Evolution Health Plan (Asia Pacific)

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 form fully. Failure to do so may result in the form being returned to you for completion. All proposals are reviewed prior to acceptance and therefore no cover shall be granted until confirmation is provided.

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 area of cover	Worldwide excluding USA, Singapore' Hong Kong & China ◯	Worldwide excluding USA ◯	Worldwide ◯	Bangladesh, Brunei,Myanmar (Burma), Cambodia, India, Indonesia, Laos, Malaysia, Pakistan, Philippines, Sri Lanka, Taiwan and Vietnam ◯

Choose your level of cover

Standard ◯ Standard Plus ◯ Comprehensive ◯

Premium ◯ Elite ◯

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.

2 Cover required — continued

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

Please specify the currency in which you wish to pay premiums and receive benefits — US Dollar $ ◯

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

If yes, which provider?

Do you or any of the persons to be included in this insurance take part in **any sport** or physical pastime ? Yes ◯ No ◯
*(For the avoidance of doubt, this would include amongst other things **but not limited** to climbing, horse riding, cycling, mountain biking, contact sports etc either as an amateur or professional).*
If you are in any doubt then you should disclose your sport or physical pastime.

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

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* ◯

Service fees - credit/debit card

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	$30

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

5 Declaration

a. I/We have 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 proposal on data protection.
c. I/We am consenting for my 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 proposal, whether in my hand or not, is true and I/we have answered all questions about this policy 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 proposal and the information provided contains statements upon which the insurers 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 proposal does not bind me/us to complete, or insurers 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 confirm that I/we understand any claims submitted in the first six months of this policy that are not accident and emergency will be evaluated as pre-existing conditions and may not be covered under the benefits of this plan.

Signature of primary applicant ✗ _____ Date _____

6 Data Protection & General Data Protection Regulations

The data protection law in the UK changed on 25 May 2018. This paragraph sets out how we process your data and your rights under the new laws, although you should refer to the Morgan Price Privacy Notice at [www.morgan-price.com/privacy-policy] for further details.

Morgan Price International Healthcare Ltd together with its insurance partners are the joint controller and processor of your personal data (the insurance partner of your policy will be advised to you when you purchase the cover). We will collect your personal data including but not limited to special categories of Personal Data about you (this includes details about your sex, ethnicity, age, and information about your health and medical conditions). We respect your privacy and we are committed to protecting your personal data.

This notice aims to give you information on how we collect and process your personal data when using our insurance services, including any data you may provide when you purchase our insurance products or services. Personal data, or personal information, means any information about an individual from which that person can be identified. It does not include data where the identity has been removed (anonymous data). Where we need to collect personal data by law, or under the terms of an (insurance) contract we have with you and you fail to provide that data when requested, we may not be able to perform the contract we have or are trying to enter into with you or provide the insurance services to you (for example, to provide you with medical claims insurance services). In this case, we may have to cancel the insurance product or insurance service you have with us but we will notify you if this is the case at the time. We will only use your personal data when the law allows us to. Most commonly, we will use your personal data in the following circumstances:

- Where we need to perform the insurance contract we are about to enter into or have entered into with you;
- Where we need to assess any medical conditions, claims and Health data to perform our obligations under the insurance contract;
- Where it is necessary for our legitimate interests (or those of a third party) and your interests and fundamental rights do not override those interests;
- Where we need to comply with a legal or regulatory obligation.

We will only use your personal data for the purposes of providing insurance products and services unless otherwise indicated to you. We may have to share your personal data with our insurance partners, which may include reinsurers, insurance intermediaries, third party medical claims administrators and other related parties to satisfy our contractual and legal obligations under the insurance contract (policy terms).

Many of our external third parties are based outside the European Economic Area (EEA) so their processing of your personal data will involve a transfer of data outside the EEA. Whenever we transfer your personal data out of the EEA, we ensure a similar degree of protection is afforded to it by ensuring that we use specific contracts approved by the European Commission. We have put in place appropriate security measures to prevent your personal data from being accidentally lost, used or accessed in an unauthorised way, altered or disclosed. In addition, we limit access to your personal data to those employees, agents, contractors and other third parties who have a business need to know. They will only process your personal data on our instructions and they are subject to a duty of confidentiality.

We will only retain your personal data for as long as necessary to fulfil the purposes we collected it for, including for the purposes of satisfying any legal, accounting, or reporting requirements.

Under certain circumstances, you have rights under data protection laws in relation to your personal data. More details of these rights can be found within our Privacy Notice and at [www.morgan-price.com/privacy-policy]. These rights include: Request access to your personal data; Request correction of your personal data; Request erasure of your personal data; Object to processing of your personal data; Request restriction of processing your personal data; Request transfer of your personal data and Right to withdraw consent.

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 ◯
6.50.	Have you received the double vaccination for Covid-19? (you may be asked to show proof of this)	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)