GlobalFusion℠

INTERNATIONAL PRIVATE MEDICAL INSURANCE

APPLICATION

Application Form

Please complete this form in block capitals using black ink. For all sections please ensure you give an answer to every question.
An incomplete form will delay the processing of your application.

Note: *When sending payment information, health information and other documents, and data regarding your confidential personal information, please send by fax or secure email.*

1. Your Personal Details *Please complete for all family members applying for cover.*

A. Applicant

1.1 Details About You

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr First Name(s):		Surname *(Family Name)*:	
Date of Birth: ___/___/____ *dd/mm/yyyy*	☐ Male ☐ Female	Height: ☐ cm ☐ in	Weight: ☐ kg ☐ lb
Occupation:		Social Security Number/ *Fiscal Code:	
Nationality on Passport:		Passport Number:	

B. Spouse

1.2 Details About Members of Your Family Applying for Cover (☐ *Tick if you have further dependents and provide details on separate sheet)*

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr First Name(s):		Surname *(Family Name)*:	
Date of Birth: ___/___/____ *dd/mm/yyyy*	☐ Male ☐ Female	Height: ☐ cm ☐ in	Weight: ☐ kg ☐ lb
Occupation:		Social Security Number/ *Fiscal Code:	
Nationality on Passport:		Passport Number:	

C. First Child *(Below Age 19)*

First Name(s):		Surname *(Family Name)*:	
Date of Birth: ___/___/____ *dd/mm/yyyy*	☐ Male ☐ Female	Height: ☐ cm ☐ in	Weight: ☐ kg ☐ lb
Nationality on Passport:	Passport Number:	Social Security Number/*Fiscal Code:	

D. Second Child *(Below Age 19)*

First Name(s):		Surname *(Family Name)*:	
Date of Birth: ___/___/____ *dd/mm/yyyy*	☐ Male ☐ Female	Height: ☐ cm ☐ in	Weight: ☐ kg ☐ lb
Nationality on Passport:	Passport Number:	Social Security Number/*Fiscal Code:	

E. Third Child *(Below Age 19)*

First Name(s):		Surname *(Family Name)*:	
Date of Birth: ___/___/____ *dd/mm/yyyy*	☐ Male ☐ Female	Height: ☐ cm ☐ in	Weight: ☐ kg ☐ lb
Nationality on Passport:	Passport Number:	Social Security Number/*Fiscal Code:	

☐ **I AGREE TO THE PROCESSING OF MY PERSONAL INFORMATION TO PROVIDE THE SERVICES I HAVE PURCHASED, INCLUDING TO ADMINISTER CLAIMS, AND TO RECEIVE MEMBER COMMUNICATIONS, IN ACCORDANCE WITH IMG'S PRIVACY POLICY.**

☐ **I AGREE TO RECEIVE RELEVANT INFORMATION AND OTHER COMMUNICATIONS FROM IMG ABOUT INSURANCE COVERAGES AND SERVICE OPTIONS. I UNDERSTAND THAT I CAN WITHDRAW MY CONSENT AT ANY TIME.**

**For the country in which you are resident as declared in Section 1.3 below.*

1.3 Residential Address

Street Address:			
Town/City:	State/County:	Postal Code:	Country:

1.4 Mail Forwarding Address - If different from address in section 1.3

Street Address:			
Town/City:	State/County:	Postal Code:	Country:

1.5 Contact Details

Primary Telephone: + Country (Area) Number	Mobile Telephone: + Country (Area) Number
Fax: + Country (Area) Number	E-mail:

2. Your Cover Details *Please complete for all family members applying for cover.*

2.1 Requested Effective Date

Date on which you wish your GlobalFusion International Private Medical Insurance to commence:	☐ On Acceptance	☐ Other: ___/___/___ *dd/mm/yyyy*	*(Must be within 30 days after signature. Cover will in no event be effective until approved.) Please note we cannot commence your plan until we have accepted your Application and received your first or annual premium payment.*

2.2 Select the Geographic Area of Cover You Would Like *(Tick One)*

☐ **Area 1** - Europe only	☐ **Area 2** - Worldwide excluding the USA, Canada, China, Hong Kong, Macau, Japan, Singapore and Taiwan	☐ **Area 3** - Worldwide*

***Important Note: USA Citizens & Persons Applying for Cover in the USA**

Effective Dates:

USA Citizens -
If you or any family member applying for cover are located in the USA on the date of this Application, the Effective Date of this insurance, if issued, will be the later of: **a)** The Effective Date requested on the Application; or **b)** The date the insured person departs the USA; or **c)** The date the Application is accepted and required payment is received and the GlobalFusion International Private Medical Insurance, including a Certificate of Insurance, is issued.

Special Eligibility:

USA Citizens -
Is your expected length of stay outside the USA at least 6 of the next 12 months? ◯ Yes ◯ No *(If your answer is NO, you are ineligible for this product.)*
Date you did (or will) Depart from the USA: ___/___/____ *dd/mm/yyyy*

Non USA Citizens applying for cover in the USA or located in the USA at time of application -
i) Are you or any family member present in the USA on the Effective Date of the Policy? ◯ Yes ◯ No
- If No, then no Affidavit of Eligibility is required, please proceed to Section 2.3
- If Yes, please answer question **ii** below

ii) Do you plan to be in the USA more than 6 of the next 12 months? ◯ Yes ◯ No
- If No, then no Affidavit of Eligibility is required, please proceed to Section 2.3

If You have answered Yes to the above two questions, an Affidavit of Eligibility (available from Us or Your Broker upon request) must be completed and submitted with Your Application. ***Note:*** *If You are still located in the USA at Your Renewal Date and Your expected stay thereafter in the USA will be at least 6 of the following 12 months, You will need to complete an Affidavit of Eligibility at Your Renewal Date.*

2.3 Select the Currency You Would Like *(Tick One)*
The plan currency also decides your premium currency

☐ GB Pounds (£)	☐ US Dollars ($)	☐ EU Euros (€)

2.4 Select Which Sub-Plan You Would Like *(Tick One)*

☐ Bronze	☐ Silver	☐ Gold Plus

2.5 Select Which Annual Excess You Would Like *(Tick One)*
Choose carefully as you cannot select a lower Annual Excess at Renewal. Currency applicable per 2.3 above.

☐ Nil Excess	☐ £138 $250 €168	☐ £275 $500 €335	☐ £550 $1,000 €670	☐ £1,375 $2,500 €1,675	☐ £2,750 $5,000 €3,350	☐ £5,500 $10,000 €6,700

2.6 Select Which Optional Add-on Covers You Would Like *(Tick All That Apply)*
If you do not want these optional covers, please proceed to Section 3.

☐ Optional Dental & Vision Cover	☐ Optional Maternity Cover	☐ Optional Sports Cover (Applies only to the Gold Plus Plan)

3. Underwriting Options

Choice of Medical Underwriting - Your application allows you a choice of either a Moratorium Underwriting Policy or a Full Medical Underwriting Policy as explained below. Please tick one only.

Note:

1. That for Bronze Sub-Plans there is no cover for Pre-Existing Conditions irrespective of your choice of Medical Underwriting below or whether the Pre-Existing Conditions are disclosed.
2. Under the terms and conditions of the Plan, if you do not provide the medical practitioner's details as requested under this Application, any claim under the Plan for a Pre-Existing Condition will be rejected.

○ **Option 1. Moratorium Underwriting Policy** ***(Only available to Applicants aged under 65 years at Original Effective Date)*:**
Enables you to apply for your Plan without completing a full health questionnaire. Instead, we apply blanket exclusions for any Pre-Existing Condition, as defined by the plan, you have. The 'moratorium' refers to the fact that if, after 24 months of continuous cover under your Plan, you demonstrate two consecutive years without symptoms or treatment, consultation, advice (excluding routine check-ups), medication (including prescription drugs, special diets or injections), for a Pre-Existing Condition (or any related conditions), then should you need subsequent treatment for that condition, you will have cover for it subject to the Plan's terms and conditions. Under the Moratorium Underwriting option, many Pre-Existing Conditions, where you need regular or periodic treatment, medication, or checkups, which existed prior to your purchase of your Plan, may never be covered. This is because each symptom or treatment, consultation, advice (excluding routine check-ups), medication (including prescription drugs, special diets or injections), for a Pre-Existing Condition (or any related conditions) starts the moratorium again.

○ **Option 2. Full Medical Underwriting Policy:** You must complete a full medical questionnaire. Upon review of your responses and any additional information we require from you or your physician, we decide whether we can accept you for cover and any limitations on your cover. We then confirm any medical conditions that are excluded. Where cover is in effect for 24 continuous months under the Plan, you are provided with Pre-Existing Condition cover for eligible fully disclosed and accepted Pre-Existing Conditions as defined by the Plan and subject to the terms and conditions of the Policy Wording. This benefit is payable even if you have received consultation or treatment for the condition(s) during the 24 month period. Where we specifically have excluded cover for a disclosed Pre-Existing Condition and after 24 months of cover your condition has improved, you may request review of that exclusion. Pre-Existing Conditions which have not been disclosed will never be covered. ***If you elect this option, Questions 1-30 of Section 4 below must be answered for the applicant and every other member of your family applying for cover. For any question answered "YES," please identify the family member to whom the answer applies (use the letter that corresponds to the family member from Section 1), and provide complete details of the medical condition at issue in the space provided in Section 5 of this application, including the name, address and telephone number of all attending physician(s), diagnoses, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. IMG reserves the right to request additional medical information.***

4. Health Declaration *Questions 1-9 to be completed by all applicants*

Please answer all questions for each applicant applying for cover.		If yes, show family member using letters from Section 1.
1. Are you or any other applicant currently disabled or unable to perform normal activities?	☐ Yes ☐ No	
2. Are you or any other applicant presently hospitalised, or scheduled for or in need of hospitalisation or surgery?	☐ Yes ☐ No	
3. Have you or any other applicant at any time ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder?	☐ Yes ☐ No	
4. Have you or any other applicant at any time ever had, been recommended to have, or are you currently on a waiting list for any organ transplant (other than corneal)?	☐ Yes ☐ No	
5. Do you or any other applicant participate in professional sports or are you a professional pilot?	☐ Yes ☐ No	
If any applicant answered YES to any of the above five questions, he or she does not qualify for this insurance. Thank you for your interest.		
6. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past 5 years? If yes, please complete Section 5.2.	☐ Yes ☐ No	
7. Are you or any other applicant currently pregnant? If yes, please provide due date: _____ *(dd/mm/yyyy)*	☐ Yes ☐ No	
8. Have you or any other applicant at any time ever applied for or purchased insurance through IMG? If yes, please provide certificate number and details. Certificate Number: _____	☐ Yes ☐ No	
9. Have you or any other applicant at any time ever had an application for health, life or disability insurance or reinstatement voided, rejected, cancelled, rated, declined or modified? If yes, please explain in Section 5.3.	☐ Yes ☐ No	
10. Have you or any other applicant been diagnosed with or been treated for COVID-19? If yes, please answer the following: **a)** Date diagnosed: ___/___/____ *dd/mm/yyyy* **b)** Date of last treatment: ___/___/____ *dd/mm/yyyy* **c)** Were you hospitalized? Yes ☐ No ☐ **d)** Were you in intensive care? Yes ☐ No ☐ **e)** Physician/hospital/clinic/health care/provider name(s), address & telephone _____ **f)** Condition(s)/diagnosis/prognosis/past and present course of treatment(s) _____	☐ ☐ ☐ Yes ☐ No ☐ ☐	
Applicants selecting either the Option 1 Moratorium Underwriting under Section 3 or the Bronze Sub-Plan in Section 2.4, please proceed to Section 5. All other applicants, please complete questions 11-31 below.		
11. Have you or any other applicant ever at any time made a claim under health, life or disability insurance cover? If yes, please explain in Section 5.3. Please also confirm whether the claim was paid or not paid; and, if the claim was not paid, the reason for this.	☐ Yes ☐ No	
12. Are you applying for 'takeover terms' to transfer from your existing medical insurance policy to a GlobalFusion plan? If yes, you need to complete and submit a GlobalFusion 'Takeover Application Form' with this Application Form.	☐ Yes ☐ No	
13. During the last 12 months, have you or any other applicant experienced manifestation or symptoms of, suffered from, sought or received any consultation, examination, testing or been treated for, or received treatment (including medications) for, or been diagnosed with any medical, health, mental, physical or nervous condition of whatsoever nature? If yes, please complete Section 5.2.	☐ Yes ☐ No	

4. Health Declaration *(Continued)*

If yes, show family member using letters from Section 1

Have you or any other applicant at any time ever experienced manifestation or symptoms of, suffered from, sought or received any consultation, examination, testing or been treated for or received treatment for, or been diagnosed with, any disease, condition, illness, injury, medical problem, disorder, sickness or other problem directly or indirectly arising from, involving, or relating to any of the following:

14. Heart, cardiac, cardiovascular and/or circulatory, including, but not limited to: congestive heart failure, heart attack, angina, chest pain, arteriosclerosis, atherosclerosis, elevated blood pressure, hypertension, swelling of feet/ankles, thrombosis, phlebitis, rheumatic fever, or heart murmur? If yes, in addition to Section 5.2, please complete the following: **a)** Last 3 blood pressure readings with dates: _____ *(dd/mm/yyyy)* **b)** Result and Date Diagnosed: _____ *(dd/mm/yyyy)* **c)** How often advised to follow up with physician: _____ **d)** Medications taken (Types & Dosage): _____	☐ Yes ☐ No	
15. Blood, blood vessels, spleen, arteries, veins or disorders of the blood, including, but not limited to: anaemia, haemophilia, leukemia, hepatitis, lymph glands, or high cholesterol? If yes for Cholesterol answer the following: **a)** Date Diagnosed: ___/___/____ *dd/mm/yyyy* **b)** Date of last testing and results: ___/___/____ *dd/mm/yyyy* Total cholesterol: _____ LDL: _____ HDL: _____ Triglycerides: _____ **c)** How often advised to follow up with physician? _____ **d)** Treatment including medication name and dosage: _____	☐ Yes ☐ No	
16. Diabetes, hyperglycemia or hypoglycemia? If yes to diabetes, in addition to Section 5.2, please complete the following: **a)** Diabetic Type: I ◯ or II ◯ **b)** Date diagnosed: ___/___/____ *dd/mm/yyyy* **c)** Controlled by diet only? Yes☐ No☐ **d)** Medications (Types and Dosage): _____ **e)** Date of most recent HbA1c Test? ___/___/____ *dd/mm/yyyy* **f)** Results of HbA1c Test (1 - 10): _____	☐ Yes ☐ No	
17. Asthma or allergies? If yes, in addition to Section 5.2, please specify which one and complete the following: **a)** Date diagnosed: ___/___/____ *dd/mm/yyyy* **b)** Has hospitalisation or emergency room treatment been required? If yes, describe and list date(s): ___/___/____ *dd/mm/yyyy* **c)** Please list known triggers: _____ **d)** Medications (Types and Dosage): _____ **e)** Frequency of attacks: _____	☐ Yes ☐ No	
18. Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump, calcification or growth of any kind?	☐ Yes ☐ No	
19. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid or metabolic disorders, or obesity?	☐ Yes ☐ No	
20. Kidney, urinary tract functions, kidney or bladder stones or infections?	☐ Yes ☐ No	
21. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy or pneumonia?	☐ Yes ☐ No	
22. Mental and nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, chemical or drug abuse or dependency, alcoholism, psychiatric counseling and/or support groups, depression, anxiety, chronic fatigue, or eating or sleeping disorders?	☐ Yes ☐ No	
23. Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebral ischemic attacks?	☐ Yes ☐ No	
24. Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease or disorder, vertebrae degeneration or any other back or neck condition, rheumatism, arthritis, gout, tendonitis, osteoporosis or inflammation?	☐ Yes ☐ No	
25. For female applicants, miscarriage, complicated pregnancy or delivery, infertility consultation, advice, diagnosis or treatment, vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus?	☐ Yes ☐ No	
26. For male applicants, reproductive systems including but not limited to prostate or elevated PSA or infertility consultation, advice, diagnosis, or treatment?	☐ Yes ☐ No	
27. Congenital, genetic or hereditary or other birth condition or defect including, but not limited to: mental retardation, Down Syndrome, or other chromosome disorder, physical disorder, deformity or defect?	☐ Yes ☐ No	
28. Digestive system, stomach, or intestines, including, but not limited to: esophageal regurgitation, gastritis, ulcers, colon, or rectum disorders?	☐ Yes ☐ No	
29. Eyes, ears, nose, mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation, chronic sinusitis, or temporomandibular joint?	☐ Yes ☐ No	
30. Any other disease, condition, illness, injury, medical problem, disorder, sickness or other problem of any kind not listed?	☐ Yes ☐ No	
31. Do you or any other applicant currently use or during the past 5 years have you or any other applicant used tobacco in any form?	☐ Yes ☐ No	

5. Confidential Medical Information

5.1 Medical Practitioner's Details - The name and address of my usual family doctor is as follows:

Indicate family member(s) this applies to using letters from Section 1:

Doctor's Name:	Telephone: + Country (Area) Number
Address:	E-mail Address:
Country:	Postal/Zip Code:
Date Last Seen: *dd/mm/yyyy*	Reason:

☐ If the above details are different for any other applicant, please give details on additional pages and indicate that you have done so by ticking this box.

5.2 Further Medical Information

For any question answered "yes" in Section 4, please identify each applicant for whom the answer applies (using the corresponding letter(s) from Section 1), and provide complete details of the medical condition at issue, including the name, address and telephone number of the attending physician(s), hospital(s), clinic(s) and all other health care providers involved, diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. When completing this section, please ensure you provide specific details of any current medications you are taking, and any past surgeries. **Please attach additional pages as necessary.**

Question Number From Section 4	Family Member (use letters from Section 1)	Condition(s)/Diagnosis, Prognosis, Past and Present Course of Treatment(s), Medications and Surgeries	Physician/Hospital/Clinic/Health Care Provider Name(s), Address & Telephone	Date of Onset *(dd/mm/yyyy)*	Date of Last Symptoms *(dd/mm/yyyy)*	Date of Last Treatment *(dd/mm/yyyy)*	Current Status *(Ongoing/ Resolved)*

☐ *Tick if you have attached additional pages.*

5.3 Prior Insurance

If any applicant applying for cover has at any time ever had an application for health, life, or disability insurance or reinstatement voided, rejected, cancelled, rated, declined or modified (see Section 4, Question 9), please explain below.

If any applicant applying for cover has at any time ever made a claim under a health, life or disability insurance (see Section 4, Question 10), please explain below and please also confirm whether the claim was paid, or not paid; and if the claim was not paid, the reason for this.

☐ *Tick if you have attached additional pages.*

Optional Additional Covers Application Form

Global Personal Accident Plan / Global Daily Indemnity[SM] - Hospital Income Plan

Global Personal Accident Plan and Global Daily Indemnity are only available at the time of application for, and with the purchase of, GlobalFusion International Private Medical Insurance. To apply, simply complete Section 6 below.

6. Application For Global Personal Accident Plan and/or Global Daily Indemnity Insurance

Please indicate the name of each family member applying for Global Personal Accident Plan and/or Global Daily Indemnity

	Name	Personal Accident First Unit of Cover	Personal Accident Second Unit of Cover	Daily Indemnity First Unit of Cover	Daily Indemnity Second Unit of Cover
A. Applicant:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
B. Spouse:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
C. First Child		☐ Yes ☐ No	**NOT AVAILABLE**		
D. Second Child		☐ Yes ☐ No			
E. Third Child		☐ Yes ☐ No			

Applicant A

For each individual applying for Global Personal Accident Plan in respect of Accidental Death, please indicate:		% of Death Benefit
Primary Beneficiary Name Address of Beneficiary	Relationship Phone No. +	%
Contingent Beneficiary Name Address of Beneficiary	Relationship Phone No. +	%

Applicant B

Primary Beneficiary Name Address of Beneficiary	Relationship Phone No. +	%
Contingent Beneficiary Name Address of Beneficiary	Relationship Phone No. +	%

Applicant C

Primary Beneficiary Name Address of Beneficiary	Relationship Phone No. +	%
Contingent Beneficiary Name Address of Beneficiary	Relationship Phone No. +	%

Applicant D

Primary Beneficiary Name Address of Beneficiary	Relationship Phone No. +	%
Contingent Beneficiary Name Address of Beneficiary	Relationship Phone No. +	%

Applicant E

Primary Beneficiary Name Address of Beneficiary	Relationship Phone No. +	%
Contingent Beneficiary Name Address of Beneficiary	Relationship Phone No. +	%

Declaration for Global Personal Accident Plan and/or Global Daily Indemnity

If accepted for the GlobalFusion International Private Medical Insurance, I (we) understand that I (we) may qualify for Global Personal Accident Plan and/or Global Daily Indemnity underwritten by Insurer. I (we) hereby incorporate herein the certifications, representations, understandings, agreements, acknowledgements, authorisations, and warranties from the foregoing Application for the GlobalFusion International Private Medical Insurance and understand and agree that the terms, conditions, restrictions and penalties thereof shall likewise apply hereto. If a U.S. citizen, I (we) understand coverage for Global Personal Accident Plan will not be effective prior to the date of my (our) departure from the U.S. If I (we) have also applied for the optional Global Daily Indemnity plan, I (we) understand that only overnight hospital stays eligible under my (our) GlobalFusion International Private Medical Insurance, excluding pregnancies, are covered. I (we) also understand: (i) there is an additional premium for Global Daily Indemnity, (ii) that in the event this Application is not accepted, the premium will be returned to me (us) and neither party will have any obligation, right or liability under the plan, (iii) that the death benefit will be determined by my (our) age at the time of my (our) death, and (iv) that the Global Personal Accident Plan and Global Daily Indemnity are issued and governed in accordance with the policy wording.

Signature of Applicant or Guardian:
(Must be signed and dated)

X _____ Date: *(dd/mm/yyyy)*

Signature of Spouse
(Only required if applying for cover)

X _____ Date: *(dd/mm/yyyy)*

7. Method and Frequency of Payment: Please choose your method and frequency of payment. The currency you have selected for your plan will also be the currency in which your premium is to be paid.

☐ **A. Credit Card**

Frequency of Payment *(Tick One)*	☐ Annually	☐ Semi-Annually	☐ Quarterly	☐ Monthly

Note: *Choosing the semi-annual payment option results in total payments of 110% of the annual premium, choosing the quarterly payment option results in total payments of 112% of the annual premium, and choosing the monthly payment option results in total payments of 120% of the annual premium.*

Your Credit/Debit Card Details

Credit Card Type: ☐ Visa ☐ MasterCard ☐ American Express

Full Card Number:

Start Date: ___/___/____ *dd/mm/yyyy*	Expiry Date: ___/___ *mm/yyyy*	Issue No.: _____	Issue Date: ___/___/____ *dd/mm/yyyy* (if applicable)

Name as on card:

Address to which card is registered:
(if different from the mailing address given)

Daytime Telephone: + Country (Area) Number

If paying by credit card, I authorise IMG to debit my credit card for the total amount due. In the event that I have chosen to pay premiums semi-annually, quarterly, or monthly, **I hereby elect to pre-authorise future credit card payment installments for the balance of the policy period and for renewals, and hereby request and authorise IMG to charge my credit card periodically as payment installments become due for premiums and renewal premiums. This authorisation will remain in effect until revoked by me in writing, and until IMG actually receives the notice of revocation.** Coverage purchased by credit card is subject to validation and acceptance by the credit card company. I understand that I will be given advance notice of the renewal premiums and that they may vary each year.

If paying by bank transfer: To avoid delays, we recommend you check your premium calculation and any taxes (if applicable) with us or your agent.

☐ **B. Bank Transfer** (annual premium payments only)

Once your Application has been processed, the necessary bank transfer information will be forwarded to you and your payment is required within 10 days. [Please ensure that the name of the Applicant (as declared in Section 1 of this form), is clearly stated on any transfer.] Liability for any bank transfer which does not clearly identify the proposer will not be accepted by the Insurer, IMG or IMG Europe Limited.

Note: *When sending payment information, health information and other documents and data regarding your confidential personal information, please send securely by fax or email.*

Signature of Cardholder:

X _____

Date: *(dd/mm/yyyy)*

_____

8. Policy Fulfilment & Despatch Options: Please tick one of the following to indicate how you would like your Certificate of Insurance and Supporting Policy documentation sent to you.	
☐ E-mail: *(Preferred)*	Certificate of Insurance and supporting documentation sent direct to your e-mail address shown in Section 1.5 in electronic format and no documentation will be sent by post.
☐ Standard Mail:	Paper Certificate of Insurance and printed supporting documentation will be mailed to your Mail Forwarding Address shown in Section 1.4 by regular international air-mail.
☐ Express Mail:	Paper Certificate of Insurance and printed supporting documentation will be mailed to you by express international air-mail. Please note there will be an additional fee of £15/$25/€25 to be paid in addition to the premium to have your Certificate of Insurance express air-mailed to you after approval. (Confirm despatch address below.)
Express Mail Despatch Address Details: If you have selected Express Mail Despatch above, please select the address where you would like your Certificate of Insurance and supporting documentation mailed to (as indicated in Section 1) - Tick One Only:	
☐ Residence Address ☐ Mail Forwarding Address ☐ Other (No PO Boxes please) _____	

9. Insurance Advisor / Broker Use Only	
IMG Producer Number:	Phone: + Country (Area) Number
Company Name:	Fax: + Country (Area) Number
Contact Name or Stamp:	E-mail:
GA # (If Applicable):	Website:

Declaration for GlobalFusion International Private Medical Insurance:

AGREEMENT

I (we) understand and hereby agree that:

(i) I (we) apply for insurance under GlobalFusion International Private Medical Insurance.

(ii) Cover will be provided in accordance with the Policy Wording; and I (we) will read it upon receipt and be bound by it unless I (we) cancel the Plan within 30 days after receiving the Policy Wording.

(iii) This Application will form a part of any insurance issued.

(iv) I (we) have read all statements, questions and responses contained in this Application or they have been read to me (us) and I (we) understand them. Any insurance provided will be based on the information that I (we) have provided in this Application and the insurance is issued on the basis that all the answers given are complete and accurate. I (we) must take reasonable care to provide true, accurate, complete and correctly recorded answers to all the questions asked in this Application.

(v) My (our) responses to the statements and questions contained in this Application are true, accurate, complete and correctly recorded in all respects, and I (we) will supplement such responses prior to the requested Effective Date in the event of any change or addition thereto. In any event, if any information shown on this Application is not true, accurate, correct or complete, or if any of my (our) past medical history has been left out, I (we) must write to IMG Europe Ltd within 10 days.

(vi) If I (we) selected a Moratorium Underwriting Policy, that it excludes all Pre-Existing Conditions as defined in the Plan for a minimum of 24 months continuous cover without symptoms or treatment of such conditions, there may be cover for such Pre-Existing Conditions if they had been disclosed and accepted under the Plan. In any event, certain Pre-Existing Conditions which require regular treatment/medication/checkups will never be covered. I (we) also understand that Pre-Existing Conditions which have not been disclosed within Section 4, Questions 1-9 will never be covered.

(vii) If I (we) have selected a Bronze Sub-Plan then I (we) understand and agree the above statement (vi) does not apply and that there is no cover for Pre-Existing Conditions at all, irrespective of choice of Medical Underwriting.

(viii) The agent/broker assigned to or assisting with this Application is the representative/agent of me (us) and is not an agent/broker of the Insurer, IMG or IMG Europe Ltd.

(ix) No cover will be effective unless and until this Application has been duly accepted in writing by the Insurer, and there has been no change since the date of this Application Form in the insurability of all persons proposed for cover or in any responses to the statements and questions in this Application. The Insurer is entitled to refuse to accept an Application without giving any reason, or to apply additional terms and conditions to take into account any information provided by me (us) in my (our) Application.

(x) The subject matter, risks, and benefits of insurance being offered are not intended or considered by the applicant or Company to be resident, located, or performed in any particular country, jurisdiction, state, or political subdivision.

(xi) Premiums will be applied from the Effective Date forward and there will be no cover for any claim that begins prior to the Effective Date.

(xii) Any misrepresentation, misstatement or omission contained in this Application may allow the Insurer to declare the Plan void and to treat the Plan as though it never existed; or to cancel the Plan; or to refuse to pay a claim; or not to pay any claim in full; or to revise premium and/or charge additional excess; or to affect the extent of cover under the Plan. Further, any false or fraudulent or dishonest representation, statement, misrepresentation, misstatement, omission or concealment, or any fraud, whether or not innocently made, in this Application, shall render the Plan null and void from the Effective Date and all claims and benefits under the Plan shall be forfeited by me (us) and recoverable by the Insurer, and the Insurer shall have no liability for any benefits or claims under the Plan.

(xiii) The Insurer, IMG and IMG Europe Ltd., their employees, representatives, agents and any other persons or organisations performing services for them or on their behalf, may use, disclose or transfer to any organisation any information about me (us) obtained or collected in connection with this Application, (whether contained in this Application or otherwise) for the purpose of: (1) assessing this Application and providing on-going insurance and customer service; (2) processing and giving effect to credit/debit card payments; (3) providing marketing material in respect of insurance related services of IMG or its associated companies; (4) processing claims or analysing the insurance; (5) the identification and prevention of fraud and crime.

AUTHORISATION

For purposes of determining my (our) insurability, I (we) authorise any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, pharmacy, medical records service, prescription history clearinghouse, other insurer, government agency, employer, social worker or family member to provide information about me (us), including my (our) entire medical record, to SiriusPoint International Insurance Corporation (publ.), International Medical Group, Inc. and IMG Europe Ltd., their employees, representatives, agents and any other persons or organizations performing insurance services for them or on their behalf. By my (our) signature below, I (we) acknowledge that any prior agreement I (we) have made to restrict or limit the disclosure of information about my (our) health does not apply to this authorisation.

This authorisation is valid from the date of my (our) signature shown below. A copy, image or facsimile of this authorisation is as valid as the original.

If applying for coverage as a habitual resident outside of the EEA and UK or at any time move to a location outside the EEA or UK, Applicant(s) must acknowledge and agree to elect the Trust: the Applicant hereby applies and subscribes, for and on behalf of each individual enrolled, to the Conyers Trust Company (Bermuda) Limited, Richmond House, 12 Par-la-Ville Road Hamilton HM 08, Bermuda, or its successors, for the insurance coverage requested above and as underwritten and offered by SiriusPoint International Insurance Corporation (publ.) on the date of its receipt hereof, and as administered by the Company's authorized representative and Policy Manager, International Medical Group, Inc (IMG).

Signature of Applicant or Guardian:
(Must be signed and dated) Date: *(dd/mm/yyyy)*

X

Signature of Spouse
(Only required if applying for cover) Date: *(dd/mm/yyyy)*

X

Send by one of the following secure methods:

Secure Message Center: www.imglobal.com/secure-message-center
Mail: International Medical Group®
Kingsgate, High Street, Redhill, Surrey RH1 1SH, UK
Fax: +44.1737.860.600

For other inquiries, contact IMG at:
Phone: +44.1737.306.710
Email: info@imgeurope.co.uk