

**Moratorium Underwriting Form**

Please complete in BLOCK CAPITALS and in dark coloured ink

**1. Primary Insured**

The Primary Insured is the person applying for this insurance, on behalf of themselves and any dependants, who will be responsible for the adherence of the terms of the contract and payment of the insurance premium.

Title:	<input type="text"/>	Mr/Mrs/Miss/Other (please specify)
First Name:	<input type="text"/>	Surname: <input type="text"/>
Date of Birth:	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year	(must be over 18 years of age)
Nationality:	<input type="text"/>	Occupation: <input type="text"/>
Correspondence Address:	<input type="text"/>	
	<input type="text"/>	
	<input type="text"/>	
	<input type="text"/>	
	<input type="text"/>	
Email:	<input type="text"/>	Home Tel: <input type="text"/>
Office Tel:	<input type="text"/>	Mobile: <input type="text"/>
Fax:	<input type="text"/>	Communication Preference: Email <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/>

**2. Insured Persons**

Please enter the details of all additional persons to be covered under this policy. This can include any family member of the Primary Insured including, the spouse plus any dependent child, who is unmarried, below 21 years of age, and financially dependent on the Primary Insured.

Title:	<input type="text"/>	Mr/Mrs/Miss/Other (please specify)
First Name:	<input type="text"/>	Surname: <input type="text"/>
Date of Birth:	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year	
Nationality:	<input type="text"/>	Occupation: <input type="text"/>
Relationship to Primary Insured:	<input type="text"/>	

Title:	<input type="text"/>	Mr/Mrs/Miss/Other (please specify)
First Name:	<input type="text"/>	Surname: <input type="text"/>
Date of Birth:	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year	
Nationality:	<input type="text"/>	Occupation: <input type="text"/>
Relationship to Primary Insured:	<input type="text"/>	



## 2. Insured Persons (continued)

Title:	<input type="text"/>	Mr/Mrs/Miss/Other (please specify)
First Name:	<input type="text"/>	Surname: <input type="text"/>
Date of Birth:	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year	
Nationality:	<input type="text"/>	Occupation: <input type="text"/>
Relationship to Primary Insured:	<input type="text"/>	

Title:	<input type="text"/>	Mr/Mrs/Miss/Other (please specify)
First Name:	<input type="text"/>	Surname: <input type="text"/>
Date of Birth:	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year	
Nationality:	<input type="text"/>	Occupation: <input type="text"/>
Relationship to Primary Insured:	<input type="text"/>	

(If there is insufficient space, please use a separate sheet of paper and attach to this application form).

## 3. Policy Commencement Date

Please confirm the date upon which You would like cover to commence.

Date:	<input type="text"/> Day <input type="text"/> Month <input type="text"/> Year
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Please note that cover is for a period of 12 months. Cover will commence from the date that We receive and accept Your application for cover, unless a future date is requested (as detailed above). Please note that if a future date is applied for, this will only be accepted where this is within 90 days of Your application date and where valid and published premiums are available.

## 4. Area of Treatment

Your premium is based upon the Area band in which You wish to receive medical treatment. Please refer to the Geographical Coverage Schedule for full details.

Area 1 <input type="checkbox"/>	Areas 1 & 2 <input type="checkbox"/>	Areas 1, 2 & 3 <input type="checkbox"/>	Areas 1, 2, 3 & 4 <input type="checkbox"/>	All Areas <input type="checkbox"/>
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## 5. Level of Cover

The level of cover requested must be identical for all family members. Please refer to the relevant Benefit Schedule and Policy Wording for full details of the various cover levels.

1. Standard International Plan:	Primary <input type="checkbox"/>	Primary Plus <input type="checkbox"/>	Select <input type="checkbox"/>
2. España y Portugal (Regional Plan):	Primario Budget <input type="checkbox"/>	Primario <input type="checkbox"/>	Primario Más <input type="checkbox"/>
3. France (Regional Plan):	Primary Top Up <input type="checkbox"/>	Primaire <input type="checkbox"/>	Primaire Plus <input type="checkbox"/>



## 6. Policy Excess

The policy excess selected will be applied to all members. Please note that the excess is applicable per person, per medical condition, per period of cover. Therefore, if You claim for the same condition twice in the same policy period, the excess is applied only once.

€Nil     
  €50 \*     
  €100\*     
  €250\*     
  €500

\* excess option not available with the Primary Plan

## 7. Method of Payment

All policies are for an annual period. However, there are various payment frequencies and methods available, please see Premiums:

Bank Transfer     
  Cheque     
  Debit Card     
  Credit Card

### Notes

- Our details for Bank transfers are: Nat West Bank *Address:* PO Box 12258, London EC2R 8PA  
You have the option to pay in € Euro, US\$ Dollar or GBP Sterling. The account details are:  
Euro €      *A/C:* 42028922    *Sort Code:* 60-00-01    *IBAN:* GB37NWBK60721442028922    *IBAN BIC:* NWBK GB 2L  
United States \$    *A/C:* 42050235    *Sort Code:* 60-00-01    *IBAN:* GB37NWBK60730142050235    *IBAN BIC:* NWBK GB 2L  
British Pounds £    *A/C:* 39321150    *Sort Code:* 60-00-01    *IBAN:* GB23NWBK60000139321150    *IBAN BIC:* NWBK GB 2L
- Please ensure that any bank transfer is clearly marked with the Primary Insured's full name.
- Please make cheques payable to "Expatriate Healthcare".
- Please ensure that any cheque clearly identifies the full name and address of the Primary Insured on the back.
- We do not accept any liability for any payment which does not clearly identify the Primary Insured.

Card Type:     
  Visa     
  Mastercard     
  Switch     
  Delta     
  Electron

Card Number:   

Address to which card is registered:

Expiry Date:              
 Issue Number:    (if shown)     
 Security Ref:   

(last three digits shown on signature strip)

**Authorisation:**  
 I authorise Expatriate Healthcare to charge my Credit/Debit Card as specified, in respect of premiums for my Private Healthcare Insurance, as and when these become due, until the instruction is cancelled by my giving written notice to Expatriate Healthcare.

Cardholder's Name:

Cardholder's Signature:      
 Date:

## 8. Pre-Existing Conditions

It is a pre-requisite of Your application that it is understood that pre-existing conditions are not covered, until such a time that You have been Treatment and Advice free for a period of not less than two continuous years following Your Effective Date.

A pre-existing condition is any disease, illness or injury, secondary or associated complaint for which You have sought or received advice, treatment, therapy or have been submitted to a special diet in the two years prior to Your Effective Date (whether or not the condition has been diagnosed).

## 9. Your Data

Your data will be protected by Us in accordance with the Data Protection Act.

You have the right to access any personal information that we hold in respect of You. You also have the right to amend or delete any information we hold about You, if You believe that it is inaccurate or out of date.

In some circumstances it will be necessary for Us to pass on Your data to third parties to enable Us to underwrite, manage and administer Your insurance coverage and any subsequent claim or renewal. This may include, but is not limited to, Underwriters, Medical Practitioners, Hospitals, Medical Assistance Companies, Claims Administrators and Loss Adjusters.

Your signing of this application form gives Us permission to pass on Your personal information and that of Your dependants, solely for the purposes referred to above, which may include any sensitive information, such as medical information.

## 10. Declaration

I declare that I have read and understood the Policy Wording in respect of the insurance for which I am applying.

I declare that all the information supplied in respect of all persons in this Application Form is true and complete, including answers that are not in my own handwriting.

I confirm that all material facts in connection with this application have been declared in full, without mis-statement or misrepresentation. I understand that failure to do so will result in cover being voided from inception. (A material fact is any piece of information that may affect Our assessment or acceptance of Your application for insurance. If You are unsure as to whether any piece of information is material it should be declared).

I understand that, for what ever reason, I may cancel the insurance within 30 days from the commencement date and, provided I have not submitted a claim, I shall be entitled to a full refund of premium.

I confirm that I have read, understood and agree to the section in this application form "Pre-existing Conditions".

I confirm that I have read, understood and agree to the section in this application form "Your Data".

I confirm that I have read and understood the attachment "Terms of Business Agreement".

Primary Insured's Name:

Primary Insured's Signature:

Date:

Day	Month	Year
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**Expatriate Healthcare**  
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**Broker's Name & Address Stamp**

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19 Jalan Pinang

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