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

# 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 ◯ |
|---|---|---|

## DEPENDANT 1

| Title | First Name | Other Initials | Surname |
|---|---|---|---|
| | | | |

| Relationship to policyholder | | Gender (please tick) | Male ◯ | Female ◯ |
|---|---|---|---|---|
| Date of birth (DD/MM/YYYY) | | Occupation | | |

| 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 ◯ |
|---|---|---|

## DEPENDANT 2

| Title | First Name | Other Initials | Surname |
|---|---|---|---|
| | | | |

| Relationship to policyholder | | Gender (please tick) | Male ◯ | Female ◯ |
|---|---|---|---|---|
| Date of birth (DD/MM/YYYY) | | Occupation | | |

| 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 ◯ |
|---|---|---|

## DEPENDANT 3

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Title | | First Name | | Other Initials | | Surname | |
| Relationship to policyholder | | Gender (please tick) | Male ◯ | Female ◯ | | | |
| Date of birth (DD/MM/YYYY) | | Occupation | | | | | |
| 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 ◯ | | | | | |

## DEPENDANT 4

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Title | | First Name | | Other Initials | | Surname | |
| Relationship to policyholder | | Gender (please tick) | Male ◯ | Female ◯ | | | |
| Date of birth (DD/MM/YYYY) | | Occupation | | | | | |
| 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 cost share percentage | | | | **No cost share** ◯ | **10%** ◯ | **20%** ◯ | **30%** ◯ |
| Choose your out of pocket maximum (This is the maximum amount of cost share under International Medical Insurance plan you must pay in the event of a claim or claims per period of cover) | | | | | | **$2,000** ◯ | **$5,000** ◯ |
| | | | | | | **€1,480** ◯ | **€3,700** ◯ |
| | | | | | | **£1,330** ◯ | **£3,325** ◯ |

## OPTIONAL BENEFITS

Do you wish to upgrade your plan with any of the following options

**International Outpatient**

**Yes** ◯ **No** ◯

**Deductible**

| | | | | |
|---|---|---|---|---|
| **$0** ◯ | **$150** ◯ | **$500** ◯ | **$1,000** ◯ | **$1,500** ◯ |
| **€0** ◯ | **€110** ◯ | **€370** ◯ | **€700** ◯ | **€1,100** ◯ |
| **£0** ◯ | **£100** ◯ | **£335** ◯ | **£600** ◯ | **£1,000** ◯ |

**Cost share after deductible** (a $3,000 / €2,200 / £2,000 out of pocket maximum is applied to cost shares on International Outpatient)

| | | | |
|---|---|---|---|
| **No cost share** ◯ | **10%** ◯ | **20%** ◯ | **30%** ◯ |

| | | |
|---|---|---|
| **International Medical Evacuation** | **Yes** ◯ | **No** ◯ |
| **International Health and Wellbeing** | **Yes** ◯ | **No** ◯ |
| **International Vision and Dental** | **Yes** ◯ | **No** ◯ |

Please note that International Outpatient, International Medical Evacuation, International Health and Wellbeing and International Vision and Dental plans can only be purchased in conjunction with the International Medical Insurance plan.

Please note that each plan chosen will apply to all dependants.

Your plan selection can only be amended at policy renewal. Should you wish to increase your level of cover at renewal, full medical underwriting and waiting periods may apply and an additional premium amount will be payable.

# SECTION C

## CONFIDENTIAL HEALTH QUESTIONNAIRE

**You now need to provide information about the medical history of yourself and each person named in Section A. If you tick Yes to a question, please provide full details in Section D.**

Once you've done this we can finalise your application. It may help to have any relevant medical documentation to hand when you are filling out this form. Depending on the medical history, we might need some further information before we can finalise your cover.

Please read the following questions very carefully. Please take reasonable care to answer all questions honestly and fully. Careless misrepresentation could result in Cigna reducing the amount of any claims proportionately; whereas deliberate or reckless misrepresentation could result in Cigna rejecting claims, and/or cancelling cover. If you need help completing your application, please contact us.

If you are unsure about the answer to any question you should make the enquiries necessary to allow you to provide an accurate answer.

## YOUR PLAN

| | **Has any applicant received treatment, tests or investigations for, or been diagnosed with, or had any signs or symptoms of:** | POLICYHOLDER | | DEPENDANT 1 | | DEPENDANT 2 | | DEPENDANT 3 | | DEPENDANT 4 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **Diabetes and other endocrine (glandular) disorders** e.g. any thyroid disorder, weight problems, gout, pituitary or adrenal gland conditions? | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| 2 | **Heart or circulatory disorders** e.g. chest pain, heart attack, high blood pressure, vascular disease, coronary artery disease, angina, irregular heartbeat, aneurysm or heart murmur. | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| 3 | **Cancer, tumours or growths** including polyps, cysts or breast lumps. | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| 4 | **Muscle or skeletal problems** e.g. back pain, whiplash, arthritis, joint pain or problems, gout, fractures, cartilage, tendon or ligament problems. | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| 5 | **Asthma, allergies, breathing or respiratory disorders** e.g. chest infections, pneumonia, bronchitis, shortness of breath, rhinitis, TB, emphysema or chronic obstructive pulmonary disease. | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| 6 | **Gall bladder, stomach, intestinal, gastric or liver problems** e.g. irritable bowel disease, colitis, Crohn's disease, gastric or peptic ulcers, reflux, indigestion, heartburn, gall stones, hernia, haemorrhoids or hepatitis. | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| 7 | **Brain or neurological disorders** e.g. multiple sclerosis, epilepsy or seizures, stroke, migraines, recurring or severe headaches, meningitis, shingles or nerve pain. | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| 8 | **Skin problems** e.g. eczema, acne, moles, rashes, allergic reactions, cysts, dermatitis or psoriasis | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| 9 | **Blood, infective or immune disorders** e.g. high cholesterol, anaemia, malaria, HIV or systemic lupus erythematosus. | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| 10 | **Urinary or reproductive disorders** e.g. urinary tract infections, kidney problems, fibroids, painful, irregular or heavy periods, fertility problems, polycystic ovarian syndrome, endometriosis, testicular or prostate problems. | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| 11 | **Anxiety, depression, psychiatric or mental health issues** including eating disorders, post-traumatic stress disorder, alcohol or drug issues. | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| 12 | **Ear, nose, throat, eye or dental problems** e.g. ear infections, sinus problems, tonsils and adenoids, cataracts, glaucoma, wisdom teeth problems. | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| | **Please also answer the following questions:** | | | | | | | | | | |
| 13 | Does anyone have any illness, condition or symptom not already mentioned? Please include details of any known or suspected issues whether or not medical advice has been sought or a diagnosis reached. | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ |
| 14 | Does anyone take any medication, receive any treatment of any kind or expect to have a review or follow up for any current or past medical problem not already mentioned? | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ | Yes ◯ | No ◯ |

## SECTION D

### ADDITIONAL HEALTH INFORMATION

Please tell us more if you have answered 'Yes' to any questions in Section C. 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 C 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** | | | | | |

# SECTION E

## DECLARATION FOR ALL CUSTOMERS

I hereby declare that I have taken reasonable care to answer all questions accurately, honestly and completely. I acknowledge that if I do not answer all questions accurately and completely as a result of my carelessness that could result in Cigna reducing the amount of any claims proportionately. I also acknowledge that if I deliberately or recklessly provide inaccurate or incomplete information in answer to questions that could result in Cigna rejecting claims, and/or cancelling cover.

The duty to answer our questions accurately, honestly and completely applies in respect of each person who is covered by this policy. Although failure to fulfil this duty by one covered person may affect coverage or payment of their claims, it will not affect coverage or payment of claims in relation to any other covered person, unless that person has also made careless, deliberate or reckless misrepresentations in relation to our questions. I warrant and represent that I have each covered person's consent to disclose the personal information, including the sensitive personal information (e.g. medical information) contained in this form to you. I confirm that each covered person is aware of their duty to take reasonable care to answer your questions accurately, honestly, completely and to the best of their knowledge.

**(Please note that if you are declaring the above on another person's behalf, it is your obligation to keep evidence of the consent you are providing hereto of your covered family members' actual declarations and consents.)**

I hereby propose to Cigna for cover to begin on the cover date or such other agreed date. In the event that it is found that I, or any covered person, have deliberately or recklessly provided any information which is false or inaccurate, Cigna may void the contract of insurance as it relates to me or the covered person and refuse all claims and need not return any premiums paid in, except for where it would be unfair for the premiums to be retained. I have carefully read, understood and agree to abide by the Policy Rules and Customer Guide as they form part of my contract of insurance.

| | |
|---|---|
| **Signature** | |
| **Date (DD/MM/YYYY)** | |

If you are signing for, or on behalf of, the Main policyholder please sign below where you are warranting and representing to us that you have read the above declaration and have the authority to enter into this application:

| | | | | |
|---|---|---|---|---|
| **Signature** | | | | |
| **Date (DD/MM/YYYY)** | | | | |
| Select the relationship to main policyholder | **Broker** ◯ | **Agent** ◯ | | |
| | **Other (please specify)** ◯ | | | |

## ADDITIONAL DECLARATION APPLICABLE FOR HONG KONG AND SINGAPORE NATIONALS LIVING IN THEIR HOME COUNTRY

If you are a customer whose nationality is either Hong Kong or Singaporean and you are resident and living in Hong Kong or Singapore under this insurance policy then under your local law and regulation you might be entitled to have a Needs Analysis conducted of your particular insurance needs and/or a Customer Protection form completed. I consent to purchase this insurance product without a Needs Analysis or a completed Customer Protection form.

| | |
|---|---|
| **I confirm and agree with the above declaration**<br><br>Policies issued by Cigna Europe Insurance Company S.A-N.V. Singapore Branch are covered under the Policy Owners' Protection Schemes Act 2011, Act No. 15 of 2011 of Singapore (the "Act") up to the limits prescribed by the Act. | ☐ |
| **Main policyholder's signature** | |
| **Date (DD/MM/YYYY)** | |

If you are signing for, or on behalf of, the Main policyholder please sign below where you are warranting and representing to us that you have read the above declaration and have the authority to enter into this application:

| | | | | |
|---|---|---|---|---|
| **Signature** | | | | |
| **Date (DD/MM/YYYY)** | | | | |
| Select the relationship to main policyholder | **Broker** ◯ | **Agent** ◯ | | |
| | **Other (please specify)** ◯ | | | |

## FRAUD NOTICE

Any person who, dishonestly and with intent to make a gain for himself or cause loss to another, or to expose another to a risk of loss: (1) makes an application for insurance or makes a claim under a policy containing any information he knows to be untrue or misleading ; or who (2) in making an application for insurance or a claim under a policy dishonestly and with intent to make a gain for himself or cause loss to another, or to expose another to a risk of loss fails to disclose information which has been asked for, commits fraud. We will investigate any claims or applications for insurance which we have grounds to believe may be fraudulent. Committing fraud may result in your policy being terminated and any claims you make under not being paid. We may, for the purposes of the detection and prevention of fraud, share information relating to suspected fraud with other insurance companies and/or with law enforcement authorities.

## HOW WE USE YOUR INFORMATION

We will collect, use, store, and disclose your personal information, including sensitive information (in particular, information relating to your medical history and any medical treatment you may have or have had), in accordance with relevant data protection legislation. We collect and will use your personal information, including sensitive information, for the purpose of carrying out our obligations under this plan.

We may share your information, including sensitive information, with other Cigna companies and authorised healthcare providers, where necessary to carry out our obligations under this plan. This statement also applies to personal information of any beneficiaries detailed on this application form.

You have the right to request a copy of your personal information held by us, and beneficiaries under your policy have the right to request a copy of personal information we hold about them. We may charge a fee to provide this information.

| | |
|---|---|
| **I acknowledge the collection, use and disclosure of my personal and special category data by Cigna for the purposes required by the contract of insurance I have entered into.** | ☐ |

## SPECIAL OFFERS, PROMOTIONS, PRODUCTS AND SERVICES

We would like to keep in touch with you to keep you updated about our special offers, promotions, products and services which we think will interest you.

| | | | | |
|---|---|---|---|---|
| If you would like to receive this information, please tick here | ☐ | | | |
| If yes, how would you like us to contact you? | **Email** | ☐ | **Telephone** | ☐ |

IQ Med Broker Romania
EU10470598
contact@iqmed.ro

## SECTION F

### PAYMENT DETAILS

**Your card details will be securely disposed of once your application has been processed.**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Payment currency | **US Dollar** | ○ | **Euro** | ○ | **Sterling** | ○ | | | | | |
| Payment frequency | **Monthly** | ○ | **Quarterly** | ○ | **Annually** | ○ | | | | | |
| Payment method | **Credit/debit card** | ○ | **Bank wire transfer (Annual payment only)** (We will call you on receipt of your application to provide the relevant details) | ○ | | | | | | | |
| Credit/debit card number | | | | | | | | | | | |
| Type of card | **MasterCard** | ○ | **Visa** | ○ | **Visa Debit** | ○ | **Visa Electron** | ○ | **Delta** | ○ | |
| | **American Express** | ○ | **Solo** | ○ | **Maestro (UK Domestic)** | ○ | **Maestro (International)** | ○ | | | |
| Name as it appears on the card | | | | | | | | | | | |
| Start date of the card (MM/YY) | | | Expiry date of the card (MM/YY) | | | | | | | | |
| Security code (This is the 3 digit number on the reverse of most cards. For American Express cards, this is the 4 digit number found on the front of the card on the right hand side) | | | | | | | | | | | |
| Please confirm that the payment card is that of the policyholder? | **Yes** | ○ | **No** | ○ | | | | | | | |
| If the cardholder is not the policyholder, please state the relationship to the policyholder | **Other beneficiary** | ○ | **Employer** | ○ | | | | | | | |
| | **Spouse/partner** | ○ | **Family member** | ○ | **Other** | ○ | | | | | |
| Date of birth of cardholder (DD/MM/YYYY) | | | | | | | | | | | |
| Nationality of cardholder | | | | | | | | | | | |
| Is the billing address the residence address you have provided for your policy? | Yes | ○ | No | ○ | | | | | | | |
| If no, please provide the full billing address | | | | | | | | | | | |

**Credit card authorisation:** I authorise Cigna to charge my credit/debit card account with my healthcare premium (of which I will be notified upon acceptance of cover/renewal). This will continue until the instruction is cancelled, and I will provide written notice to Cigna according to my Policy Rules documentation.

| | |
|---|---|
| Cardholder's signature | |
| Date (DD/MM/YYYY) | |

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

**Cigna Global Health Options**
**The Grosvenor Building**
**72 Gordon Street**
**Glasgow**
**G1 3RS**
**United Kingdom**

IQ Med Broker Romania
EU10470598
contact@iqmed.ro

**cgi.sales@cigna.com**

**Together, all the way.℠**

Cigna®



CGHO Application Form EN Broker 05/2018