

Thank you for downloading this information.

For more information, advice or for a free quote, please contact our global head office at the address below who will redirect you to a regional office located near you:

Tel: (852) 3113 1331
Fax: (852) 2915 7770
Email: info@pacificprime.com

Address: Unit 1-11, 35th Floor,
One Hung To Road,
Kwun Tong,
Hong Kong.

If you would like to submit an application to us, you can fax, email or post the completed form to us at the above address.



Broker's stamp Pacific Prime International Limited
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Policy number
Effective date <i>(Cover may not be backdated)</i>

Return completed form to your Financial Advisor or Broker or to:
 MediCare International
 The Matrix, 9 Aldgate High Street
 London EC3N 1AH, England
 Telephone: +44 (0)20 7816 2033
 Facsimile: +44 (0)20 7816 2188
 E-mail: medicare@medicare.co.uk
 Website: www.medicare.co.uk

Individual Plan

Individual Application Form

PLEASE COMPLETE IN BLOCK CAPITALS AND TICK RELEVANT BOXES

Your personal details

Applicant's full name: _____

Mailing address: _____

Postcode: _____ Country: _____

Telephone: _____ Facsimile: _____ Email: _____

Occupation: _____ Nationality: _____
(Which will be used to establish the Home Country of the Applicant and Dependents)

Cover required

International Plan	<input type="checkbox"/>	Area 1 Worldwide ex USA, Canada & Caribbean	<input type="checkbox"/>
International Plus Plan	<input type="checkbox"/>	Area 2 Worldwide	<input type="checkbox"/>
Executive Plan	<input type="checkbox"/>		
Executive Plus Plan	<input type="checkbox"/>		
Waive Outpatient Excess*	<input type="checkbox"/>		

*applicable to International Plus, Executive and Executive Plus Plans only

Required start date On Acceptance Other (please specify)

Persons to be insured

Surname	First Names	Date of Birth	Sex	Country of Residence	Area of Cover Required
<i>Applicant:</i>					
<i>Spouse/Partner:</i>					
<i>Child:†</i>					
<i>Child:†</i>					
<i>Child:†</i>					
<i>Child:†</i>					

†Up to the age of 18, or 24 if still in full-time education. Evidence will be required.

Your Doctor's contact details

Please give details of the doctor(s) who is(are) most familiar with your/your dependants medical history

Doctor's Name: _____	Doctor's Name: _____
Address: _____	Address: _____
Telephone No: _____	Telephone No: _____

Declaration

I hereby apply to be enrolled in the Plan together with the persons to be insured listed above. I declare to the best of my knowledge and belief that the information given in this Application is true and complete. I have read and understood the Plan Rules, particularly in relation to newborn children and I understand them to be part of any contract of insurance issued as a result of this Application and agree they will be binding on me and all eligible dependants included in my membership. I acknowledge on behalf of all the persons to be insured that benefits will not apply to treatment arising from any pre-existing conditions as more fully defined in the Plan Rules. It is agreed that this declaration and the information given in this Application shall form the basis of the contract(s) between the Insured Person(s) and the Insurer.

Signature of applicant: _____ Date: _____
(On behalf of all persons to be insured)

PLEASE COMPLETE THE METHOD OF PAYMENT FORM AND RETURN IT WITH YOUR APPLICATION FORM TO MEDICARE INTERNATIONAL

Data Protection Act

The information you have provided will become part of the personal data held by MediCare International and will be used for the provision and administration of insurance products and services. MediCare International may disclose your personal data to insurance companies and to their agents for underwriting, claims handling and fraud prevention services. In addition, it may seek information from insurance companies to check the answers you have provided. Full details of MediCare International's processing of personal data appear in the register maintained by the Information Commissioner.

Medical Questionnaire (for 65 years and over only)

If you or your spouse/partner are 65 years or older you must complete this form

PLEASE COMPLETE FULLY IN BLOCK CAPITALS AND TICK RELEVANT BOXES

Personal details

Applicant's full name: _____ Spouse/Partner's full name: _____

Height (cms): _____ Weight (kgs): _____ Height (cms): _____ Weight (kgs): _____

Please provide details of the Doctor(s) who is (are) most familiar with your/your spouse/partner's medical history

Doctor's name: _____ Doctor's name: _____

Address: _____ Address: _____

Telephone No: _____ Telephone No: _____

1. Have you had any surgical procedure, been confined or treated in a hospital, clinic, sanatorium, nursing home or other medical institution within the last five years, or is any treatment or tests currently being performed or any operation/hospital confinement scheduled?

Applicant: Yes No

Spouse/Partner: Yes No

2. Have you ever had any treatment, tests or medical examinations performed by a General Practitioner or Consultant, including Prescription Drugs, within the last five years?

Applicant: Yes No

Spouse/Partner: Yes No

3. Are you currently suffering from any medical condition or disability or experiencing symptoms of any kind which might reasonably be considered to require medical treatment in the future?

Applicant: Yes No

Spouse/Partner: Yes No

Important

If the answer to any of the above questions is "Yes", please give full details, including dates, nature of ailment or disability, medical procedure or tests performed and details of any drugs prescribed. Please state the name and address of the treating physician/consultant and/or medical facility where tests or treatment took place.

Applicant: _____

Spouse/Partner: _____

Declaration

I declare that the answers to the above questions are accurately represented and are to the best of my knowledge and belief, full, complete and true, and that I do not have any knowledge of any circumstance that could affect the results of the evaluation by the Insurer related to my application for insurance. I authorise any physician or practitioner who has observed me or my spouse/partner for diagnosis, treatment, disease or ailment, to give to the Insurer full particulars of these, including any prior medical history. I waive in my name, and that of any other person who shall have or claim an interest in any policy issued as a result of the answers, all provisions of law forbidding such action. The refusal to submit medical information by any Insured or doctor, clinic, hospital or institution shall be considered as a waiver of benefit by such Insured and/or supplier of services and the Insurer shall have no further obligation towards such persons or entity. I consent to the processing by MediCare International of any of the personal data I provide or which is provided to MediCare International about me by any other person.

Signature of Applicant: _____ Date: _____

Signature of Spouse/Partner: _____ Date: _____

Cover will not commence until you have been advised by MediCare International of any special terms that may apply and you have confirmed acceptance of such terms and paid the premium due.

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 of 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.