Evolution Health Plan (UK/GIB)

FMU

morganprice international

Application form

Part A

Please complete all parts of this form and return it to your agent/ insurance broker. It is important that you complete this Application Form fully. Failure to do so may result in the form being returned to you for completion.

This Application Form asks questions that are material to both the risk underwritten and the calculation of the premium by Endurance Worldwide Insurance Limited (the "Insurer"). You must take care when answering any questions the Insurer asks by ensuring that all the information provided is accurate and complete (the 'Duty'), and the Duty applies when the policy is varied or renewed.

The Insurer may withdraw from the insurance contract and decline all claims, should it determine that you provided false or misleading information to the Insurer and were negligent or grossly negligent when doing so or did so intentionally.

All Application Forms are reviewed prior to acceptance and therefore no cover shall be granted until confirmation is provided.

Please indicate that you agree to communicate with Insurers in respect of this Application Form and all subsequent communications in the English language: I consent ◯ I do not consent ◯

1 Your personal details

Title | Forename(s) | Surname/Family Name

Date of birth | Gender | Height | Weight

Overseas address | Post/Zip code

Phone | Mob | Email

Home address | Post/Zip code

Occupation | Nationality

Home country *(for which you have a passport)*

Country for which this cover is required *(where you will be spending most of you time)*?

How long have you been resident in your country of residence *(years/months)*?

2 Cover required

Date upon which annual cover to commence, or the date on which your proposal is accepted by insurers, whichever is the later

Choose your geographical area of cover	Europe ◯	Worldwide excluding USA, China, Singapore & Hong Kong ◯	Worldwide excluding USA ◯	Worldwide ◯

Choose your level of cover: Standard ◯ Standard Plus ◯ Comprehensive ◯ Premium ◯ Elite ◯

2 Cover required — continued

Please select the annual excess you wish to apply to your policy

Nil ◯ 100 ◯ 250 ◯ 500 ◯ 1000 ◯
2500 ◯ 5000 ◯ 7500 ◯ 10000 ◯

In addition you may select a co-insurance applicable to out-patient claims only. In effect this is a percentage of each out-patient claim for which you are responsible.

Nil co-insurance ◯ 10% co-insurance ◯ 20% co-insurance ◯

N.B. This option is not applicable to the Standard level of cover as there are no out-patient benefits on Standard.

Home country evacuation module (120 adult/75 child) ☐

Please specify the currency in which you wish to pay premiums and receive benefits

US Dollar $ ◯ Sterling £ ◯ Euro € ◯

Do you or any of the persons to be included in this proposal, have existing health insurance? Yes ◯ No ◯

If yes, which provider?

To avoid any delays and ensure that we can process your application swiftly and efficiently - Please ensure that you include the following items with your application:

- Copy of passport

Have you or any of the people to be included in the proposal, ever been refused cover by an insurance company or been accepted on special terms? *(If yes provide details on a separate sheet)* Yes ◯ No ◯

3 Dependants to be included

	Full name of dependants	Relationship to proposer	D.O.B	Nationality	Gender	Height	Weight	Occupation
Spouse								
Dep. 1								
Dep. 2								

Please provide us with the name and address of your regular personal or family doctor/physician. If you do not have a regular doctor, please give the last doctor you visited and approximate date. - If there is a different doctor for each applicant, please provide all details and indicate which physician applies to each applicant.

NB. This must be supplied for us to be able to process your application

4 Payment method

Please specify how you would like to pay

- Annually by credit/debit card ◯
- Semi annual by credit/debit card ◯
- Quarterly by credit/debit card ◯
- Monthly by credit/debit card ◯
- Annually by bank transfer *- details supplied on request* ◯
- Monthly by direct debit *- only available in the EU on Euro policies only* ◯

Service fees - credit/debit card & SEPA Direct Debits

Annual payment	0%
Semi annual payments	+4%
Quarterly payments	+5%
Monthly payments	+8%

- If paying by credit/debit card please complete attached payment form

Service fees - bank transfer

Annual bank transfer	£10/€15/$30

The bank transfer fee does not need to be included as long as the payee selects to pay all charges.

5 Declaration

For the purpose of this declaration, ("I/We") means any insured person intended to benefit from insurance cover as per the policy wording.

a. I/We have been provided with a copy and read the policy wording and I/we understand it to be part of the contract of insurance. In particular I/We have read, understand and accept the definitions, benefits and exclusions of the policy.
b. I/We have read, understand and accept Section 6 of this application form on data protection.
c. I/We am consenting for my/our insurance broker to act on my behalf for the purposes of transferring sensitive data.
d. To the best of my/our knowledge and belief the information given in connection with this application form, whether in my hand or not, is true and I/we have answered all questions asked in this application form honestly and fully. I/We also understand that I/we must tell the insurer straight away if anything that I/we have already told the insurer changes. I/we understand that non-disclosure or misrepresentation of any facts may entitle the insurer to void the insurance. This application form and the information provided contains statements upon which the Insurer will rely in deciding whether to accept this insurance and in determining the terms and conditions of such acceptance.
e. I/We understand that the signing of this application form does not bind me/us to complete, or the insurer to accept this insurance.
f. If I/we have elected to pay our premium by instalments using credit or debit cards and Morgan Price have agreed to this, I/we authorise Morgan Price to continue to deduct such instalments as and when they become due unless I/we cancel this credit/debit card authorisation by giving at least 14 days notice in writing. I/we understand that if I/we have made a claim, no refund will be due and I/we will have to pay any outstanding instalments due in the current period of cover.
g. I/We am authorised to sign this application form on behalf of all my/our dependents declared at Section 3 of this Application Form.
h. I/We consent to communicate with Insurers in respect of this Application Form including all subsequent communications in the English language.

Signature of primary applicant ✗ _____ Date _____

6 Data Protection & General Data Protection Regulations

Data Protection

The Insurer, Endurance Worldwide Insurance Limited ("We/Us/Our") is the Data Controller of the data collected about you. As such, We are responsible for the way in which this data is processed and will use personal information and, to the extent applicable, special category data given by you, together with other information for, amongst other things, the administration of this Policy, the handling of claims, the provision of customer services, credit checks and to prevent and detect fraud, as described more fully below in the Sompo International General Privacy Policy. We are a member of the Sompo International 1 group; as such, the information you provide may also be disclosed to Our affiliates or parent, service providers and agents for these purposes. It may also be disclosed to the insured's insurance advisor, where appointed.

We may need to collect and process information relating to individuals who may benefit from this Policy, which may include both personal data and special category data (such as medical history).
You must ensure that you have explicit verbal or written consent from these individuals to such information being processed by Us.

In collecting or processing personal data, including special category data, about the insured or related third parties under this Policy, We shall comply with applicable data protection legislation. We are committed to protecting your personal information and respecting the data protection and privacy rights you have under applicable law and regulations.

When you submit any information to Us for the purpose of requesting information from Us about, or obtaining, Our products or services, We will use the information you provide, including any personal information, in its insurance business to conduct its business and perform its legal obligations, including:

i. verifying your identity;
ii. preventing, investigating or reporting fraud or potential fraud, money laundering, terrorism, misrepresentation, security incidents, sanctions violations or any crime, all in accordance with applicable law and regulations;
iii. assessing, establishing and managing claims and arranging or entering into any appropriate settlements;
iv. managing, reporting and auditing Our business operations;
v. recovering debt;
vi. developing, improving and protecting Our products, services, website, systems and relationships with you;
vii. carrying out research, risk management and statistical analyses;
viii. establishing, exercising or defending legal claims; and
ix. meeting regulatory and compliance requirements.

We will ensure that your personal data is processed in a manner consistent with the purposes set out above. We will retain your personal data for as long as it is necessary for the purposes mentioned above or as long as required by law.

To the extent applicable, We may also use your contact details (including email address(es)) to send you information about related products and services or other products and services provided by Us or one of Our group companies.

We may share your information for the purposes outlined above with:

i. Our group companies;
ii. brokers, other insurers and underwriters;
iii. healthcare professionals;
iv. law enforcement authorities;
v. other government authorities;
vi. fraud prevention agencies; and
vii. third parties involved in any aspect of claims management including surveyors, loss adjusters, claims agents, solicitors and private investigators;
viii. parties that may have a financial interest in the insurance policy or claim;
ix. other service providers that may process your personal information on Our behalf (for example, IT service providers that host or support Our business and may have data that includes your personal information); and
x. others with your consent or in accordance with applicable law and regulations.

If you have provided information about another person, in doing so you confirm that you have such person's consent to provide the personal information to Us, that you have told such person that you have provided the information to Us and how We will use the personal information as described in this notice.

To the extent you have provided your consent, and your consent provides the basis for Our use of the information, you may withdraw your consent at any time by contacting Us as described below.

More details about how We use your personal information may be found in the Sompo International General Privacy Policy, available on Our website at: https://www.sompo-intl.com/privacy-policies/.

The website also provides additional information about your data protection rights, how you may access and update your personal information and other choices you have about how We use your personal information (including how to object to processing or withdrawing your consent at any time). If you have any questions regarding this notice, please contact Us at:
Attn: Chief Compliance Officer Sompo International
1221 Avenue of the Americas
New York City, NY 10020
Email: Privacy@sompo-intl.com

FOR OFFICE USE ONLY!

Policy No. _____

Surname: _____

morganprice international

7. Confidential medical declaration

Part B

Important: You and the persons applying for cover under this policy must declare to us any and all known pre-existing medical conditions. If you do not tell us, your policy may be cancelled and any claim you make may not be paid.

		Policyholder	Spouse	Dep. 1	Dep. 2
1.	Are any medical/surgical/dental consultations and/or procedures (including x-ray, lab or other testing) recommended, scheduled or contemplated for any applicant?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
	Additional information MUST be provided here if "Yes" is answered.				
2.	Has any applicant ever been refused medical or dental insurance, or ever had a policy postponed, rated or accepted on special terms?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
	Additional information MUST be provided here if "Yes" is answered.				
3.	Has any applicant been examined by, consulted with, or received medical treatment from a medical professional in the last 12 months?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
	Additional information MUST be provided here if "Yes" is answered.				
4.	Has any applicant been examined by, consulted with, or received medical treatment from a medical specialist or consultant in the last 5 years?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
	Additional information MUST be provided here if "Yes" is answered.				
5.	Has any applicant been confined (stayed overnight) in a hospital, clinic, sanatorium, or other treatment facility in the last 5 years?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
	Additional information MUST be provided here if "Yes" is answered.				

6. Has any applicant had any disease or impairment of or suffered any symptoms or required any medication, treatment or hospital consultation(s) for the following? - *Please answer all questions.*
Please note that if you answer yes to any of these questions, you MUST provide further details in the additional information section.

6.1.	AIDS/ARC/HIV	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.2.	Alcohol dependency or drug/substance abuse	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯

		Policyholder	Spouse	Dep. 1	Dep. 2
6.3.	Anaemia or any blood disorder	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.4.	Arthritis, or any disorder of any muscles or joints	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.5.	Asthma, bronchitis or any other respiratory disorder	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.6.	Back/spine/neck	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.7.	Blood pressure/hypertension *If yes, please complete our hypertension questionnaire*	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.8.	Blood vessels/clots/circulatory system	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.9.	Bones (including fractures)	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.10.	Brain/head	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.11.	Cancer, tumour, growth or cyst *If yes, please complete our cancer questionnaire*	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.12.	Carpal tunnel syndrome	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.13.	Cerebrovascular disease/disorder or stroke	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.14.	Chest pains, palpitations, heart murmur, angina, heart attack or any other heart disorder	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.15.	Cholesterol/Hypercholesterolemia *If yes, please complete our cholesterol questionnaire*	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.16.	Cystic fibrosis	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.17.	Dental/gum disease	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.18.	Diabetes (including where under control by medication) *If yes, please complete our diabetes questionnaire*	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.19.	Ears, eyes, nose or throat	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.20.	Epilepsy, convulsions, seizures, fits	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.21.	Gastrointestinal disorder (stomach/intestines)	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.22.	Gout	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.23.	Hernia	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
	If yes, please state the type of hernia i.e inguinal				
6.24.	Immune system disorder	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.25.	Injury, operation, physical defect or deformity	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯

		Policyholder	Spouse	Dep. 1	Dep. 2
6.26.	Kidney/bladder/urinary tract	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.27.	Liver, gall-bladder, pancreas or spleen	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.28.	Lungs/breathing	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.29.	Mental/nervous disorder	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.30.	Neurological/nervous system	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.31.	Paralysis	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.32.	Prostate	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.33.	Rheumatic fever	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.34.	Reproductive disorder or infertility	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.35.	Skin	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.36.	Sleep disorder	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.37.	Stroke	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.38.	Surgical operation	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.39.	Ulcer	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.40.	Thyroid (including where under control by medication) *If yes, please complete our thyroid questionnaire*	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.41.	Urinary abnormality	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.42.	Other medical condition not listed	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.43.	Are you currently undergoing or been advised to undergo any dental treatment?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.44.	Have you smoked, used tobacco or nicotine replacements in the last 12 months? If so, how many per day?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.45.	Do you have any known allergies, including food allergies?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.46.	Have you suffered any symptoms for which you have not sought medical advice?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.47.	Do you have any known check-ups or doctor appointments pending now or in the future?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.48.	Are you currently under the care of any specialist? (e.g. a cardiologist or oncologist)	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.49.	Are you currently pregnant?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯

Additional information

If you answered "Yes" to any of the questions in Section 7, you MUST complete the additional information below. If you require additional space, please continue on a separate sheet.

	Question no.	Name of illness/medical condition*	Dates (to and from)	What medical treatment was provided?	Current medication name and daily dose	Have you had any hospital stay in relation to this condition?	What is the current status of the condition?**
Policyholder							
Spouse							
Dep. 1							
Dep. 2							

*Where applicable, please state the area of the body affected (e.g. left or right arm)
**Please enter either Complete Recovery, Ongoing or Recurrent (or likely to recur)