William Russell
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Global Health Plans

Individual Application Form (Full Medical Underwriting)

Please complete this form in **BLOCK CAPITALS** using black ink, and return it to us by email, fax or post. You can find our contact details at the end of this form.

Broker/intermediary details

If you were introduced to William Russell through an intermediary/broker, please state their name and company.

Name of broker: J. Hubert ..... Name of company: BML Services Ltd. (ehealthscanner.com) .....

Your personal details

First name: ..... Surname: ..... Title: .....

Address: .....

.....

Telephone number: ..... Mobile number: ....

Email: ..... Occupation: .....

Date of birth: ..... Nationality: ..... ☐ Male ☐ Female

Country where you will be living/working: ..... How long have you lived here? ..... years

Dependants to be included

Please enter details of all dependants to be included in your plan. You may include your spouse/partner, and dependent children up to age 18 (or 25 if in full-time education). Children aged 18 and over, and not in full-time education, must complete their own application form.

	Spouse/partner	Child 1	Child 2	Child 3
First name				
Surname				
Date of birth				
Gender				
Relationship to you				
Country where they will be living				
Occupation/full-time education				

Start date required

When would you like your Global Health plan to start?

☐ On acceptance of your application ☐ Specific date: .....

Please note that your application is only valid for 28 days from the date we receive it. Cover cannot be backdated.

Previous/current insurance

Have you, or any persons named on this form, ever:

1. **Applied for a plan or been insured with William Russell?** ☐ Yes ☐ No

If YES, please state the plan number: ..... Date of expiry of plan: .....

2. **Had an application for insurance declined or accepted with special terms, or had an insurance policy cancelled by any insurance provider?** ☐ Yes ☐ No

If YES, please provide details: .....

.....

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3. Are you currently insured with another health insurer? ☐ Yes ☐ No

If YES, please provide details: ..... Date of expiry of plan: .....

Choose your health insurance plan

Please choose either **A) an Elite plan** or **B) an Essential plan**, then select the **optional benefits** you require. If you have one, please state the quote illustration ID for the quote you wish to accept: .....

A) Elite plans

Plan:	Excess required:			
GOLD	☐ Nil	☐ $50/£30/€45 per claim ☐ $100/£60/€90 per claim	☐ $250/£150/€225 per annum ☐ $1,600/£1,000/€1,500 per claim	☐ $5,000/£3,000/€4,500 per claim
SILVER	☐ Nil	☐ $50/£30/€45 per claim ☐ $100/£60/€90 per claim	☐ $250/£150/€225 per annum ☐ $1,600/£1,000/€1,500 per claim	☐ $5,000/£3,000/€4,500 per claim
BRONZE	☐ Nil	☐ $250/£150/€225 per annum	☐ $1,600/£1,000/€1,500 per claim	☐ $5,000/£3,000/€4,500 per claim

Optional benefits available with the Elite plans

☐ **Enhanced emergency evacuation.**

☐ **Complex dental benefit** – only available with Gold.

☐ **Routine & complex dental benefit** – only available with Silver.

☐ **Semi-private room discount** – only available to residents of Hong Kong with Area One cover.

☐ **Out-patient direct billing in Hong Kong and China** – only available with Silver and Gold**.** Available to residents of Hong Kong with nil excess, and to residents of China with a nil or $50/£30/€45 excess. A 7.5% surcharge applies in China.

Choose your Elite Area of Cover

☐ **Area One** Worldwide cover, excluding the USA.

☐ **Area Two** Worldwide cover, with cover in the USA limited to $100,000 during temporary trips of not more than 45 days. This limit is increased to $250,000 for unforeseen emergency treatment.

☐ **Area Three** Worldwide cover, with cover in the USA limited to $250,000 during temporary trips of not more than 90 days.

☐ **Area Four** Cover in Africa & the Indian Subcontinent, plus cover for unforeseen emergency treatment received during temporary trips of up to 90 days outside Africa & the Indian Subcontinent up to $100,000 or £62,500 or €88,750. No cover is provided for any treatment in the USA, Canada, all Caribbean countries and islands, or within the London area.

B) Essential plans

Plan:	Excess required:		
ESSENTIAL CARE PLUS	☐ Nil	☐ $50 per claim	☐ $250 per annum
ESSENTIAL CARE	☐ Nil	☐ $250 per annum	

Optional benefits available with the Essential plans

☐ **Enhanced emergency evacuation.**

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The Essential Area of Cover

Cover is provided everywhere, except in the following restricted or excluded countries/regions. Cover is restricted to treatment for accidents or unforeseen illnesses only, and limited to $50,000 per period of cover if you travel to any European country, Bali, Japan, Hong Kong, Macau, China, Taiwan, Singapore, Australia or New Zealand. No cover at all is provided in the USA, Canada, any Caribbean country or island, and any hospital in the London area.

Add-ons available with your health insurance plan

GLOBAL TRAVEL PLAN ☐ You ☐ Spouse/partner ☐ Family

GLOBAL PERSONAL ACCIDENT PLAN ☐ You ☐ Spouse/partner

Please answer the following questions ONLY if you have opted for Personal Accident cover. If you have opted for cover for your spouse/partner, we also require details of their occupation and any hazardous activities.

Please select the level of Personal Accident benefit you require:

☐ $75,000/£50,000/€75,000 ☐ $150,000/£100,000/€150,000 ☐ $225,000/£150,000/€225,000

☐ $300,000/£200,000/€300,000 ☐ $375,000/£250,000/€375,000

Is your occupation and the occupation of your partner/spouse 100% office-based? ☐ Yes ☐ No

If NO, please provide a job description, or full details of any non-office-based activities and how often they are participated in:

.....

Do you or your partner/spouse participate in any hazardous activities? ☐ Yes ☐ No

If YES, please provide full details of any hazardous activities and how often they are participated in:

.....

The Global Personal Accident plan does not cover accidents as a result of hazardous activities/occupations. Cover for hazardous activities/occupations may be subject to a premium loading, special terms, or we may decline to offer cover.

Hazardous activities include off-piste skiing, scuba diving to a depth of more than 30 metres (or any unsupervised scuba diving), rock climbing or mountaineering, pot-holing, hang-gliding, parachuting (including tandem), bungee jumping, kite surfing/windsurfing, hunting on horseback, driving or riding in any kind of race or competition, flying other than as a passenger in a commercial aircraft, riding a motorcycle (or riding pillion), motor scooter, moped or quad bike, or any other activity that places you in a similar degree of danger as any of those mentioned here.

Paying for your plan

Please select the currency in which you would like to pay your premiums:

☐ US Dollars ☐ GBP Sterling ☐ Euros

Your plan benefits and excess will be denominated in the currency in which you pay your premiums. The Essential plans are only available in US Dollars.

Please select your payment method and frequency:

Credit/debit card	☐ Annually	☐ Half-yearly**	☐ Quarterly***	☐ Monthly***
Direct debit*	☐ Annually	☐ Half-yearly**	☐ Quarterly***	☐ Monthly***
Bank transfer	☐ Annually			
Cheque	☐ Annually (payable to William Russell Ltd., and must be drawn on a UK bank account)			

*Direct debit payments are only available when you pay in Sterling from a UK bank account.

**Half-yearly premiums are subject to a 3% surcharge.

***Quarterly or monthly premiums are subject to a 5% surcharge.

Supplementary medical questionnaires available below

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Health declaration

Your Global Health plan will be underwritten on a full medical underwriting basis. Please complete the following health declaration and provide us with full details of any medical conditions existing before the start date of your plan. **Pre-existing conditions and related conditions will not be covered**, unless you have told us about them and we have agreed to cover them. This includes conditions arising between the time you submit this application and the start date of your plan, so please contact us immediately if the information provided changes.

Please answer the following questions for each person named on this form fully, accurately, and to the best of your knowledge and belief. If you answer YES to any question, please supply full details in the spaces provided. If you do not answer the questions fully and accurately, your plan may be cancelled, claims may be rejected, or special terms may be applied retroactively. If you are in any doubt as to whether you should tell us anything, please tell us anyway.

Please complete the following table for yourself, your spouse/partner, and any dependants over age 18 only:

	You	Spouse/partner	Dependants over age 18
Height (cm)			
Weight (kg)			
If you smoke, how many cigarettes/cigars do you smoke daily?			
If you consume alcohol, how many of the following do you consume each week? • *Pints of regular-strength beer or cider* • *Pints of strong beer or cider* • *175ml glasses of wine* • *250ml glasses of wine* • *35ml measures of spirits*			

Medical questions for EACH person to be insured

① Has any person named on this form ever suffered from any of the following conditions?

a) **Brain or nervous system conditions?** ☐ Yes ☐ No
For example: stroke/transient ischemic attack (TIA), epilepsy, migraines or repeated headaches, multiple sclerosis, meningitis, shingles, nerve pain.

b) **Cancer, tumours or growths?** ☐ Yes ☐ No
For example: polyps, benign growths or cysts, lymphomas, any cancers or pre-cancerous conditions.

c) **Heart or circulatory conditions?** ☐ Yes ☐ No
For example: high blood pressure, angina/chest pains, heart attacks or failure, abnormal heartbeat, varicose veins, raised cholesterol, stroke, deep vein thrombosis.

d) **Psychiatric or psychological conditions, drug & alcohol issues or sleep disorders?** ☐ Yes ☐ No
For example: depression, anxiety, stress, anorexia nervosa, autism, bipolar disorder, insomnia, narcolepsy, sleep apnoea, alcohol or drug dependency.

② In the last five years, has any person named on this form seen a physician, or experienced any symptoms, or been admitted to a hospital or medical facility for an operation or procedure, or undergone any tests or investigations, for any of the following conditions:

a) **Auto-immune disorders?** ☐ Yes ☐ No
For example: HIV/AIDS, rheumatoid arthritis, systemic lupus erythematosus, scleroderma.

b) **Back, joint, muscular or skeletal problems?** ☐ Yes ☐ No
For example: back or joint pain, whiplash, sciatica, degenerative changes, osteoarthritis, osteoporosis, gout, bunions, joint replacements, fractures, cartilage or ligament problems.

c) **Breathing or respiratory conditions (including allergies)?** ☐ Yes ☐ No
For example: asthma, chronic obstructive pulmonary disease (COPD), shortness of breath, chest infections, pneumonia, bronchitis, tuberculosis (TB), hay fever, allergies to food substances and animals.

d) **Diabetes, thyroid or any other endocrine disorder?** ☐ Yes ☐ No
For example: diabetes type 1 or 2, overactive or underactive thyroid, pituitary or adrenal problems, obesity.

e) **Eyes, ear, nose and throat or oral/dental conditions?** ☐ Yes ☐ No
For example: glaucoma, cataracts, retinal detachment, macular degeneration, hearing difficulties, repeated ear infections, tonsillitis, sinusitis, dental problems, wisdom teeth problems, gingivitis.

f) **Gynaecological or breast conditions?** ☐ Yes ☐ No
For example: complications of pregnancy, heavy or irregular periods, fibroids, endometriosis, ovarian cysts, abnormal smear tests, miscarriage, pre- and post-natal complications, breast lumps/cysts.

g) **Skin conditions (including allergies)?** ☐ Yes ☐ No
For example: eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed or allergic reactions.

h) **Stomach, liver/gall bladder, or digestive system conditions?** ☐ Yes ☐ No
For example: ulcers, irritable bowels, Crohn's disease, colitis, reflux/heartburn abdominal pain, anaemia, hepatitis, cirrhosis, gallstones, hernias, haemorrhoids/piles.

i) **Urinary, kidney or prostate conditions?** ☐ Yes ☐ No
For example: kidney infections, kidney stones, incontinence, prolapse, prostate problems, recurrent bladder or urine infections.

j) **Any alcohol and/or drug dependency problems?** ☐ Yes ☐ No

k) **Any physical defect, infirmity or congenital condition?** ☐ Yes ☐ No

l) **Any other medical condition not mentioned above?** ☐ Yes ☐ No

③ **Is any person named on this form currently taking any medication, prescribed or otherwise?** ☐ Yes ☐ No

④ **Has any person named on this form experienced any signs or symptoms of any medical condition in the last six months, whether or not a physician has been consulted?** ☐ Yes ☐ No

⑤ **Is any person named on this form currently undergoing any treatment or periodic reviews for a medical condition, physical impairment, disability or recurrent illness not already mentioned?** ☐ Yes ☐ No

⑥ **Is anyone named on this form currently pregnant?** ☐ Yes ☐ No

If you have answered YES to any of the above questions, please give full details

Question #: ..... Name of person affected by the illness/injury/condition: .....

Date(s) on which the illness/injury/condition occurred: ..... Date symptoms were last suffered: .....

What diagnosis was made and what treatment was received: .....

.....

.....

Is any future treatment required, including consultations with a physician and/or periodic tests or reviews? ☐ Yes ☐ No

If YES, please give details: .....

Please provide the name and address of the treating physician: .....

Question #: ..... Name of person affected by the illness/injury/condition: .....

Date(s) on which the illness/injury/condition occurred: ..... Date symptoms were last suffered: .....

What diagnosis was made and what treatment was received: .....

.....

.....

Is any future treatment required, including consultations with a physician and/or periodic tests or reviews? ☐ Yes ☐ No

If YES, please give details: .....

Please provide the name and address of the treating physician: .....

If you require more space, please continue on a separate sheet of paper. If you are attaching any supporting medical documents, please note that we can only accept them in English.

Supplementary medical questionnaires available below

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Physician's details

Please provide details of the physician who is most familiar with the medical history of all those named on this form. If any dependants regularly see a different physician, please provide this information on a separate piece of paper.

Name of physician: .....

Address: .....

Telephone number: ..... Email: .....

How long have you been known to this physician? .....

Save paper and make a donation to charity

At William Russell, we are committed to reducing waste. Unless you specifically request paper documents and a plastic membership card, we will email your insurance documents as PDF files. If you agree to accept your documents via email, we will donate $5 to our supported charity, Oxfam.

Please tick one of the boxes below:

☐ I would like to receive my documents as PDF files, please donate $5 to charity.

☐ I would like to receive hard copies of my documents and a plastic card.

OXFAM

How we use your information

By submitting this application, you consent to William Russell Limited processing the personal data of each person named in this application, including sensitive medical information. We will use this data strictly within the provisions of the Data Protection Act 1998, and for the purposes of administrating your plan and processing your claims only.

In certain cases, it may be necessary to pass your data to the insurers and reinsurers of your plan, cost control agents, your appointed intermediary (if any), and our emergency assistance service providers. If you require emergency assistance or treatment outside the European Economic Area (EEA), we may pass your data to parties outside the EEA. If required, we will pass your data to legal or regulatory bodies, and to relevant parties in the interests of fraud prevention.

We will never share your data with a third party not strictly necessary to the administration of your plan or the processing of your claims.

Declaration for your Global Health plan

Please read this section carefully and sign below.

I understand that this application is subject to written acceptance by William Russell Limited. I declare that I have taken reasonable care to answer all questions for each person named on this form fully, accurately, and to the best of my knowledge and belief. I confirm that I have checked with each person that the information I have provided is a true representation of the facts.

I understand that misrepresentation could result in claims being rejected or not fully paid, and/or my plan being cancelled. I also understand that this plan does not cover medical conditions existing before the start date of the plan, unless I have provided full details to William Russell Limited and they have agreed to cover it. I also understand that my Certificate of Insurance will advise me of any medical conditions excluded from cover based on the information provided on this form.

I understand that I must inform William Russell Limited, in writing, of any changes in the facts provided in this application, including any change in health of any persons named on this form occurring before the start date of my plan.

I give consent on behalf of myself and each person named on this form for William Russell Limited to process our personal data within the provisions of the Data Protection Act 1998. I confirm that I have brought the data protection notice above to the attention of each person named on this form.

I understand that, to process my claims, William Russell Limited may need to obtain details of my medical history or of persons named on this form.

I authorise William Russell Limited to send all insurance documents as PDF files to the email address I have provided on this form. If I have applied through a broker or intermediary, I give consent for these documents to be sent via email to that broker or intermediary.

I understand that telephone calls to and from William Russell Limited may be recorded and monitored.

I understand that, upon receipt of my insurance documents, if I am not entirely satisfied, I can cancel my application from

inception and receive a full refund of the premium paid, provided I notify William Russell Limited within 30 days of the plan start date, and provided no claim has been made.

Important notes

- Your completed application form is valid for 28 days from the date you signed the form. If cover is not commenced within 28 days, we reserve the right to request that you complete a new application form.
- If the health of any person named on this form changes after you submit this form, but before your plan starts, you must let us know immediately.
- We are unable to accept electronic signatures below.

Name of applicant: .....

Signature of applicant: ..... **Date:** .....

William Russell Ltd.
William Russell House,
The Square, Lightwater,
Surrey, GU18 5SS, UK

T: +44 1276 486477
F: +44 1276 486466
E: sales@william-russell.com

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Health declaration

Your Global Health plan will be underwritten on a full medical underwriting basis. Please complete the following health declaration and provide us with full details of any medical conditions existing before the start date of your plan. **Pre-existing conditions and related conditions will not be covered**, unless you have told us about them and we have agreed to cover them. This includes conditions arising between the time you submit this application and the start date of your plan, so please contact us immediately if the information provided changes.

Please answer the following questions for each person named on this form fully, accurately, and to the best of your knowledge and belief. If you answer YES to any question, please supply full details in the spaces provided. If you do not answer the questions fully and accurately, your plan may be cancelled, claims may be rejected, or special terms may be applied retroactively. If you are in any doubt as to whether you should tell us anything, please tell us anyway.

Please complete the following table for yourself, your spouse/partner, and any dependants over age 18 only:

	You	Spouse/partner	Dependants over age 18
Height (cm)			
Weight (kg)			
If you smoke, how many cigarettes/cigars do you smoke daily?			
If you consume alcohol, how many of the following do you consume each week? • *Pints of regular-strength beer or cider* • *Pints of strong beer or cider* • *175ml glasses of wine* • *250ml glasses of wine* • *35ml measures of spirits*			

Medical questions for EACH person to be insured

① Has any person named on this form ever suffered from any of the following conditions?

a) **Brain or nervous system conditions?** ☐ Yes ☐ No
For example: stroke/transient ischemic attack (TIA), epilepsy, migraines or repeated headaches, multiple sclerosis, meningitis, shingles, nerve pain.

b) **Cancer, tumours or growths?** ☐ Yes ☐ No
For example: polyps, benign growths or cysts, lymphomas, any cancers or pre-cancerous conditions.

c) **Heart or circulatory conditions?** ☐ Yes ☐ No
For example: high blood pressure, angina/chest pains, heart attacks or failure, abnormal heartbeat, varicose veins, raised cholesterol, stroke, deep vein thrombosis.

d) **Psychiatric or psychological conditions, drug & alcohol issues or sleep disorders?** ☐ Yes ☐ No
For example: depression, anxiety, stress, anorexia nervosa, autism, bipolar disorder, insomnia, narcolepsy, sleep apnoea, alcohol or drug dependency.

② In the last five years, has any person named on this form seen a physician, or experienced any symptoms, or been admitted to a hospital or medical facility for an operation or procedure, or undergone any tests or investigations, for any of the following conditions:

a) **Auto-immune disorders?** ☐ Yes ☐ No
For example: HIV/AIDS, rheumatoid arthritis, systemic lupus erythematosus, scleroderma.

b) **Back, joint, muscular or skeletal problems?** ☐ Yes ☐ No
For example: back or joint pain, whiplash, sciatica, degenerative changes, osteoarthritis, osteoporosis, gout, bunions, joint replacements, fractures, cartilage or ligament problems.

c) **Breathing or respiratory conditions (including allergies)?** ☐ Yes ☐ No
For example: asthma, chronic obstructive pulmonary disease (COPD), shortness of breath, chest infections, pneumonia, bronchitis, tuberculosis (TB), hay fever, allergies to food substances and animals.

d) **Diabetes, thyroid or any other endocrine disorder?** ☐ Yes ☐ No
For example: diabetes type 1 or 2, overactive or underactive thyroid, pituitary or adrenal problems, obesity.

e) **Eyes, ear, nose and throat or oral/dental conditions?** ☐ Yes ☐ No
For example: glaucoma, cataracts, retinal detachment, macular degeneration, hearing difficulties, repeated ear infections, tonsillitis, sinusitis, dental problems, wisdom teeth problems, gingivitis.

f) **Gynaecological or breast conditions?** ☐ Yes ☐ No
For example: complications of pregnancy, heavy or irregular periods, fibroids, endometriosis, ovarian cysts, abnormal smear tests, miscarriage, pre- and post-natal complications, breast lumps/cysts.

g) **Skin conditions (including allergies)?** ☐ Yes ☐ No
For example: eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed or allergic reactions.

h) **Stomach, liver/gall bladder, or digestive system conditions?** ☐ Yes ☐ No
For example: ulcers, irritable bowels, Crohn's disease, colitis, reflux/heartburn abdominal pain, anaemia, hepatitis, cirrhosis, gallstones, hernias, haemorrhoids/piles.

i) **Urinary, kidney or prostate conditions?** ☐ Yes ☐ No
For example: kidney infections, kidney stones, incontinence, prolapse, prostate problems, recurrent bladder or urine infections.

j) **Any alcohol and/or drug dependency problems?** ☐ Yes ☐ No

k) **Any physical defect, infirmity or congenital condition?** ☐ Yes ☐ No

l) **Any other medical condition not mentioned above?** ☐ Yes ☐ No

③ **Is any person named on this form currently taking any medication, prescribed or otherwise?** ☐ Yes ☐ No

④ **Has any person named on this form experienced any signs or symptoms of any medical condition in the last six months, whether or not a physician has been consulted?** ☐ Yes ☐ No

⑤ **Is any person named on this form currently undergoing any treatment or periodic reviews for a medical condition, physical impairment, disability or recurrent illness not already mentioned?** ☐ Yes ☐ No

⑥ **Is anyone named on this form currently pregnant?** ☐ Yes ☐ No

If you have answered YES to any of the above questions, please give full details

Question #: ..... Name of person affected by the illness/injury/condition: .....

Date(s) on which the illness/injury/condition occurred: ..... Date symptoms were last suffered: .....

What diagnosis was made and what treatment was received: .....

.....

.....

Is any future treatment required, including consultations with a physician and/or periodic tests or reviews? ☐ Yes ☐ No

If YES, please give details: .....

Please provide the name and address of the treating physician: .....

Question #: ..... Name of person affected by the illness/injury/condition: .....

Date(s) on which the illness/injury/condition occurred: ..... Date symptoms were last suffered: .....

What diagnosis was made and what treatment was received: .....

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Please complete the following table for yourself, your spouse/partner, and any dependants over age 18 only:

	You	Spouse/partner	Dependants over age 18
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Weight (kg)			
If you smoke, how many cigarettes/cigars do you smoke daily?			
If you consume alcohol, how many of the following do you consume each week? • *Pints of regular-strength beer or cider* • *Pints of strong beer or cider* • *175ml glasses of wine* • *250ml glasses of wine* • *35ml measures of spirits*			

Medical questions for EACH person to be insured

1 Has any person named on this form ever suffered from any of the following conditions?

a) **Brain or nervous system conditions?** ☐ Yes ☐ No
For example: stroke/transient ischemic attack (TIA), epilepsy, migraines or repeated headaches, multiple sclerosis, meningitis, shingles, nerve pain.

b) **Cancer, tumours or growths?** ☐ Yes ☐ No
For example: polyps, benign growths or cysts, lymphomas, any cancers or pre-cancerous conditions.

c) **Heart or circulatory conditions?** ☐ Yes ☐ No
For example: high blood pressure, angina/chest pains, heart attacks or failure, abnormal heartbeat, varicose veins, raised cholesterol, stroke, deep vein thrombosis.

d) **Psychiatric or psychological conditions, drug & alcohol issues or sleep disorders?** ☐ Yes ☐ No
For example: depression, anxiety, stress, anorexia nervosa, autism, bipolar disorder, insomnia, narcolepsy, sleep apnoea, alcohol or drug dependency.

2 In the last five years, has any person named on this form seen a physician, or experienced any symptoms, or been admitted to a hospital or medical facility for an operation or procedure, or undergone any tests or investigations, for any of the following conditions:

a) **Auto-immune disorders?** ☐ Yes ☐ No
For example: HIV/AIDS, rheumatoid arthritis, systemic lupus erythematosus, scleroderma.

b) **Back, joint, muscular or skeletal problems?** ☐ Yes ☐ No
For example: back or joint pain, whiplash, sciatica, degenerative changes, osteoarthritis, osteoporosis, gout, bunions, joint replacements, fractures, cartilage or ligament problems.

c) **Breathing or respiratory conditions (including allergies)?** ☐ Yes ☐ No
For example: asthma, chronic obstructive pulmonary disease (COPD), shortness of breath, chest infections, pneumonia, bronchitis, tuberculosis (TB), hay fever, allergies to food substances and animals.

d) **Diabetes, thyroid or any other endocrine disorder?** ☐ Yes ☐ No
For example: diabetes type 1 or 2, overactive or underactive thyroid, pituitary or adrenal problems, obesity.

e) **Eyes, ear, nose and throat or oral/dental conditions?** ☐ Yes ☐ No
For example: glaucoma, cataracts, retinal detachment, macular degeneration, hearing difficulties, repeated ear infections, tonsillitis, sinusitis, dental problems, wisdom teeth problems, gingivitis.

f) **Gynaecological or breast conditions?** ☐ Yes ☐ No
For example: complications of pregnancy, heavy or irregular periods, fibroids, endometriosis, ovarian cysts, abnormal smear tests, miscarriage, pre- and post-natal complications, breast lumps/cysts.

g) **Skin conditions (including allergies)?** ☐ Yes ☐ No
For example: eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed or allergic reactions.

h) **Stomach, liver/gall bladder, or digestive system conditions?** ☐ Yes ☐ No
For example: ulcers, irritable bowels, Crohn's disease, colitis, reflux/heartburn abdominal pain, anaemia, hepatitis, cirrhosis, gallstones, hernias, haemorrhoids/piles.

i) **Urinary, kidney or prostate conditions?** ☐ Yes ☐ No
For example: kidney infections, kidney stones, incontinence, prolapse, prostate problems, recurrent bladder or urine infections.

j) **Any alcohol and/or drug dependency problems?** ☐ Yes ☐ No

k) **Any physical defect, infirmity or congenital condition?** ☐ Yes ☐ No

l) **Any other medical condition not mentioned above?** ☐ Yes ☐ No

③ **Is any person named on this form currently taking any medication, prescribed or otherwise?** ☐ Yes ☐ No

④ **Has any person named on this form experienced any signs or symptoms of any medical condition in the last six months, whether or not a physician has been consulted?** ☐ Yes ☐ No

⑤ **Is any person named on this form currently undergoing any treatment or periodic reviews for a medical condition, physical impairment, disability or recurrent illness not already mentioned?** ☐ Yes ☐ No

⑥ **Is anyone named on this form currently pregnant?** ☐ Yes ☐ No

If you have answered YES to any of the above questions, please give full details

Question #: ..... Name of person affected by the illness/injury/condition: .....

Date(s) on which the illness/injury/condition occurred: ..... Date symptoms were last suffered: .....

What diagnosis was made and what treatment was received: .....

.....

.....

Is any future treatment required, including consultations with a physician and/or periodic tests or reviews? ☐ Yes ☐ No

If YES, please give details: .....

Please provide the name and address of the treating physician: .....

Question #: ..... Name of person affected by the illness/injury/condition: .....

Date(s) on which the illness/injury/condition occurred: ..... Date symptoms were last suffered: .....

What diagnosis was made and what treatment was received: .....

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If you require more space, please continue on a separate sheet of paper. If you are attaching any supporting medical documents, please note that we can only accept them in English.

William Russell
A greater degree of expat protection

Health declaration

Your Global Health plan will be underwritten on a full medical underwriting basis. Please complete the following health declaration and provide us with full details of any medical conditions existing before the start date of your plan. **Pre-existing conditions and related conditions will not be covered**, unless you have told us about them and we have agreed to cover them. This includes conditions arising between the time you submit this application and the start date of your plan, so please contact us immediately if the information provided changes.

Please answer the following questions for each person named on this form fully, accurately, and to the best of your knowledge and belief. If you answer YES to any question, please supply full details in the spaces provided. If you do not answer the questions fully and accurately, your plan may be cancelled, claims may be rejected, or special terms may be applied retroactively. If you are in any doubt as to whether you should tell us anything, please tell us anyway.

Please complete the following table for yourself, your spouse/partner, and any dependants over age 18 only:

	You	Spouse/partner	Dependants over age 18
Height (cm)			
Weight (kg)			
If you smoke, how many cigarettes/cigars do you smoke daily?			
If you consume alcohol, how many of the following do you consume each week? • *Pints of regular-strength beer or cider* • *Pints of strong beer or cider* • *175ml glasses of wine* • *250ml glasses of wine* • *35ml measures of spirits*			

Medical questions for EACH person to be insured

1 Has any person named on this form ever suffered from any of the following conditions?

a) **Brain or nervous system conditions?** ☐ Yes ☐ No
For example: stroke/transient ischemic attack (TIA), epilepsy, migraines or repeated headaches, multiple sclerosis, meningitis, shingles, nerve pain.

b) **Cancer, tumours or growths?** ☐ Yes ☐ No
For example: polyps, benign growths or cysts, lymphomas, any cancers or pre-cancerous conditions.

c) **Heart or circulatory conditions?** ☐ Yes ☐ No
For example: high blood pressure, angina/chest pains, heart attacks or failure, abnormal heartbeat, varicose veins, raised cholesterol, stroke, deep vein thrombosis.

d) **Psychiatric or psychological conditions, drug & alcohol issues or sleep disorders?** ☐ Yes ☐ No
For example: depression, anxiety, stress, anorexia nervosa, autism, bipolar disorder, insomnia, narcolepsy, sleep apnoea, alcohol or drug dependency.

2 In the last five years, has any person named on this form seen a physician, or experienced any symptoms, or been admitted to a hospital or medical facility for an operation or procedure, or undergone any tests or investigations, for any of the following conditions:

a) **Auto-immune disorders?** ☐ Yes ☐ No
For example: HIV/AIDS, rheumatoid arthritis, systemic lupus erythematosus, scleroderma.

b) **Back, joint, muscular or skeletal problems?** ☐ Yes ☐ No
For example: back or joint pain, whiplash, sciatica, degenerative changes, osteoarthritis, osteoporosis, gout, bunions, joint replacements, fractures, cartilage or ligament problems.

c) **Breathing or respiratory conditions (including allergies)?** ☐ Yes ☐ No
For example: asthma, chronic obstructive pulmonary disease (COPD), shortness of breath, chest infections, pneumonia, bronchitis, tuberculosis (TB), hay fever, allergies to food substances and animals.

d) **Diabetes, thyroid or any other endocrine disorder?** ☐ Yes ☐ No
For example: diabetes type 1 or 2, overactive or underactive thyroid, pituitary or adrenal problems, obesity.

e) **Eyes, ear, nose and throat or oral/dental conditions?** ☐ Yes ☐ No
For example: glaucoma, cataracts, retinal detachment, macular degeneration, hearing difficulties, repeated ear infections, tonsillitis, sinusitis, dental problems, wisdom teeth problems, gingivitis.

f) **Gynaecological or breast conditions?** ☐ Yes ☐ No
For example: complications of pregnancy, heavy or irregular periods, fibroids, endometriosis, ovarian cysts, abnormal smear tests, miscarriage, pre- and post-natal complications, breast lumps/cysts.

g) **Skin conditions (including allergies)?** ☐ Yes ☐ No
For example: eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed or allergic reactions.

h) **Stomach, liver/gall bladder, or digestive system conditions?** ☐ Yes ☐ No
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i) **Urinary, kidney or prostate conditions?** ☐ Yes ☐ No
For example: kidney infections, kidney stones, incontinence, prolapse, prostate problems, recurrent bladder or urine infections.

j) **Any alcohol and/or drug dependency problems?** ☐ Yes ☐ No

k) **Any physical defect, infirmity or congenital condition?** ☐ Yes ☐ No

l) **Any other medical condition not mentioned above?** ☐ Yes ☐ No

③ **Is any person named on this form currently taking any medication, prescribed or otherwise?** ☐ Yes ☐ No

④ **Has any person named on this form experienced any signs or symptoms of any medical condition in the last six months, whether or not a physician has been consulted?** ☐ Yes ☐ No

⑤ **Is any person named on this form currently undergoing any treatment or periodic reviews for a medical condition, physical impairment, disability or recurrent illness not already mentioned?** ☐ Yes ☐ No

⑥ **Is anyone named on this form currently pregnant?** ☐ Yes ☐ No

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Supplementary information :