Freedom Health Insurance

WORLDWIDE INDIVIDUAL APPLICATION FORM

(Continued Personal Medical Exclusions (CPME) & Continued Moratorium)

Each of the following parts should be completed by you and the completed form returned to: **Freedom Health Insurance, Bourne Gate, 25 Bourne Valley Road, Poole, BH12 1DY, United Kingdom.** Please use **BLOCK CAPITALS**.
Maximum age of entry is 70.

About you

Title:	(Dr/Mr/Mrs/Miss/Ms/Other):
Forename(s):	
Surname:	
Country of Residence:[2]	
When did you move there?	M M Y Y
Home country:	
Nationality on passport:	
Date of birth:	D D M M Y Y Y Y *(Maximum age of entry is 70)*
Occupation:	
Residential Address:[3]	Postcode:
Telephone numbers: *(inc. area code)*	Daytime: Evening:
Mobile number:	
E-mail address:	
Start date:	D D M M Y Y Y Y *(We cannot backdate cover under any circumstances)*
Correspondence Address: (if different from above)[3]	Postcode:
Telephone numbers: *(inc. area code)*	Daytime: Evening:
Mobile number:	
E-mail address:	

[2] Your country of residence will determine the value of Insurance Premium Tax that is added to your premium. Please speak to your adviser or contact us if you are unsure whether your premium will be affected.

[3] All correspondence will be sent to this address unless you have completed the correspondence address details above. It is very important that you tell us immediately of any changes to your contact or personal details. A change in circumstances could affect your cover.

About your family If you require further dependants to be covered please use a separate sheet

Surname:	Forename:
Date of birth (dd/mm/yyyy):	Nationality on passport:
Country of residence:	Relationship to you:
Occupation:	

continued overleaf>>

Surname:	Forename:
Date of birth (dd/mm/yyyy):	Nationality on passport:
Country of residence:	Relationship to you:
Occupation:	

Surname:	Forename:
Date of birth (dd/mm/yyyy):	Nationality on passport:
Country of residence:	Relationship to you:
Occupation:	

Surname:	Forename:
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Occupation:	

About your existing Private Medical Insurance cover

Do you have Private Medical Insurance at the moment? ☐ Yes ☐ No

Who is the insurer? ______ Renewal date? D D M M Y Y Y Y

The cover you require

Select the area of cover from the descriptions below based upon the location of your country of residence and your home country if you require the option of returning to your home country for treatment. Please see the eligibility section in the Policy Document for restrictions on US Citizens. You and your dependants must have the same area of cover.

Area 1 – Europe ☐ Area 2 – Worldwide excluding USA ☐ Area 3 – Worldwide ☐

Please indicate the plan type that you require. Please be sure that you have read the policy summary and details of cover before making your selection to ensure the product meets your requirements. Please contact us if you require copies of these documents.

			Category 1
Freedom Diamond	–	2,000,000 (€/£/$) overall limit	☐
Freedom Platinum	–	1,000,000 (€/£/$) overall limit	☐
Freedom Gold	–	750,000 (€/£/$) overall limit	☐
Freedom Silver	–	500,000 (€/£/$) overall limit	☐
Freedom Bronze	–	500,000 (€/£/$) overall limit	☐

Excess

Do you require an excess?

Yes ☐ No ☐

If Yes, please choose appropriate selection from the table:

Note: An excess does not apply to the Dental Benefit.

Excess Per Year €/£/$	Premium Reduction %	Please Select
Nil Excess	n/a	
50	5%	
100	10%	
250	15%	
500	20%	
1000	25%	
2500	30%	
5000	40%	

Doctor's/Medical Practitioner's Details

Please provide the contact details of your family doctor(s) or medical practitioner(s) who last treated you or your family in the last 2 years. Failure to provide this information may cause a delay in processing any claims submitted.

Name: Hospital/Clinic/Practice:

Address:

Postcode:

Telephone number: Fax number:

Email address:

About Your Underwriting Options

If you are able to answer "no" to the following questions, Freedom Health Insurance will offer continuation of cover from your previous insurer with no further underwriting.

If you have answered 'yes' to any of the questions, Freedom Health Insurance cannot offer continuation of cover from your previous insurer.

Please feel free to contact us to discuss your application.

If your current cover is on a Moratorium basis, we will transfer the start date of your previous Moratorium to the new plan.

If your current cover is on a Full Medical Underwriting basis, we will transfer any personal exclusions applied by your previous insurer and will not add further personal exclusions to the Freedom Worldwide plan (providing there has been no break in cover).

Please answer the questions below for every applicant:

Do you or any applicant have any consultations, investigations or treatment planned or pending in the next 12 months (NHS or Private)? ☐ Yes ☐ No

Have you or any applicant had any consultations, investigations or treatment in the last 12 months (NHS or Private)? ☐ Yes ☐ No

Have you or any applicant ever been treated for, diagnosed with, or advised that they have a heart condition, cancer or mental illness? ☐ Yes ☐ No

Declaration

I/We hereby apply to be covered under the selected Freedom Health Insurance Worldwide Policy together with the dependants listed in this application.

I/We declare that the statements made on this application form and any additional information supplied as part of this application is full and accurate. Failure to take reasonable care in answering any questions may result in claims being declined, your or any applicant's underwriting terms being changed or the cover being cancelled.

I/We shall read the Policy documents when I receive them and agree that I, and any other dependants included in this application, will be bound exclusively by the terms and conditions of the Policy. This agreement shall constitute the entire agreement between the parties.

I/We understand and accept the information provided in the underwriting section of the Worldwide brochure.

I/We understand that this application is subject to acceptance by Freedom Health Insurance and the medical information provided may result in a Policy endorsement(s) being applied or in some circumstances Freedom Health Insurance being unable to offer cover.

Please provide your previous Certificate of Insurance including endorsements.

Proposer's Signature: Date*: D D M M Y Y Y Y

* This must be dated (a) prior to the start date of the policy (b) not more than 30 days in advance of the start date

Note: A specimen copy of the policy is available on request. You are advised to keep a record (including copies and letters) of all information supplied to Freedom Health Insurance. A copy of this application will be supplied to you on request within three months of completion. Completion of this form should not be construed as acceptance of risk by Freedom Health Insurance.

Use of personal information

Personal information given on this application form will be used to administer your insurance policy. This includes underwriting your policy to decide what cover we can offer, administering your policy and handling claims, and helping to detect and prevent fraud.

Personal information may be shared with third parties that help us administer your policy. We may also share personal information with regulatory bodies, medical professionals involved in your treatment, and any broker acting on your behalf.

The way we use personal information is explained in our Privacy Policy which is on our website at **freedomhealthinsurance.co.uk/privacy-policy**. Alternatively you can ask us for a copy.

Marketing choices

☐ From time to time, we would like to tell you about products and services that may be of interest to you. If you would like to receive this information, please tick this box. You can unsubscribe at any time by contacting us at dataprotection@freedomhealthinsurance.co.uk.

Signature: Date: D D M M Y Y Y Y

Methods of payment

In which currency do you wish to pay your premiums?

Euros (€) ☐ GB Pounds (£) ☐ US Dollars ($) ☐

Methods of Payment

Annual Cheque	☐	Please attach the Annual Cheque payment
Credit Card or Annual Debit Card	☐	Please complete section 1 below
Direct Debit - Monthly or Annually	☐	Please complete a separate Direct Debit Mandate

1. Credit Card or Debit Card

Credit/Debit Card authorisation form (Mastercard and Visa only)

Please complete these instructions if you wish to pay premiums by Credit Card

Type of card: ☐ Mastercard ☐ Visa

Payment time period: ☐ Monthly ☐ Quarterly ☐ Annually

Name on card:

Card number:

Security number: Expiry date: M M Y Y Y Y

To Freedom Health Insurance
I authorise you, until further notice in writing, to charge my Mastercard/Visa account with unspecified amounts in respect of premiums as and when they become due.

Signed: Date: D D M M Y Y Y Y

Please complete these instructions if you wish to pay premiums by Annual Debit Card

Payment time period: ☑ Annually

Name on card:

Card number: Issue Number:

Security number: Valid from date: M M Y Y Y Y Expiry date: M M Y Y Y Y

To Freedom Health Insurance
I authorise you, until further notice in writing, to charge my Mastercard/Visa account with unspecified amounts in respect of premiums as and when they become due.

Signed: Date: D D M M Y Y Y Y

(For office use only)

Agent/Broker Name: Agent/Broker Number:

Freedom Health and Freedom Health Insurance are trading names of Freedom Healthnet Limited.
Freedom Healthnet Limited is authorised and regulated by the Financial Conduct Authority with the registration number 312282.
Registered address: Bourne Gate, 25 Bourne Valley Road, Poole, BH12 1DY. Company registration number: 04815524.