



Please complete this application form and return it to us, either by electronic mail, fax or post. See our contact information at the end of this form. Please complete this form in BLOCK CAPITALS, either by electronic mail, fax or post.

## SECTION A

### APPLICATION DETAILS

Please complete this section for all persons to be covered under the policy, including the main policyholder and any dependents.

### YOUR PLAN

Which plan are you applying for?

Silver

Gold

Platinum

### POLICYHOLDER

You must notify us of any change of contact details so we can ensure that correspondence reaches you.

Title  First Name  Other Initials  Surname

Gender (please tick)  Male  Female  Date of birth (DD/MM/YYYY)

Occupation

Correspondence address

Daytime telephone number  (Country code – Number)

Mobile telephone number  (Country code – Number)

Fax  (Country code – Number)

Email address

Nationality  (What is the nationality of the primary passport that you hold?)

Location  (The country in which you live/will live for the majority of your time for the period of cover)

Height: Feet  Inches  Centimetres  Weight: Stones  Pounds  Kilogrammes

Have you smoked, or used tobacco or nicotine replacement products in the last 12 months?  Yes  No

If Yes, how many per day?  Less than 20 per day  20 or more per day

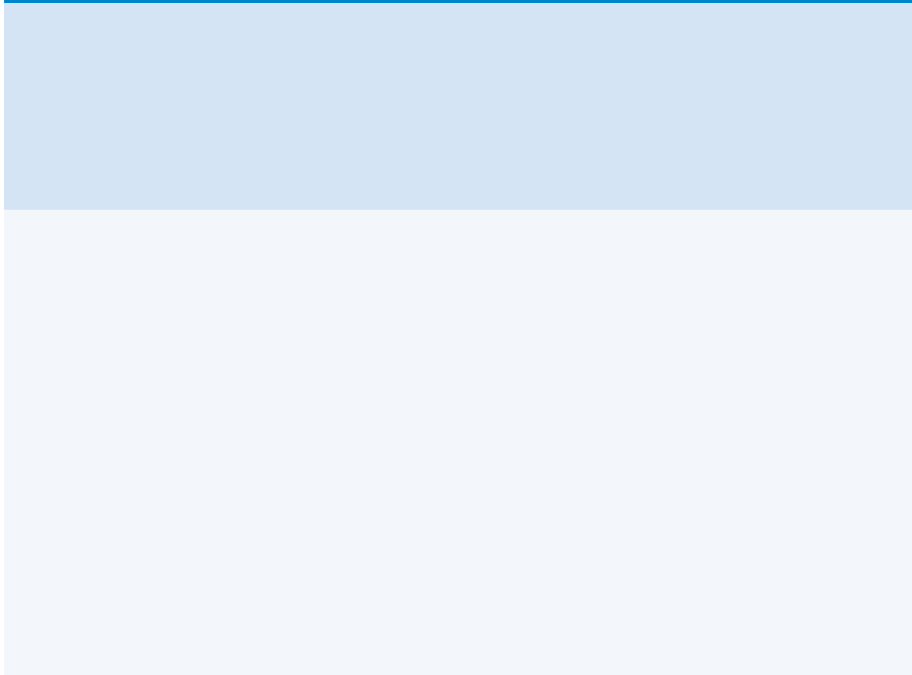
## SECTION B

### APPLICANT DETAILS

Where do you want your cover?	Worldwide	Worldwide excluding USA
When do you want your cover to begin? (DD/MM/YYYY)		

### INTERNATIONAL MEDICAL INSURANCE PLAN

Choose your deductible	\$0	\$375	\$750	\$1,500	\$3,000	\$7,500	\$10,000
	€0	€275	€550	€1,100	€2,200	€5,500	€7,400
	£0	£250	£500	£1,000	£2,000	£5,000	£6,650
Then, select your co-insurance percentage							



7	Brain or neurological disorders e.g. multiple sclerosis, epilepsy or seizures, stroke, migraines, recurring or severe headaches, meningitis, shingles or nerve pain.
8	Skin problems e.g. eczema, acne, moles, rashes, allergic reactions, cysts, dermatitis or psoriasis
9	Blood, infective or immune disorders e.g. high cholesterol, anaemia, malaria, HIV or systemic lupus erythematosus.
10	Urinary or reproductive disorders e.g. urinary tract infections, kidney problems, broids, painful, irregular or heavy periods, fertility problems, polycystic ovarian syndrome, endometriosis, testicular or prostate problems.
11	Anxiety, depression, psychiatric or mental health issues including eating disorders, post-traumatic stress disorder, alcohol or drug issues.
12	Ear, nose, throat, eye or dental problems e.g. ear infections, sinus problems, tonsils and adenoids

## SECTION E

### ADDITIONAL HEALTH INFORMATION

Please tell us more if you have answered 'Yes' to any questions in Section D. If you are unsure if any details are relevant, please include them anyway. If you run out of space, please use a separate sheet.

	Section D Question Number	The name of the illness or medical problem. Where applicable state the area of the body affected (e.g. left arm, right foot).	When did the symptoms occur and when did you last have symptoms?	What treatment was provided? (Include details of medication and dates of when treatment started and ended.)	What is the current status of the illness or medical problem? (E.g. ongoing, complete, recovery, recurrent or likely to recur.)
POLICYHOLDER					
DEPENDANT 1					
DEPENDANT 2					
DEPENDANT 3					
DEPENDANT 4					





Please return your fully completed form by post, email or fax to:

International Travel Insurance Group  
**18 Shipyard Drive, Suite 2A**  
**Hingham, MA 02043**

[Info@Internationalinsurance.com](mailto:Info@Internationalinsurance.com)

USA Toll-Free: 1-877-758-4881  
Direct/Int'l: +1 617-500-6738

Fax: 1 617-505-1484

[www.internationalinsurance.com](http://www.internationalinsurance.com)