

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, County Gates House, 300 Poole Road, Poole, BH12 1AZ, 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 <i>(Maximum age of entry is 70)</i>
Occupation:		
Residential Address: ³		
		Postcode:
Telephone numbers: <i>(inc. area code)</i>	Daytime:	Evening:
Mobile number:		
E-mail address:		
Start date:	D D	M M Y Y Y Y <i>(We cannot backdate cover under any circumstances)</i>
Correspondence Address: (if different from above) ³		
		Postcode:
Telephone numbers: <i>(inc. area code)</i>	Daytime:	Evening:
Mobile number:		
E-mail address:		

²Your 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.

³All 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:	

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Country of residence:	Relationship to you:
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?

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%	

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:

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:

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:

Expiry date:

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:

(For office use only)

Agent/Broker Name:

Agent/Broker Number:

Freedom Health Insurance is a trading name of Freedom Healthnet Limited.

Freedom Healthnet Limited is authorised and regulated by the Financial Conduct Authority with the registration number 312282.

Registered address: County Gates House, 300 Poole Road, Poole, BH12 1AZ. Company registration number: 04815524.

