

COMPANY APPLICATION - PART 1

To be completed by the Employer (the Policyholder)



(PLEASE USE BLOCK LETTERS)

FOR ADMINISTRATION USE

Ref. _____	Agreement Number _____	Producer ID _____
Date _____	_____	

COMMENCEMENT DATE

The company requests that this agreement commences from 01 day month year

COMPANY INFORMATION

Company Name _____	Company Registration Number _____
Address _____ _____ _____	
City _____	Postal Code _____
Country _____	State _____
Telephone _____	Fax _____
E-mail _____	
Web Address _____	

EMPLOYEE GROUPS TO BE INCLUDED IN THE AGREEMENT

If the company has different needs for different organisational groups in the company (e.g. Board of Directors, executives, blue-collar), IHI may offer to accept a split up into different combination groups. For each combination group a PART 2 and 3 of the Company Application must be completed to specify the exact cover needed for the employees in each combination group. (Please feel free to contact your IHI contact person for help in completing this form).

Total number of employees expected to be included under this agreement _____

Does the company need different combinations of cover Yes No A split up must be pre-approved by IHI

Number of combinations _____

Combination group 1 _____

Combination group 2 _____

Combination group 3 _____

Combination group 4 _____

Combination group 5 _____

Combination group 6 _____

Combination group 7 _____

Combination group 8 _____

DETAILS OF COMPANY CONTACT PERSON (RESPONSIBLE)

Contact person

Title _____ Preferred language of communication _____

Address (only if different from the above company address)

City _____ Postal Code _____

Country _____ State _____

Telephone _____ Fax _____

E-mail _____

DETAILS OF COMPANY CONTACT PERSON (DAILY ADMINISTRATOR)

Contact person

Title _____ Preferred language of communication _____

Address (only if diferent from company adresse)

City _____ Postal Code _____

Country _____ State _____

Telephone _____ Fax _____

E-mail _____

COMPANY APPLICATION - PART 2

To be completed by the Policyholder (The Employer)



(PLEASE USE BLOCK LETTERS)

Please complete a separate sheet for each combination group

FOR ADMINISTRATION USE

Ref. _____

Agreement Number

Producer ID

Date _____

COMPANY INFORMATION (AS STATED IN PART 1)

Company name

COMBINATION GROUP

Combination Number _____*

Name of Combination _____*

Number of Employees in this Combination _____

*Please take this information from PART 1

CHOICE OF COVER

Please choose Modules

- Module 1 - Hospitalisation & Inpatient Treatment* Module 2 - Outpatient Treatment
 Module 3 - Medicine & Appliances Module 4 - Medical Evacuation
 Module 5 - Rehabilitation & Nursing Module 6 - Dental & Optical

*Module 1 is mandatory

MEDICAL UNDERWRITING METHODS

Please note that, if the employees are underwritten individually you cannot choose MHD for the dependant.

Please have each of your employees and their dependants to be insured fill in the relevant forms.

Employees:

- Individual (Form A & B) MHD (Form A) Other (to be agreed with IHI)

Dependant:

- Individual (Form A & B) MHD (Form A) Other (to be agreed with IHI)

CHOICE OF CURRENCY AND DEDUCTIBLE

USD Nil 175 1,750

EUR Nil 150 1,500

GBP Nil 100 1,000

Please note that the chosen currency is binding

EXTENSION OF COVER

- Worldwide Add-On Option: Yes No
 Critical Illness Yes No (Requires special underwriting - in accordance with IHI)
 Personal Accident Yes No (Requires special underwriting - in accordance with IHI)
 Security Monitor Yes No

Part 2, page 1 of 1

COMPANY APPLICATION - PART 3

To be completed by the Policyholder (The Employer)



(PLEASE USE BLOCK LETTERS)

FOR ADMINISTRATION USE

Ref. _____	Agreement Number _____	Producer ID
Date _____	_____	

INVOICE INFORMATION (AS STATED IN PART 1)

Company Name

Address

City _____ Postal Code _____

Country _____ State _____

PREMIUM PAYMENT

- Annual
- Semi-annual
- Quarterly
- Monthly*

*To be eligible for the monthly payment option, the company must be able to qualify for an automated payment procedure, e.g. a pre-arranged bank transfer. Must be pre-approved by IHI.

PAYMENT OPTION: BANK OR ALTERNATIVE INVOICE ADDRESS (IF DIFFERENT FROM THE ABOVE COMPANY ADDRESS)

Name(s)

Account No. (if bank)

Address

City _____ Postal Code _____

Country _____ State _____

PAYMENT OPTION: INTERNATIONAL CREDIT CARD

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 (except American Express)
_____	____ ____	____ ____

Cardholder's data:

Name(s)

Address

City	Postal Code
_____	_____

Country	State
_____	_____

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

Cardholder's signature _____ Date _____

BANK IDENTIFICATION NUMBER (IBAN, ABA OR SWIFT)

In case we need to transfer any amount to your bank account in the future, please state your Bank ID number
