Evolution Health Plan (Asia Pacific)

FMU

morganprice international

Application form

Please complete this form and return it to your agent/insurance broker. It is important that you complete this form fully. Failure to do so may result in the form being returned to you for completion. All proposals are reviewed prior to acceptance and therefore no cover shall be granted until confirmation is provided.

1 Your personal details

Title | Forename(s) | Surname

Date of birth | Height | Weight

Overseas address | Post/Zip code

Phone | Mob | Fax | Email

Home address | Post/Zip code

Occupation | Occupation of spouse

Nationality | Country of residence | Home country *(for which you have a passport)*

How long have you been resident in your country of residence *(years/months)*?

Have you or any of the people to be included in the proposal, ever been refused cover by an insurance company or been accepted on special terms? *(If yes provide details on a separate sheet)* Yes ◯ No ◯

2 Cover required

Date upon which annual cover to commence, or the date on which your proposal is accepted by insurers, whichever is the later

Choose your area of cover

Worldwide excluding USA, Hong Kong, Singapore and China ◯ Worldwide excluding USA ◯ Worldwide ◯

If you want to be able to have treatment in Hong Kong, Singapore or China you must select Worldwide excluding USA.

Choose your level of cover

Standard ◯ Standard Plus ◯ Comprehensive ◯

Premium ◯ Elite ◯ Home country evacuation module (120 adult/75 child) ◯

Please select the annual excess you wish to apply to your policy

Nil ◯ 100 ◯ 250 ◯ 500 ◯ 1000 ◯

2500 ◯ 5000 ◯

2 Cover required — continued

Do you or any of the persons to be included in this proposal, have existing health insurance? Yes ◯ No ◯

If yes, which provider?

3 Dependants to be included

Full name of dependants	Relationship to proposer	D.O.B	Sex	Nationality	Height	Weight	Occupation

Do you or anyone included in this proposal, participate in any occupation, sport, pastime or activity which is likely to involve extra risk in connection with this plan? *(eg, Mountaineering, Hang Gliding or other sports)* Yes ◯ No ◯

If yes, please give details:

4 Confidential medical declaration

Important: You and the persons applying for cover under this policy must declare to us any and all known pre-existing medical conditions. If you do not tell us, your policy may be cancelled and any claim you make may not be paid.

4 Confidential medical declaration — continued

1.	Are any medical/surgical/dental consultations and/or procedures (including x-ray lab or other testing) recommended, scheduled or contemplated for any applicant?	Yes ◯	No ◯
2.	Has any applicant ever been refused medical or dental insurance, or ever had a policy postponed, rated or accepted on special terms?	Yes ◯	No ◯
3.	Has any applicant been examined by, consulted with, or received medical treatment from a physician in the last 12 months?	Yes ◯	No ◯
4.	Has any applicant been examined by, consulted with, or received medical treatment from a medical specialist or consultant in the last 4 years?	Yes ◯	No ◯
5.	Has any applicant been confined (stayed overnight) in a hospital, clinic, sanatorium, or other treatment facility in the last 4 years?	Yes ◯	No ◯

Has any applicant listed had any disease or impairment of or suffered any symptoms or required any medication, treatment or hospital consultation(s) for the following? - *Please answer all questions.*

1.	AIDS/ARC/HIV	Yes ◯	No ◯
2.	Alcohol dependency or drug/substance abuse	Yes ◯	No ◯
3.	Anaemia or any blood disorder	Yes ◯	No ◯
4.	Arthritis, or any disorder of any muscles or joints	Yes ◯	No ◯
5.	Asthma, bronchitis or any other respiratory disorder	Yes ◯	No ◯
6.	Back/spine/neck	Yes ◯	No ◯
7.	Blood pressure/hypertension	Yes ◯	No ◯
8.	Blood vessels/clots/circulatory system	Yes ◯	No ◯
9.	Bones (including fractures)	Yes ◯	No ◯
10.	Brain/head	Yes ◯	No ◯
11.	Cancer, tumour, growth or cyst	Yes ◯	No ◯
12.	Carpal tunnel syndrome	Yes ◯	No ◯
13.	Cerebrovascular disease/disorder or stroke	Yes ◯	No ◯
14.	Chest pains, palpitations, heart murmur, angina, heart attack or any other heart disorder	Yes ◯	No ◯
15.	Cystic fibrosis	Yes ◯	No ◯
16.	Dental/gum disease	Yes ◯	No ◯
17.	Diabetes	Yes ◯	No ◯

4 Confidential medical declaration — continued

18. Ears, eyes, nose or throat	Yes ◯	No ◯
19. Epilepsy, convulsions, seizures, fits	Yes ◯	No ◯
20. Gastrointestinal disorder (stomach/intestines)	Yes ◯	No ◯
21. Gout	Yes ◯	No ◯
22. Hernia	Yes ◯	No ◯
23. Immune system disorder	Yes ◯	No ◯
24. Injury, operation, physical defect or deformity	Yes ◯	No ◯
25. Kidney/bladder/urinary tract	Yes ◯	No ◯
26. Liver, gall-bladder, pancreas or spleen	Yes ◯	No ◯
27. Lungs/breathing	Yes ◯	No ◯
28. Mental/nervous disorder	Yes ◯	No ◯
29. Neurological/nervous system	Yes ◯	No ◯
30. Paralysis	Yes ◯	No ◯
31. Prostate	Yes ◯	No ◯
32. Rheumatic fever	Yes ◯	No ◯
33. Reproductive disorder or infertility	Yes ◯	No ◯
34. Skin	Yes ◯	No ◯
35. Sleep disorder	Yes ◯	No ◯
36. Stroke	Yes ◯	No ◯
37. Surgical operation	Yes ◯	No ◯
38. Ulcer	Yes ◯	No ◯
39. Urinary abnormality	Yes ◯	No ◯
40. Other medical condition not listed	Yes ◯	No ◯

Please give the name and address of your personal/family physician(s) including zip/postcode. - *If there is a different family physician for each applicant, please provide all details and indicate which physician applies to each applicant)*

4 Confidential medical declaration — continued

Additional information

Please use this space to provide details if you answered "Yes" to any of the questions in the rest of Section 4. If you require additional space, please continue on a separate sheet.

Question no.	Applicant name	Details	Dates	Diagnosis	Treatment/current status

Consent authorisation

To all physicians and medical practitioners, hospitals and other medical facility: my signature below provides my authorisation for you to provide Morgan Price International Healthcare Limited and their Insurers with any information requested in connection with my application for me or any of the family members named on this application.

Signature of primary applicant _____ Date _____

5 Data Protection Act 1998

Morgan Price International Healthcare Ltd is registered under the data protection act 1998. We will collect information in the course of your dealings with us regarding your personal details (including but not limited to your sex, age, ethnic origin and state of health). Any information we do collect will only be used for the purpose of conducting our relationship with you and will be used for the purposes of underwriting your insurance cover, managing the policy we issue for you, and administering any claims you may make. We may need to transfer some or all of this information to our insurance underwriters, their claims handlers, medical assistance companies or other medical practitioners. You have the right to access any details that we hold about you and to amend or delete anything that you may believe is inaccurate or out of date. By signing this declaration you are consenting to us using the information we hold about you in the ways described above. Without this consent we are unable to offer you any insurance cover.

Declaration

a. I/We have read the policy wording and I/we understand it to be part of the contract of insurance. In particular I/We have read, understand, and accept the definitions, benefits and exclusions of the policy.

b. I/We have read, understand and accept section 5 of this proposal.

c. To the best of my/our knowledge and belief the information given in connection with this proposal, whether in my hand or not, is true and I/we have answered all questions about this policy honestly and fully. I/We also understand that I/we must tell the insurer straight away if anything that I/we have already told the insurer changes. I/we understand that nondisclosure or misrepresentation of any facts may entitle the insurer to void the insurance. This proposal and the information provided in connection therewith contains statements upon which the insurers will rely in deciding whether to accept this insurance and in determining the terms and conditions of such acceptance.

d. I/We understand that the signing of this proposal does not bind me/us to complete, or insurers to accept this insurance.

e. If I/we have elected to pay our premium by instalments using credit or debit cards and Morgan Price have agreed to this, I/we authorise Morgan Price to continue to deduct such instalments as and when they become due unless I/we cancel this credit card authorisation by giving at least 14 days notice in writing. I/we understand that if I/we have made a claim, no refund will be due and I/we will have to pay any outstanding instalments due in the current period of cover.

Signature of primary applicant _____ Date _____