7. **Do you have additional medical information?** YES ❍ NO ❍

   All relevant up-to-date medical reports should be enclosed in the event of any pre-existing medical conditions.

8. **Further remarks, if any:**

9. **Applicant's signature**

I hereby accept that the Company will record the information given for the purpose of processing data in connection with e.g. premium collection, processing of claims, reimbursements etc. In case of non acceptance of the application, the information given may be recorded. The Danish Act on Processing of Personal Data allows me the right of access to see documents and information recorded. I also accept that all correspondence concerning the insurance will be sent to the person registered as policyholder.

If your state of health changes after the application has been signed and before the Company has approved the insurance, the Company must be notified immediately of such a change. In this case and in case of other pre-existing conditions, you are requested to enclose any relevant up-to-date medical reports.

I, the undersigned, solemnly declare that I and any co-insured children are in completely good health and do not, apart from the aforementioned, suffer or have suffered from any recurring illness or physical debility. I have answered in accordance with the truth and hereby give International Health Insurance danmark a/s permission to seek such information from treating doctors and hospitals concerning my / our state of health as the Company deems necessary.

**If supplementary insurance for dental treatment is required:** I am / we are not under or about to undergo dental treatment, and hereby give the Company permission to seek information from treating dentists concerning my / our dental status or any dental treatment.

Date (day/month/year) Signature



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E-mail: ihi@ihi.com ■ www.ihi.com ■ Reg. CVR No. 88076516 ■ IHI Assist (24-hour emergency service): +45 33 15 33 00 / E-mail: assist@ihi.com

# Contact Information

In order to help us work with you more effectively we ask you to complete the following contact data sheet. By completing this fully then we will be able to ensure you get the best possible service even though you may change your employer, country or location.

**Policyholder**

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other: ……..…… Family Name: ……..…….....….....

Given Name: …… Middle Name(s): ……..……...

Home Address: ……..……..…

..... Country: ……..……

**Contact info in the country you now live in**

Mobile: …….. Home: …….. Work: ……..…….

Personal email (1): …….. Personal email (2): ……..

Work email: …….. Employer: ……..

Employers address: ……

..... Country: ……..……

**Permanent contact information in your home country**

Mobile: …….. Home: …….. Work: ……..….

Permanent Address: ……..……..……

..... Country: ……..……

**Spouse**

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other: …… Family Name: ……..….....….....

Given Name: …… Middle Name(s): ……..……...

**Contact info in the country you now live in**

Mobile: …….. Work: ..……

Personal email (1): …….. Personal email (2): ……..

Work email: …….. Employer: ……..

Employers address: ……

..... Country: ……..……

**Emergency Contact Person**

In the event of an emergency whereby we are unable to contact you or your spouse or should you be incapacitated then please provide us with the permanent contact details of an immediate family member who we should contact in this situation.

Family Name: ……..…... Given Name: ……

Mobile: …….. Home: …….. Work: ……..…….

email: ……..….. Relationship to you: ……..

Home address: ……

..... Country: ……..……

Please help us by keeping us fully informed or all changes to your contact details as soon as possible. Please note all information given to us is only used to help us manage your insurance policy and is never used for any other purpose.