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 CAPIn5C /Span <<>>BDC 0.02 Tw , either by electronic mail, fYe sa58am a44a3 [552C C8

# 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 | 65,000 | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 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 aden/Span .9(ohoicT1_1(ob inf9(oglauconsilacnewistri5(es)10es)12(oblems.)]TJ EMC an <> /T1_ f 0.022 626 Td (Please)14s | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | | | | | |
| | | ☐ | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ | ☐ |

## 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 a ected (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

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

Fax: 1 617-505-1484

www.internationalinsurance.com