

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.

Application Form A



(Please use block letters)

Pacific Prime International Limited

For Administration Use

Ref. _____	Policy Number _____	# _____
Date _____	_____	

Commencement date

I / we request that the policy commences from 01 day _____ month _____ year _____

Policyholder

First name(s) _____	Date of birth (day/month/year) _____
Family name(s) _____	Sex (M/F) <input type="checkbox"/>
Address _____	
Address _____	Postal Code _____
City _____	Telephone _____
Country _____	Fax _____
E-mail _____	

Online customer sign up

I hereby sign up as an online customer with Bupa Denmark, filial af Bupa Insurance Limited, England. As an online customer, I will receive all documents and correspondence from ihi Bupa via my personal site myPage on www.ihl.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 Bupa 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 _____

IBAN No. _____

SWIFT No. _____

Dependants

First name(s) _____	Date of birth (day/month/year) _____
Family name(s) _____	Sex (M/F) <input type="checkbox"/>
First name(s) _____	Date of birth (day/month/year) _____
Family name(s) _____	Sex (M/F) <input type="checkbox"/>
First name(s) _____	Date of birth (day/month/year) _____
Family name(s) _____	Sex (M/F) <input type="checkbox"/>

Cover - please choose cover, currency and deductible by ticking the relevant boxes

Main insurance						Supplementary insurance
<input type="radio"/> Complete Plan, deductible			<input type="radio"/> Hospital Plan, deductible			<input type="radio"/> Dental & Optical
CHF	EUR	USD	CHF	EUR	USD	<input type="radio"/> Medical Evacuation & Repatriation
<input type="radio"/> Nil	<input type="radio"/> Nil	<input type="radio"/> Nil	<input type="radio"/> Nil	<input type="radio"/> Nil	<input type="radio"/> Nil	
<input type="radio"/> 300	<input type="radio"/> 200	<input type="radio"/> 200	<input type="radio"/> 600	<input type="radio"/> 400	<input type="radio"/> 400	
<input type="radio"/> 600	<input type="radio"/> 400	<input type="radio"/> 400	<input type="radio"/> 2,000	<input type="radio"/> 1,350	<input type="radio"/> 1,350	
<input type="radio"/> 2,000	<input type="radio"/> 1,350	<input type="radio"/> 1,350	<input type="radio"/> 4,000	<input type="radio"/> 2,700	<input type="radio"/> 2,700	
<input type="radio"/> 4,000	<input type="radio"/> 2,700	<input type="radio"/> 2,700				

Please note that the chosen currency is binding.

Premium payment

Annual Semi-annual

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. Bupa Denmark, filial af Bupa Insurance Limited, England will charge the credit card company directly.

American Express VISA Eurocard / MasterCard

JCB Diners

Card no. _____ Expiry date (m/y) _____ CVC code* _____

* CVC code: The last three/four 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 Bupa Denmark, filial af Bupa Insurance Limited, England, 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 _____

Medical Questionnaire B

(Please use block letters)

A Medical Questionnaire B must be completed for each person applying for cover. All the Medical Questionnaires B should be sent together with the Application Form A to the insurer.

For administration use

Ref. _____	Policy Number _____	# _____
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.

<p>a) Tumours: Benign <input type="radio"/> Malignant <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>b) Migraine <input type="radio"/> Neurological Disorders <input type="radio"/></p> <p>Epilepsy <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>c) Mental Illnesses <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>d) Eye Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>e) Asthma <input type="radio"/> Allergies <input type="radio"/></p> <p>Pulmonary Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>f) Cardiovascular Diseases <input type="radio"/></p> <p>Arterial Hypertension <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>g) Liver Diseases <input type="radio"/> Pancreas Diseases <input type="radio"/></p> <p>Stomach Diseases <input type="radio"/> Intestinal Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>h) Diabetes <input type="radio"/> Other Hormone Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p>	<p>i) Urinary Tract and Kidney Diseases <input type="radio"/></p> <p>Diseases of the Sexual Organs <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>j) Rheumatism <input type="radio"/></p> <p>Muscle, Joint or Bone Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>k) Back Problems <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>l) Skin Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>m) Cosmetic Operations <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>n) Any other diseases, disorders, illnesses <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>o) Have you ever had any fertility treatment? YES <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p>p) Have you ever been tested for HIV-antibodies?</p> <p>YES <input type="radio"/> NO <input type="radio"/></p> <p>If YES, what was the result:</p> <p>HIV-Positive <input type="radio"/> HIV-Negative <input type="radio"/></p>
--	--

Policy Number

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 _____ 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 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 and that all insured on the policy have access to correspondence etc. from the Company on its webpage via login. The Company may choose to have data processed in or outside the EU. The Company can exchange the information within the Group and with my intermediary.

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 co-insured children are in excellent 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 Bupa Denmark, filial af Bupa Insurance Limited, England permission to seek and exchange any information from treating doctors and hospitals concerning my/our state of health as the Company deems necessary. If insurance for dental treatment is required: I am not under or about to undergo dental treatment, and hereby give the company permission to seek information from treating dentists concerning any dental treatment.

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.

Date (day/month/year) _____ Signature _____

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.