

Policy Start Date

We would like our GlobalHealth policy to start on (ddmmyy)

Proposer

Company Name:

Proposer Location and Contact Details

Company Address:

Postal Code: City:

Country:

Telephone: Fax:

Correspondence Address (if different from company address):

Address:

Postal Code: City:

Country:

Telephone: Fax:

Persons to be Insured (census may be attached separately if preferred)

Name (last, first, middle):

Please note that unless otherwise stated each person to be insured must complete a Medical Questionnaire.

Online Access

I would like to register the following email address with GlobalHealth so that I may access my policy details online at www.globalhealthasia.com

Email:

I would like my insurance intermediary to have access to my policy details through their online account Yes No

Choose Your Cover

Select your Area of Cover

- Worldwide
- Worldwide excluding *North America and the Caribbean*

Select your Plan

- Hospitalisation Only
 - Plan A
- Hospitalisation & Outpatient
 - Plan A (with optional outpatient)
 - Plan AA
 - Plan AAA

Select Optional Modules

- Maternity Option 1
- Maternity Option 2
- Dental with copay
- Dental without copay

Premium Payment

Frequency of Payment

- Annual (no surcharge)
- Semi-Annual (4% surcharge)
- Quarterly (5% surcharge)

- Cheques/ Banker's Drafts**
- US\$
- HK\$

Cheques should be drawn on a Hong Kong or United States clearing bank and made payable to "GlobalHealth Asia Limited"

Bank Transfer

For direct premium remittances, please send full payment (inclusive of all bank charges) to:

Intermediary Bank

ABA No.: 026009593
 Recipient Bank: Bank of America N.A., New York
 USA CHIPS UID 009953
 Account No.: 6550-4-90452
 Swift Address: B0FAUS3N

Beneficiary Bank

Bank: The Bank of East Asia, Limited. Hong Kong
 Account Holder: GlobalHealth Asia Limited
 Account No.: 015-521-50-00132-1 (US\$ Account)
 Swift Address: BEASHKHH (SWIFT MT103)

- Note:
1. All bank charges will be borne by the remitter.
 2. Please indicate your Policy Number as a payment detail to your banker.
 3. Please fax (+852 2526 0769) or email the bank remittance advice or instruction slip with your Policy Number to GlobalHealth for our accounting records and to issue an Official Receipt.

Company Credit Card (personal credit cards not accepted unless authorised)

I/we, the undersigned, authorise you to charge the following credit card for payment of GlobalHealth insurance premiums:

- Visa MasterCard
- US\$ HK\$

Card No.:

Issuing Bank:

Card Holder's Name:

Expiry Date (mmyy):

I also authorise GlobalHealth Asia Limited, until further notice in writing, to charge this credit card with unspecified amounts in respect of annual premium payments as and when these become due. GlobalHealth Asia Limited will inform us in advance of any premium adjustments.

Do you wish to opt for automatic credit card billing for future renewals? Yes No

Signature

Date

We will cover *you* on Standard Terms if *you* are of sound health at the time of acceptance and must not suffer nor have suffered from any recurring disease, *Illness, Injury*, bodily infirmity or physical or mental disability, and *you* must not have attained 65 (sixty-five) years of age at the time of acceptance.

Declaration

I acknowledge that presentation of this form does not entitle me or anyone else to cover under this, or any other insurance product or service provided by Liberty International Insurance Limited (Hong Kong) and or its representative GlobalHealth Asia Limited. I also acknowledge that the decision as to whether I will be offered cover under this, or any other insurance product or service provided by Liberty International Insurance Limited (Hong Kong) and or its representative GlobalHealth Asia Limited, remains entirely at Liberty International Insurance Limited (Hong Kong) and or its representative GlobalHealth Asia Limited absolute discretion at all times.

Cashless Out-patient Facility: (Applicable only to nil *deductible* policies with Out-patient Benefits selected) I/We authorise GlobalHealth Asia Limited to release the names, dates of birth, sex, passport and/or identification number, any information provided on the Application and any records GlobalHealth Asia Limited may have regarding the insured person(s) shown on the *namelist* to *hospitals*, clinics, laboratories, physicians, specialists, *dentists*, chiropractors, acupuncturists, physiotherapists, or other medical practitioners for the purpose of providing direct bill paying services for the insured person(s). By signing this declaration, I/We also acknowledge the specific Policy term listed below:

Right of Recovery: In the event of authorisation of payment and/or payment is made by Liberty International Insurance Limited (Hong Kong) for a claim which is not covered under this Policy or when the limit of liability of this insurance is exceeded, Liberty International Insurance Limited (Hong Kong) reserves the right to recover the said sum or excess from *you*.

This recovery includes but is not limited to deducting the payments owed from other claims made by *you* during the Policy period. If the amount owed remains outstanding for more than 90 days, then GlobalHealth Asia Limited reserves the right to suspend the direct billing service to *you* without further notice.

Name and Title

Signature

Date

**Please send completed form to
GlobalHealth Asia Limited**

Suite 1401-3, Chinachem Hollywood Centre, 1-13 Hollywood Road, Hong Kong, SAR.
Telephone: (852) 2526-0918 Facsimile: (852) 2526-0769 Email: hkapan@globalhealthasia.com
www.globalhealthasia.com

Producer Name: _____

Email: _____ Contact Number: _____



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Tel : +852 2530 2530 | Fax : +852 2530 2535
Email : ctgw@navigator-insurance.com | www.navigator-insurance.com



