

## Worldwide Plans Application Form Groups

<b>For internal use only</b>			<input type="checkbox"/> MHD
<input type="checkbox"/> FMU	<input type="checkbox"/> CPME	<input type="checkbox"/> Moratorium	<input type="checkbox"/> EMD

### 1. Policyholder details

Company name :	
Address :	
Postal code :	Town / City :
State :	Country :

### 2. Details of company contact person

Last name :	First name :	Title :
Address (if different from above) :		
Postal code :	Town / City :	
Telephone :	Mobile :	
Email :	Fax :	

### 3. Correspondence

Correspondence to be sent to :	<input type="checkbox"/> Policyholder only	<input type="checkbox"/> Broker only	<input type="checkbox"/> Policyholder and broker
Membership Cards to be sent to :	<input type="checkbox"/> Policyholder	<input type="checkbox"/> Broker	

### 4. Plans and Options available

A. Medical Plan <sup>1</sup>	<input type="checkbox"/> Hospitalisation			<input type="checkbox"/> Global 80			<input type="checkbox"/> Global 100			<input type="checkbox"/> Global 100 Plus							
B. Currency <sup>1&amp;2</sup>	C. Optional Policy Deductibles <sup>1&amp;2</sup> (in the same currency as the policy)																
EUR <input type="checkbox"/>	<input type="checkbox"/> Nil	<input type="checkbox"/> 500	<input type="checkbox"/> 1,000	<input type="checkbox"/> 2,000 <sup>3</sup>	<input type="checkbox"/> 5,000 <sup>3</sup>	USD <input type="checkbox"/>	<input type="checkbox"/> Nil	<input type="checkbox"/> 675	<input type="checkbox"/> 1,350	<input type="checkbox"/> 2,700 <sup>3</sup>	<input type="checkbox"/> 6,750 <sup>3</sup>	CHF <input type="checkbox"/>	<input type="checkbox"/> Nil	<input type="checkbox"/> 750	<input type="checkbox"/> 1,500	<input type="checkbox"/> 3,000 <sup>3</sup>	<input type="checkbox"/> 7,500 <sup>3</sup>
D. Area of cover <sup>1</sup>	<input type="checkbox"/> Worldwide					<input type="checkbox"/> Worldwide excluding USA & Canada											
E. Semi-Private Room Restrictions Option <sup>8</sup> (Hong Kong Residents Only)	<input type="checkbox"/>																
F. Dental & Optical Plans <sup>1,4&amp;7</sup>	<input type="checkbox"/> None			<input type="checkbox"/> Standard				<input type="checkbox"/> Plus									
G. Evacuation/ Repatriation <sup>1&amp;2</sup>	<input type="checkbox"/> Yes					<input type="checkbox"/> No											
H. Accidental Death and Dismemberment <sup>2&amp;5</sup>	<input type="checkbox"/> Sum insured shall be minimum EUR 50,000 / US\$ 67,500 / CHF 75,000 up to a maximum of EUR 500,000 / US\$ 675,000 / CHF 750,000																
I. Loss of Income <sup>2</sup> (Benefits payable up to age 65)																	
- Temporary incapacity <sup>2&amp;5</sup>			<input type="checkbox"/>			Minimum monthly allowance shall be EUR 1,000 / US\$ 1,350 / CHF 1,500 up to a maximum of EUR 10,000 / US\$ 13,500 / CHF 15,000. The monthly allowance cannot exceed 80% of the gross monthly salary.											
- Permanent disability <sup>2,5&amp;6</sup>			<input type="checkbox"/>														
<sup>1</sup> These elements must be chosen on a per group (or sub-group basis to be pre-agreed by the Insurer; conditions apply). <sup>2</sup> Premiums and claims shall be payable in EUR, in US\$ or in CHF, according to the currency in which the medical policy has been concluded. <sup>3</sup> Deductible not available with Hospitalisation plan. <sup>4</sup> Dental & Optical options can only be purchased in addition to Global 80, Global 100 & Global 100 Plus. Not available with Hospitalisation plan or separately. <sup>5</sup> Sum Insured must be in the same currency as the medical policy. <sup>6</sup> Permanent disability can only be taken out as complementary to temporary incapacity. <sup>7</sup> Options not available with deductibles EUR 5,000 / US\$ 6,750 / CHF 7,500. <sup>8</sup> Cover is restricted to Semi-Private Room and corresponding rates when receiving treatment as Inpatient or Day patient.																	

### 5. Policy start date

Start date (dd - mm - yyyy)    __ __ / __ __ / __ __ __ __
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## 6. Employees to be insured under the plan (please contact us in case you need assistance)

For all employees to be covered under the plan, our document (member's list) must be completed specifying the personal details and the exact cover needed for the employees and family members.

## 7. Premium payment

### A. Your choice of currency is as per part B in section 4.

**Note:** The choice of currency has to be made by the Policyholder before the coverage takes effect, and can only be changed at the annual renewal date.

### B. Your method of payment Annual Semi-annual

**Bank transfer.** If selected, please ensure your name is clearly stated on your transfer order and send a copy of your transfer order to your intermediary. Our bank details will be provided on the premium invoice.

### **Credit card** (Visa, MasterCard only)

If selected, please complete the credit card authorisation section below.

**Credit card authorisation**  Visa  MasterCard

Credit card number : \_\_\_\_\_ CVC Code : \_\_\_\_\_

Expiry date : \_\_\_\_ / \_\_\_\_ (mm/yyyy)

Credit card statement mailing address.....

Exact name on credit card \_\_\_\_\_

Signature: .....Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (dd/mm/yyyy)

I hereby authorise A+ International Healthcare, or its agents, as of today and until further notice in writing, to charge my credit card account with unspecified amounts in respect of my premium payments as and when these become due. The Company will inform me in advance of any premium adjustments and I will have the possibility to cancel the policy.

**Note:** For payment by credit card, your premium will be collected upon receipt of this application which may be in advance of the commencement date. Future premiums will be collected 7 days in advance of the renewal date of this policy.

## 8. Invoicing address (only if different from the principal company address)

Company name :

Address :

Postal code :

Town / City :

State :

Country :

## 9. Declaration by Policyholder

- 1) I hereby apply for cover on behalf of all the persons named with this application form.
- 2) I certify that the statements made and the information provided by me in this application are true, complete and to the best of my knowledge and belief. I understand that nullity of the insurance or reduction of the insured capital sum might be applied if it were proved that the person to be insured had established a false declaration. I confirm that I have checked and found correct any answers or statements in this application that are not in my own handwriting.
- 3) I accept that the policy will be subject to the policy terms and conditions effective at the time of commencement. I confirm that I have read and I understand the full definitions, benefits, exclusions and conditions of this policy.
- 4) In view of a smooth administration of the contract and/or settlement of insurance claims, and only for that purpose, I, the undersigned, hereby give my special permission regarding the processing of the medical data concerning all the persons included in this application either directly with the Insurers or through A+ International Healthcare and/or its agents (French Law 78-17 of 6 January, 1978, relating to data freedom).
- 5) I agree to accept and conform to the terms of the policy when issued unless I cancel this policy within 30 days from the commencement date.
- 6) I have read and understood the Important Note below.

**Important Note:** This policy is written in the English language and is intended for use only by persons who are able to read and understand its terms. Do not sign this Application Form if you do not understand the Policy.

Policyholder's signature and Company chop \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (dd/mm/yyyy)

Please send this application form back to your insurance agent or directly to the Insurers representative :

**A Plus International Holdings Limited**  
Correspondence Address  
29/F, Fook Lee Commercial Centre, 33 Lockhart Road  
Wanchai, Hong Kong China S.A.R.  
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Email : cs@aplusii.com

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