NAVIGATOR
Insurance Brokers Ltd.
Unit 8E, Golden Sun Centre, 223 Wing Lok St, Sheung Wan, Hong Kong
Tel : +852 2530 2530 | Fax : +852 2530 2535
Email : crew@navigator-insurance.com | www.navigator-insurance.com

Henner™

CARE & HEALTH

Application Form

INDIVIDUALS

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Your details

Last name _____ First name _____

Date of birth (dd/mm/yyyy)_____ Gender (M/F) _____ Nationality _____

Residential address [1] _____

City _____ Country _____ Postcode _____

Mailing address (if different from above) _____

City _____ Country_____ Postcode _____

Phone number _____ Mobile [2] _____

E-mail [2] _____ @_____ Occupation _____

Dependants to be included in the plan

Relationship (eg: Spouse, Child)	Last name	First name	Date of birth (dd/mm/yyyy)	Gender (M/F)	Country of Usual Residence [1]

[1] Any country in which you and your dependants will reside for at least 6 months of the year is called Country of Usual Residence.
[2] We can send you confirmation by SMS of any hospital guarantee we issue if you provide us with your mobile phone number. An email address, however, must be provided as we will send invoices and claim statements by email.

Payment

How would you like to pay your premium?

☐ Annually ☐ Semi-annually ☐ Quarterly

(Semi-annual and Quarterly premiums are subject to a 3% loading)

Select your method of payment:

☐ Visa / MasterCard *(For payment by credit card, upon receipt of your invoice, go to www.henner.com, log into your secure personal access page and register your credit card details online)*

☐ Bank Transfer *(Account details for transfer will be provided with your invoice)*

Effective date of coverage

When would you like your cover to start?

_____ / _____ / _____
dd mm yyyy

Your membership and that of your dependants are effective on the date indicated on your Certificate of Enrollment, and at the earliest on the day after we receive the Application Form and Health Declaration Form duly filled and signed, along with all requested additional information, subject to approval by Henner - GMC Medical Advisory Board and payment of first premium.

▶ Choose your Area of Coverage

☐ Area 1	☐ Area 2	☐ Area 3	☐ Area 4	☐ Area 5
Brazil, Hong Kong, Mainland China, Macau, Switzerland + countries in areas 2, 3, 4, and 5.	Argentina, Australia, Belarus, Bosnia, Canada, Colombia, Ireland, Israel, Italy, Japan, Mexico, Monaco, Russia, Singapore, South Korea, Spain, United Kingdom, Venezuela + countries in areas 3,4 and 5.	Belgium, Chile, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, New Caledonia, New Zealand, Portugal, South Africa, Sweden, Rest of Latin America, Rest of Europe + countries in areas 4 and 5.	Bahrain, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syria, Turkey, United Arab Emirates, Yemen, Rest of Middle East + countries in area 5.	Rest of Africa, Rest of Asia (Bangladesh, Cambodia, India, Indonesia, Laos, Malaysia, Mongolia, Myanmar, North Korea, Philippines, Sri Lanka, Thailand, Vietnam, etc.)

- You will be covered outside your chosen Area of cover for unexpected illnesses and accidents only.
- The Assistance Company evacuates to "the nearest place of suitable care" and repatriates to a country that belongs to your Area of Cover.

▶ Choose your Plan

PREMIUMS

☐ Primary ☐ Vitality ☐ Serenity ☐ Prestige

1 Choose your Maximum Annual Limit:

☐ US$ 200,000 ☐ US$ 300,000
☐ US$ 500,000 ☐ US$ 4,500,000

2 Semi-private hospital room restriction: ☐ Yes ☐ No

3 Choose your level of coverage for Outpatient benefits:
(It will also apply to Maternity, Dental & Vision if chosen)

☐ 80% of usual benefits ☐ 90% of usual benefits ☐ 100% of usual benefits

Emergency Assistance, Repatriation & Evacuation and Personal Liability are included.

US$ _____

▶ Choose your Options

☐ Maternity * Not available with Primary — US$ _____

☐ Dental * Not available with Primary — US$ _____

☐ Vision * Not available with Primary or Vitality
Only available if Dental is also chosen — US$ _____

▶ Choose your Life Insurance

☐ Death (all causes) or Total Permanent Disability

Select your lump sum benefit:

☐ US$ 25,000 ☐ US$ 50,000
☐ US$ 100,000 ☐ US$ 250 000

US$ _____

☐ Optional double benefit when death is caused by accident (1)

Your Death (all causes) or Total Permanent Disability lump sum multiplied by 2.
(1) Only available if Death (all causes) or Total Permanent Disability is chosen.

US$ _____

Total annual premium including all dependants

TOTAL US$_____/ year

Your declaration

I, the undersigned, certify that the information filled in this Application Form and the Health Declaration Form is accurate and true. I certify having provided full disclosure and not having withheld any information which might affect the risk assessment.
I understand and have taken note that any false declaration or non-disclosure will void coverage under this policy, and that in this case the insurer will retain paid premiums as civil damages and that I shall have to reimburse benefits paid for all beneficiaries.

I hereby request to become a member of La Garantie Médicale et Chirurgicale (GMC), under the Care & Health insurance plan designed by Henner and underwritten by La GMC. I acknowledge that I have read and understood the coverage described in the table of benefits and the General Conditions of the Care & Health plan for which I am applying.

I have duly noted that my enrollment under the Care & Health policy shall be effective subject to:

- Approval by the Henner - GMC Medical Advisory Board of the enclosed health declaration duly filled out by myself and all my dependants who have reached majority
- Payment of premium

In the event of my death, I appoint as beneficiary my surviving spouse unless legally separated; otherwise in equal shares my children born or to be born, the share of a deceased child going to his/her own children or to his/her brothers and sisters if he/she has no children; otherwise in equal shares my surviving parents; or in their absence, my heirs.
I further note that should I wish to change beneficiaries at any time, I shall write formally to Henner - GMC with details of the requested changes and clearly identify any new beneficiaries.

Signed in (city; country) _____ **Policy holder's signature, preceded by "read and agreed":**

On (date) _____/___ /_____ (dd/mm/yyyy)

R.C.S. PARIS B 323 377 739 - GMCG12474 - 04/2016

How to apply

Check list of documents required for your application:

FOR YOU:
- Copy of identity card or passport
- Bank account details for reimbursement of claims
- Application form completed and signed
- Health Declaration completed and signed addressed to the Medical Board in a separate envelope
- Certificate of your current insurance (and Table of Benefits) for us to consider waiving the 6-month waiting period.

FOR YOUR FAMILY:
- Copy of identity card or passport
- Certificate of full-time attendance at school for your children from 20 to 28 years

Once you have all these documents, you just have to send it to these email addresses:
For the Application form: **hennerpro.asia@henner.com**
For the Health Declaration: **health.declaration@henner.com**

Please send the originals to: Henner - GMC Services Asia Pacific Pte Ltd,
137 Telok Ayer street #07-01/02/03, Singapore 068602

If your Application is accepted we will send you a Premium Invoice and your Policy will be effective upon confirmation of premium payment. We look forward to being of service.

Henner - Simplified private joint stock company - Registered capital of € 8,212,500 RCS Nanterre 323 377 739 - VAT No. FR 48323377739 - Registered in France with ORIAS No. 07.002.039 – and regulated by the ACPR - ISO 9001 certified - Headquarters: 14 bd du Général Leclerc, 92200 Neuilly-sur-Seine France - www.henner.com

Hauteville Insurance Company Limited, Harbour Court - Les Amballes, St. Peter Port, GUERNSEY GY1 4QA - CHANNEL ISLANDS Licensed by the Guernsey Financial Services Commission Registered Number: 24676

La Garantie Médicale et Chirurgicale - Association constituted in accordance with the 1901 French law regarding non-profitable organizations - 14 bd du Général Leclerc, 92200 Neuilly-sur-Seine - France

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