

# APPLICATION FORM A



(PLEASE USE BLOCK LETTERS)

## FOR ADMINISTRATION USE

Ref. <input type="text"/>	Policy Number <input type="text"/>	# <input type="text"/>
Date <input type="text"/>	<input type="text"/>	<input type="text"/>

## COMMENCEMENT DATE

I / we request that the policy commences from  0,  1 day  month  year

## POLICYHOLDER

First name(s) <input type="text"/>	Date of birth (day/month/year) <input type="text"/>
Family name(s) <input type="text"/>	Sex (M/F) <input type="checkbox"/>
Address <input type="text"/>	
Address <input type="text"/>	Postal Code <input type="text"/>
City <input type="text"/>	Telephone <input type="text"/>
Country <input type="text"/>	Fax <input type="text"/>
E-mail <input type="text"/>	

## IBAN NUMBER AND BIC NUMBER

If you would like us to transfer future reimbursements to your bank account, please state your IBAN number and BIC number

IBAN number <input type="text"/>
BIC number <input type="text"/>

## DEPENDANT 1

First name(s) <input type="text"/>	Date of birth (day/month/year) <input type="text"/>
Family name(s) <input type="text"/>	Sex (M/F) <input type="checkbox"/>

## DEPENDANT 2

First name(s) <input type="text"/>	Date of birth (day/month/year) <input type="text"/>
Family name(s) <input type="text"/>	Sex (M/F) <input type="checkbox"/>

## DEPENDANT 3

First name(s) <input type="text"/>	Date of birth (day/month/year) <input type="text"/>
Family name(s) <input type="text"/>	Sex (M/F) <input type="checkbox"/>

## DEPENDANT 4

First name(s) <input type="text"/>	Date of birth (day/month/year) <input type="text"/>
Family name(s) <input type="text"/>	Sex (M/F) <input type="checkbox"/>

\_\_\_\_\_

**COVER** – PLEASE CHOOSE COVER, CURRENCY AND DEDUCTIBLE BY TICKING THE RELEVANT BOXES

<input checked="" type="checkbox"/> Hospital Plan	<b>DEDUCTIBLE / CURRENCY</b>		
<input type="checkbox"/> Module 1 - Non-Hospitalisation Benefits	<input type="radio"/> Nil	<input type="radio"/> Nil	<input type="radio"/> Nil
<input type="checkbox"/> Module 2 - Medicine & Appliances	<input type="radio"/> EUR 350	<input type="radio"/> GBP 250	<input type="radio"/> USD 400
<input type="checkbox"/> Module 3 - Medical Evacuation & Repatriation	<input type="radio"/> EUR 1,050	<input type="radio"/> GBP 750	<input type="radio"/> USD 1,600
<input type="checkbox"/> Module 4A - Dental & Optical	<input type="radio"/> EUR 4,000	<input type="radio"/> GBP 2,750	<input type="radio"/> USD 5,000
<input type="checkbox"/> Module 4B - Dental & Optical	<input type="radio"/> EUR 8,000	<input type="radio"/> GBP 5,500	<input type="radio"/> USD 10,000
<b>Please note that the chosen currency is binding.</b>			

**PREMIUM PAYMENT**

Annual                       Semi-annual                       Quarterly

**REQUEST FOR PAYMENT FROM A BANK OR ANOTHER ADDRESS** (IF DIFFERENT FROM RESIDENTIAL ADDRESS)

Name(s) \_\_\_\_\_

Address \_\_\_\_\_ Account No. (if bank) \_\_\_\_\_

Address \_\_\_\_\_ Postal Code \_\_\_\_\_

City \_\_\_\_\_ Country \_\_\_\_\_

**REQUEST FOR PAYMENT BY INTERNATIONAL CREDIT CARD**

I / we wish to pay the premium via credit card. International Health Insurance danmark a/s will charge the credit card company directly.

American Express                       VISA                       Eurocard / MasterCard

JCB                       Diners

Card no. \_\_\_\_\_ Expiry date (m/y) \_\_\_\_\_ CVC code \* (except American Express) \_\_\_\_\_

\* CVC code: The last three digits after the card number on the back of the card or the last three digits in the signature field.

**Cardholder's data if cardholder and policyholder are not the same person:**

Name(s) \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_ Postal Code \_\_\_\_\_

City \_\_\_\_\_ Country \_\_\_\_\_

I also authorise International Health Insurance danmark a/s, until further notice in writing, to charge my credit card account with unspecified amounts in respect of my premium payments as and when these become due. The Company will inform me in advance of any premium adjustments.

**Please note that the Company will need the original, signed form to be able to charge the credit card.**

Cardholder's signature \_\_\_\_\_ Date \_\_\_\_\_

# MEDICAL QUESTIONNAIRE B



(PLEASE USE BLOCK LETTERS)

A Medical Questionnaire B must be completed for each person aged 10 years or over applying for cover, and also for any adopted children or any child under the age of 10 with a pre-existing condition or who is not in good health. All the Medical Questionnaires should be sent together with the Application Form A.

## FOR ADMINISTRATION USE

Ref. _____	Policy Number _____	# _____
Date _____	_____	

## APPLICANT (PLEASE UNDERLINE THE NAMES YOU WISH TO BE INDICATED ON YOUR INSURANCE CARD, MAX. 29 FIELDS)

First name(s) _____	Occupation _____
Family name(s) _____	
Date of birth (day/month/year) _____	Nationality _____
Sex (M/F) <input type="checkbox"/>	Height (cm) _____
	Weight (kg) _____

## OTHER INSURANCE

Do you have a health insurance with another company?	NO <input type="radio"/>	YES <input type="radio"/>
Company name _____	Policy Number _____	
Do you intend to continue being insured with another company?	NO <input type="radio"/>	YES <input type="radio"/>
Have you ever had an application for health or life insurance declined or accepted subject to exclusions or at a premium above the insurer's standard rates? NO <input type="radio"/> YES <input type="radio"/> If yes, please enclose complete information.		

## MEDICAL HISTORY

If you have or previously have had any of the following illnesses / disorders, please tick the appropriate box and provide details. If you have any additional comments, please state details under "Further Remarks" (question 8). All questions must be answered.

<p><b>a)</b> Tumours: Benign <input type="radio"/> Malignant <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>b)</b> Migraine <input type="radio"/> Neurological Disorders <input type="radio"/></p> <p>Epilepsy <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>c)</b> Mental Illnesses <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>d)</b> Eye Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>e)</b> Asthma <input type="radio"/> Allergies <input type="radio"/></p> <p>Pulmonary Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>f)</b> Cardiovascular Diseases <input type="radio"/></p> <p>Arterial Hypertension <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>g)</b> Liver Diseases <input type="radio"/> Pancreas Diseases <input type="radio"/></p> <p>Stomach Diseases <input type="radio"/> Intestinal Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>h)</b> Diabetes <input type="radio"/> Other Hormone Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p>	<p><b>i)</b> Urinary Tract and Kidney Diseases <input type="radio"/></p> <p>Diseases of the Sexual Organs <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>j)</b> Rheumatism <input type="radio"/></p> <p>Muscle, Joint or Bone Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>k)</b> Back Problems <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>l)</b> Skin Diseases <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>m)</b> Cosmetic Operations <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>n)</b> Any other diseases, disorders, illnesses <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>o)</b> Have you ever had any fertility treatment? YES <input type="radio"/> NO <input type="radio"/></p> <p>Details _____</p> <p><b>p)</b> Have you been tested for HIV-antibodies? YES <input type="radio"/> NO <input type="radio"/></p> <p>If YES, what was the result: HIV-Positive <input type="radio"/> HIV-Negative <input type="radio"/></p>
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\_\_\_\_\_

1. Do you take or have you taken any kind of medicine on a regular basis? YES  NO

If YES, please state type and daily dosage \_\_\_\_\_

Diagnosis \_\_\_\_\_ Expense per month \_\_\_\_\_

2. Have you ever been hospitalised or received treatment for any illness? YES  NO

If YES, please state name of hospital / clinic / doctor. (You can use Further Remarks (question 8) if you have more info.)

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail \_\_\_\_\_

Diagnosis \_\_\_\_\_ Dates \_\_\_\_\_

3. Do you suffer from any side effects or consequences of the above conditions? YES  NO

If YES, please enclose complete information.

4. Do you use spectacles or contact lenses – if so please indicate strength \_\_\_\_\_

5. For women only: are you currently pregnant? YES  NO

6. Family Doctor

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail \_\_\_\_\_

7. Do you have additional medical information? YES  NO

All relevant up-to-date medical reports should be enclosed in the event of any pre-existing medical conditions.

8. Further Remarks, if any: \_\_\_\_\_

\_\_\_\_\_

9. Applicant's signature

If your state of health changes after the application has been signed and before the Company has approved the insurance, the Company must be notified immediately of such a change. In this case and in case of other pre-existing conditions, you are requested to enclose any relevant up-to-date medical reports.

I, the undersigned, solemnly declare that I and any co-insured children are in completely good health and do not, apart from the aforementioned, suffer or have suffered from any recurring illness or physical debility. I have answered in accordance with the truth and hereby give International Health Insurance danmark a/s permission to seek such information from treating doctors and hospitals concerning my / our state of health as the Company deems necessary.

If supplementary insurance for dental treatment is required: I am / we are not under or about to undergo dental treatment, and hereby give the Company permission to seek information from treating dentists concerning my / our dental status or any dental treatment.

Date (day/month/year) \_\_\_\_\_ Signature \_\_\_\_\_