MORATORIUM APPLICATION FORM
2017 – 2018

# MEDICARE LONG-TERM INTERNATIONAL HEALTH PLAN

Insurance made easy.

# MEDICARE LONG-TERM INTERNATIONAL HEALTH PLAN

## MORATORIUM APPLICATION FORM 2017 - 2018

Insurance made easy.

For Office Use: Inception Date: d d / m m / y y y y Policy Number: Broker Code:

## HOW TO APPLY

1

1. Complete all sections in full and sign the declaration ensuring you have understood all aspects of the application.
2. Complete the Method of Payment details.
3. Submit the application form to APRIL International UK.

Insurance Premium Tax will be added to the premium if you and/or your dependants are resident in a country where we are required to charge tax.

All correspondence from us (your Certificate of Insurance, Policy Guide, Claims Reimbursements etc.) will be sent via email. Your Insurance Identification Card will be sent to you by post.

## PLEASE WRITE IN CAPITAL LETTERS

## YOUR PERSONAL DETAILS

2

Title: ○ Mr ○ Mrs ○ Ms ○ Miss ○ Other..........................................

Surname: ........................................................................................ First Name(s): ........................................................................................

Address: ........................................................................................

........................................................................................

City: ........................................................................................ State/Region/County: ........................................................................................

Postcode: Country: ........................................................................................

Telephone: Email: ........................................................................................

Occupation: ........................................................................................

Nationality*: ........................................................................................

*used to establish the Home Country of the Applicant and Dependants

## COVER REQUIRED (please tick)

3

**Plans**

○ International Plan

○ International Plus Plan

○ Executive Plan

○ Executive Plus Plan

○ Waive Outpatient Excess
(applicable to the Executive Plus Plan only)

**Area of Cover**

○ Area 1: Worldwide excluding USA & Caribbean

○ Area 2: Worldwide

**Voluntary Excess Options**

○ £100/$200/€150

○ £250/$500/€375

○ £500/$1,000/€750

○ £1,000/$2,000/€1,500

○ £2,500/$5,000/€3,750

○ £5,000/$10,000/€7,500

○ £10,000/$20,000/€15,000

## REQUIRED START DATE (please tick)

4

○ On Acceptance ○ Other (please specify) d d / m m / y y y y

5

## PERSONS TO BE INSURED

Please give details of all the persons to be covered under the plan

| | Surname | First Names | Date of Birth* | Gender | Country of residence | Area of cover |
|---|---|---|---|---|---|---|
| Applicant | | | | | | |
| Spouse/Partner | | | | | | |
| Child† | | | | | | |
| Child† | | | | | | |
| Child† | | | | | | |
| Child† | | | | | | |

†Up to the age of 18, or 24 if still in full-time education. Evidence will be required. *Applicants aged 65 years and over are required to complete a full medical questionnaire.

6

## DOCTOR DETAILS

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

Doctor's Name:..........................................................................................

Address: ..................................................................................................

..................................................................................................

City: ..................................................................................................

State/Region/County: ..................................................................................

Postcode: ☐☐☐☐☐☐☐

Country: ..................................................................................................

Telephone: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Doctor's Name: ..........................................................................................

Address:..................................................................................................

..................................................................................................

City:..................................................................................................

State/Region/County:..................................................................................

Postcode: ☐☐☐☐☐☐☐

Country: ..................................................................................................

Telephone: ☐☐☐☐☐☐☐☐☐☐☐☐☐

7

## DECLARATION

I hereby apply to be enrolled in the Plan together with the persons to be insured listed above. I/we declare that the information disclosed in this application form, is to the best of my/our knowledge and belief both accurate and complete. I/we have taken care not to make any misrepresentation in the disclosure of this information and understand that all information provided is relevant to the acceptance and assessment of this insurance. For my benefit and protection, I have read the Policy Guide carefully and requested further information on any points I do not understand. I understand the Policy Guide to be part of any contract of insurance issued as a result of this Application. I agree that they will be binding on me and all eligible dependants included in my membership. 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 Policy Guide.

Applicant's Signature

Date: d d / m m / y y y y

(On behalf of all persons to be insured)

Signing this application form does not bind you to enter into this insurance. No cover is in force until this application form is accepted by the insurer and the premium is paid. The insurer reserves the right to decline any insurance application or to offer different premium and terms from those quoted dependent on the information you have provided.

8

## METHOD OF PAYMENT

Frequency of payment: ○ Annual ○ Quarterly (Credit Card payment only)

Premium amount: ☐☐☐☐☐ . ☐☐

Currency (delete as applicable): £GBP | $USD | €EUR

Method of payment:

○ Bank Transfer (Annual payment only) ○ Credit/Debit Card

### Bank Transfer

Please make bank transfers to the following accounts, instructing your bank to ensure that the transfer identifies you as the source

**Account Name:** APRIL International UK | **Bank:** Barclays | **Address:** 1 Churchill Place, London E14 5HP

| Currency | Sort Code | Account No. | IBAN | SWIFT |
|---|---|---|---|---|
| £GBP | 20-00-00 | 53869067 | GB03BARC20000053869067 | BARCGB22 |
| $USD | 20-00-00 | 76383566 | GB61BARC20000076383566 | BARCGB22 |
| €EUR | 20-00-00 | 44928922 | GB97BARC20000044928922 | BARCGB22 |

## METHOD OF PAYMENT (CONTINUED)

### Credit Card Details

Credit/Debit Card:

◯ Visa ◯ Mastercard ◯ Amex

I authorise APRIL International UK Limited to debit the following credit/debit card for the premium amount indicated:

8

Card No. ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiry Date ☐☐☐☐ Security Code ☐☐☐☐
(Last 3 digits on back of card or if AMEX 4 digits on front of card)

Name of Cardholder: ....................................................................................................

Card Billing Address: ....................................................................................................

....................................................................................................

City: .................................................. State/Region/County: ..................................................

Postcode: ☐☐☐☐☐☐☐ Country: ..................................................

Signature of Cardholder

Date: d d / m m / y y y y

## SUBMITTING YOUR APPLICATION

9

By Post: APRIL International UK,
Minster House, 42 Mincing Lane,
London EC3R 7AE, United Kingdom

By Fax: + 44 (0) 20 7118 1178

By Email: info@april-international.co.uk

**DATA PROTECTION ACT** Any information you have provided will be dealt with by APRIL International UK and the Insurer of the plan in compliance with the provisions of the Data Protection Act 1998. For the purpose of providing this insurance and handling of any claims or complaints which may arise under it, APRIL International UK and the Insurer of the plan may need to transfer certain information which you have provided to other parties. By signing this proposal you agree that such transfer(s) may be made.

All APRIL International UK trademarks, logos, graphics and commercial material contained in this document are registered and are the property of APRIL International UK.
Any reproduction of any kind, either partial or total, of the said elements and text is prohibited and will result in prosecution. July 2017. AP17013.

april international | UK

Minster House, 42 Mincing Lane,
London EC3R 7AE, United Kingdom
Tel: +44 (0) 20 3418 0470 – Fax: +44 (0) 20 7118 1178
info@april-international.co.uk – www.april-international.co.uk

Insurance made easy.

APRIL International UK Limited is an Appointed Representative of APRIL Medibroker Limited
which is authorised and regulated by the Financial Conduct Authority, registered number 304773.
Registered Office: Minster House, 42 Mincing Lane, London EC3R 7AE, United Kingdom.
Registered in England No. 7261287.