A member of the BUPA group

International Health Insurance danmark a/s

Application Form A

PACIFIC PRIME

(PLEASE USE BLOCK LETTERS)

NEW IHI Premier 1 - Diamond • Gold

For Administration Use

Ref. _____ Policy Number _____ - 2001 # 361600000

Date _____

Policyholder

First name(s) _____

Family name(s) _____

Date of birth (day/month/year) _____ Sex (M/F) _____ Choice of deductible USD _____

Choice of plan: ❍ Diamond ❍ Gold Worldwide ❍ Gold Latin America Premium USD _____

Dependant 1

First name(s) _____

Family name(s) _____

Date of birth (day/month/year) _____ Sex (M/F) _____ Choice of deductible USD _____

Choice of plan: ❍ Diamond ❍ Gold Worldwide ❍ Gold Latin America Premium USD _____

Dependant 2

First name(s) _____

Family name(s) _____

Date of birth (day/month/year) _____ Sex (M/F) _____ Choice of deductible USD _____

Choice of plan: ❍ Diamond ❍ Gold Worldwide ❍ Gold Latin America Premium USD _____

Dependant 3

First name(s) _____

Family name(s) _____

Date of birth (day/month/year) _____ Sex (M/F) _____ Choice of deductible USD _____

Choice of plan: ❍ Diamond ❍ Gold Worldwide ❍ Gold Latin America Premium USD _____

Dependant 4

First name(s) _____

Family name(s) _____

Date of birth (day/month/year) _____ Sex (M/F) _____ Choice of deductible USD _____

Choice of plan: ❍ Diamond ❍ Gold Worldwide ❍ Gold Latin America Premium USD _____

Total premium for all the above-mentioned applicants USD _____

Please continue on page 2

General data valid for all persons on the application form A

Commencement date

I / We request that the policy commences from 01 day ____ month ____ year

Payment terms

❍ Annual ❍ Semi-annual

Residential address *(only residents outside the U.S. can apply)*

Address

Address Postal Code

City Country

State Telephone

E-mail Fax

Note: If the address of any of the applicants changes after the application has been signed and before the Company has accepted the insurance, the Company must be notified immediately of such a change.

Non-residential postal address for mailing purposes only *(p.o. box or c/o)*

Complete name registered under this postal address

Name

Address

City Postal Code

State Country

Insurance consultant

If advised by an insurance consultant, please state his / her full name

Name

Policyholder's signature

I declare that I and all the applicants have received and read the Policy Conditions and that I / we acknowledge and are aware that the Policy Conditions together with the policy schedule and the application (Application Form A and Medical Questionnaire B) will represent the insurance contract with the Company, if the application is accepted.

Date (day/month/year) Name in capital letters Signature

20XE6-41/04.2006

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Medical Questionnaire B

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(PLEASE USE BLOCK LETTERS)

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

For Administration Use

Ref. _____ Policy Number _____ # 361600000

Date _____ - 2001

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) or use the form Further Remarks C.
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 ❍

Please continue on page 2

- 2001

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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 information)

   Name

   Address

   Telephone Fax

   E-mail

   Diagnosis Dates

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, the undersigned, solemnly declare that I and any applicants under the age of 10 are in excellent health and do not, except as disclosed on the application (Application Form A and Medical Questionnaire B), suffer from any recurring illness or physical debility. I hereby give International Health Insurance danmark a/s (the Company) permission to seek any information from treating doctors and hospitals concerning our state of health as the Company deems necessary. I declare that if my or any person to be insured's state of health changes after the application has been signed and before the acceptance of cover by the Company, I will notify the Company of any change immediately.
I declare that I and any persons to be insured have received and read the Policy Conditions and accept that the Policy Conditions together with the Policy Schedule and the application will represent the insurance contract with the Company if the application is accepted. I also declare that I and any persons to be insured on this policy are not residents of the U.S.
I further declare that, to the best of my knowledge and belief, all information on the application is true. I acknowledge that any misrepresentation or nondisclosure of information requested may result in no coverage or modification of coverage under the policy.
I acknowledge and understand that acceptance of this application by the Company will be made in reliance on the accuracy of the information presented in the application.
A parent or person with legal custody of the child must sign on behalf of any applicant under 18 years of age.

Date (day/month/year) Name in capital letters Signature

20XE6-42/04.2006

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