

Freedom Health Insurance

# WORLDWIDE INDIVIDUAL APPLICATION FORM (Full Medical Underwriting)

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 70.**

## About you

Title:	(Dr/Mr/Mrs/Miss/Ms/Other):	
Forename(s):		
Surname:		
Country of Residence: <sup>2</sup>		
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 70)</i>
Occupation:		
Residential Address: <sup>3</sup>		
		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) <sup>3</sup>		
		Postcode:
Telephone numbers: <i>(inc. area code)</i>	Daytime:	Evening:
Mobile number:		
E-mail address:		

<sup>2</sup>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.

<sup>3</sup>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:
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:
Date of birth (dd/mm/yyyy):	Nationality on passport:
Country of residence:	Relationship to you:
Occupation:	

## 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.

- 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:	<input type="text"/>		
Hospital/Clinic/Practice:	<input type="text"/>		
Address:	<input type="text"/>		
		Postcode:	<input type="text"/>
Telephone number:	<input type="text"/>	Fax number:	<input type="text"/>
Email address:	<input type="text"/>		

## Full Medical Underwriting Questionnaire

Benefits will not be payable for the treatment of any disease, illness or injury (whether or not diagnosed) for which the member has received medication, advice or treatment or of which the member has experienced symptoms prior to the date of acceptance of this application, or any related condition, unless fully disclosed on this application and accepted by us. Failure to provide full information may lead to the cancellation of the policy at a later date.

Please complete the following questionnaire for ALL members:

**A:** In the previous five years have you been diagnosed with, treated for or require any ongoing medication or tests for the following conditions:

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Cancer, tumours, lumps or growths?                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart disease, rheumatic fever, chest pain or circulatory problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood disorders?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Respiratory disorders?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Abdominal/Digestive disorders?                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Genito/urinary disorders?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Musculo-skeletal/nervous system disorders?                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Gynaecological disorders?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ear, nose & throat disorders?                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neurological or mental disorders?                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Skin disorders?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Eye disorders?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any operations, special investigations?                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**B:** Have you ever been treated or been recommended for treatment for the use of alcohol or drugs? Been advised to stop/reduce the amount of alcohol intake or ever been convicted of any drug related offences?

Yes  No

**C:** In the previous five years have you been advised to obtain treatment in a hospital or a clinic for any tests, x-rays, treatment or procedures which are not covered within any other questions on this medical questionnaire?

Yes  No

**D:** Are you aware of any tests, treatment, or specialist consultations that may be necessary within the following two years?

Yes  No

**E:** Do you have any disorders, deformities or disabilities which you have not disclosed in answers for any other questions on this medical questionnaire?

Yes  No

**F:** Have you ever been declined for any life or health insurance products (including refusal of a renewal)?

Yes  No

**G:** Have you undergone a surgical procedure or have reason to believe that a surgical procedure will be required in the future?

Yes  No

If any member to be insured on this application form answers "Yes" to any of the questions above please give full details.

Applicant name:	
Details of condition/symptom, medication and/or treatment received. Please include dates:	
Initial symptom date:	
Details of ongoing tests, medication and treatment required:	
Please include dates:	

Applicant name:	
Details of condition/symptom, medication and/or treatment received. Please include dates:	
Initial symptom date:	
Details of ongoing tests, medication and treatment required:	
Please include dates:	

Applicant name:	
Details of condition/symptom, medication and/or treatment received. Please include dates:	
Initial symptom date:	
Details of ongoing tests, medication and treatment required:	
Please include dates:	

Applicant name:	
Details of condition/symptom, medication and/or treatment received. Please include dates:	
Initial symptom date:	
Details of ongoing tests, medication and treatment required:	
Please include dates:	

**If you require additional space, please attach a separate sheet.**

## 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.

I authorise and request the doctor named in this application and/or any other medical establishment, including any other health professional who has attended me and any of my dependants included under this plan for treatment of a medical condition, to provide Freedom Health Insurance with the information they may need in connection with any claim made under this plan.

I accept, if I do not provide the information required in the medical practitioner section that, in the event of a claim being made by me, or any of my dependants included under this plan, which is deemed as being treatment for a pre-existing medical or related medical condition by Freedom Health Insurance, such claim will be rejected.

### 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](https://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](mailto:dataprotection@freedomhealthinsurance.co.uk).

Signature:

Date:

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

*continued overleaf>>*

## 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 your premiums by Annual Debit Card**

Annual Payment:

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 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.

