

Broker's stamp

Policy number

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Effective date  
*(Cover may not be backdated)*

Return completed form to your  
Financial Advisor or Broker or to:  
MediCare International Limited  
The Matrix, 9 Aldgate High Street  
London, EC3N 1AH, England  
Telephone: +44 (0) 20 7204 3700  
Facsimile: +44 (0) 20 7204 3746  
Email: medicare@medicare.co.uk  
Website: www.medicare.co.uk

# Group Employee Application Form

PLEASE COMPLETE IN BLOCK CAPITALS AND TICK RELEVANT BOXES

## Your personal details

Company name: \_\_\_\_\_

Employee name: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Postcode: \_\_\_\_\_ Country: \_\_\_\_\_

Occupation: \_\_\_\_\_ Nationality: \_\_\_\_\_

(Which will be used to establish the Home Country of the Applicant and Dependants)

## Cover required - As selected by your employer

International Plan	<input type="checkbox"/>	Area 1 Worldwide ex USA, Canada & Caribbean	<input type="checkbox"/>	Voluntary Excess Option	
International Plus Plan	<input type="checkbox"/>	Area 2 Worldwide	<input type="checkbox"/>	£500/\$850/€650	<input type="checkbox"/>
Executive Plan	<input type="checkbox"/>			£1,000/\$1,700/€1,300	<input type="checkbox"/>
Executive Plus Plan	<input type="checkbox"/>			£5,000/\$8,500/€6,500	<input type="checkbox"/>
Waive Outpatient Excess*	<input type="checkbox"/>			£10,000/\$17,000/€13,000	<input type="checkbox"/>

\*applicable to International Plus, Executive and Executive Plus Plans only

## Persons to be insured

Surname	First Names	Date of Birth	Sex	Country of Residence	Area of Cover Required
<i>Applicant:</i>					
<i>Spouse/Partner:</i>					
<i>Child:†</i>					
<i>Child:†</i>					
<i>Child:†</i>					
<i>Child:†</i>					

†Up to the age of 18, or 24 if still in full-time education. Evidence will be required.

## Your Doctor's contact details

Please give details of the doctor(s) who is(are) most familiar with your/your dependants medical history

Doctor's Name: _____	Doctor's Name: _____
Address: _____	Address: _____
Telephone No: _____	Telephone No: _____

## Declaration

I hereby apply to be enrolled in the Plan together with the persons to be insured listed above. I declare to the best of my knowledge and belief that the information given in this application is true and complete. I acknowledge on behalf of all the persons to be insured that benefits will not apply to treatment arising from any Pre-Existing Conditions, as more fully defined in the Plan Rules. This does not apply if you are insured under a Group Plan where the Pre-Existing Condition exclusion has been waived. It is agreed that this declaration and the information given in this application shall form the basis of the contract(s) between the Insured Person(s) and the Insurer.

Signature of applicant: \_\_\_\_\_ Date: \_\_\_\_\_

(On behalf of all persons to be insured)

## Data Protection Act

The information you have provided will become part of the personal data held by MediCare International Limited and will be used for the provision and administration of insurance products and services. MediCare International Limited may disclose your personal data to other insurance companies for underwriting, claims handling and fraud prevention purposes. In addition, we may seek information from other insurance companies to check the answers you have provided. Full details of MediCare International Limited's use of personal data appear in the Data Protection Register.