expacare

TOKIO MARINE NICHIDO

APPLICATION FORM
Securus

Please use BLOCK CAPITALS and Black Ink when completing the form.

1. MAIN APPLICANT

First name: Last name:

Nationality: Country of overseas residence:

Residential address:

Telephone: Email:

Occupation and Industry/nature of business:

Name and address of Employer:

Male ☐ Female ☐ Date of birth: DD / MM / YY

2. FAMILY MEMBERS TO BE INCLUDED ON COVER

You may include your partner/spouse and children. Child dependants aged 18-24 can join as long as we receive written confirmation from their place of study that they are in full time education.

PARTNER / SPOUSE

First Name	Last Name	Nationality	Country of Residence	Occupation	Male / Female	Date of Birth DD / MM / YY

CHILD DEPENDANTS

First Name	Last Name	Nationality	Country of Residence	Occupation	Male / Female	Date of Birth DD / MM / YY

3. YOUR DOCTOR

Please give details of your regular physician or a physician with whom you have most recently consulted and preferably in the last two years:

Name:

Address:

Telephone:

4. PLAN

- ☐ Securus Extensivecare
- ☐ Securus Ultracare

5. AREA OF COVER:

- ☐ Area 1 – Worldwide excluding USA, Bermuda and all islands of the Caribbean
- ☐ Area 2 – Worldwide

6. THE DATE YOU WANT COVER TO START: DD / MM / YY

7. PAYMENT DETAILS

a) Payment method:

I will be paying by bank transfer ☐

b) Payment frequency: Annual ☐ Semi-annual* ☐ Quarterly* ☐

** An administration charge of 2% on semi-annual and 4% on quarterly options will be applied (these fees are not applicable when Individual policies are issued to policyholders in the EEA). If you do not live in the EEA and are paying for your insurance via instalments then you will not benefit from protections under the Consumer Credit Act or the Consumer Credit Sourcebook of the Financial Conduct Authority.*

8. DATA PROTECTION FAIR PROCESSING NOTICE

In your dealings with us you may provide information that includes data that is known as personal data.

The personal data we collect will include data relating to your name, address, email address, IP address, date of birth, nationality, country of residence, occupation, credit card details and medical information.

We will process your personal data to allow us to administer your health insurance policy and any associated claims and for actuarial analysis.

It will also be used to manage future communications between ourselves in relation to your policy and claims.

We will only use your data for the purpose for which it was collected. We will only grant access to or share your data where we are required or entitled to do so by law under lawful data processing. This is within our firm or other firms associated with us, our authorised partners, your broker if you have appointed one, third party service providers such as insurers, assistance companies and claims administration providers.

If you require further information on how we process your data and our lawful bases for doing so, please contact us.

9. AUTHORISATION AND DECLARATION

Are you aware of any person to be covered having any on-going serious condition, including but not limited to any type of cancer, heart condition or stroke? Yes ☐ No ☐

Are you aware of any person to be covered having any medical condition likely to result in, or already requiring planned/pending in-patient treatment? Yes ☐ No ☐

Is any person to be covered currently pregnant or undergoing any form of fertility treatment? Yes ☐ No ☐

If Yes, please provide full details:

Are you opting for cover that includes dental treatment? Yes ☐ No ☐

If yes, please provide details of the last time you and anyone else to be covered went for a dental check-up.

Was all necessary work concluded? Yes ☐ No ☐

Supplementary Pregnancy Questionnaire

Are you currently pregnant or showing signs and symptoms of pregnancy or planning to get pregnant? Yes ☐ No ☐

If you are currently pregnant please answer the below questions.

Name of the Pregnant Female:

Last Menstrual period date:

Do you have earlier history of Caesarean Section, Premature Delivery or Premature babies? Or any other complications related to maternity, till date? :

Have you undergone any treatment or taken any medications for infertility to achieve this pregnancy?

Please send a copy of the latest ultrasound report and specify if there are any abnormal findings or more than one foetus seen.

Do you have any of the below conditions?

Medical Condition	YES/NO
Any Heart Disease or hypertension	Yes ☐ No ☐
Autoimmune Diseases	Yes ☐ No ☐
Diabetes/gestational diabetes	Yes ☐ No ☐
Thyroid Diseases	Yes ☐ No ☐
Kidney Diseases	Yes ☐ No ☐
Any placenta problems with the current pregnancy	Yes ☐ No ☐
Any episode of vaginal bleeding with this pregnancy	Yes ☐ No ☐

If answer to any of the above is yes please support with relevant medical records and detailed information on the same.

Disclaimer: I understand and acknowledge any pregnancy not declared at the time of this application's coverage will be at the sole discretion of the insurer. The insurer has the right to not cover any maternity claims to any undeclared pregnancy. I also acknowledge and understand any pregnancy, which arises within forty calendar days from the date of this application; coverage will also be at the discretion of the insurer.

Name:

Signature:

Date:

I am applying to be covered under the Expacare plan as chosen on this application form together with the dependants listed in this application.

I declare that to the best of my knowledge and belief, the information given on this form and any additional information supplied is true and complete and that the information completed is full and accurate. I understand and accept that in the event of this application form being fraudulent in whole as or in part, the policy may be invalidated and I will be liable for prosecution.

I understand that if I provide inaccurate or incomplete information, or do not provide the information asked for in this application and make a claim, which Expacare view as being treatment for a pre-existing medical or related medical condition, my claim may be rejected.

If you are in any doubt as to whether information is relevant or not, or do not know the answer, or how to answer, any specific question, then please contact us for guidance.

I understand that Expacare will advise me of any medical conditions which they will exclude from cover based on the information I have provided to them.

I will tell Expacare about any change in the information given in this application which occurs between the date of signing and the date that cover starts.

I understand that the answers provided are necessary in order for Expacare to process my application and I understand that Expacare will process my personal data, including medical data in relation to my insurance policy.

I authorise and herewith agree that Expacare Limited may forward data obtained from the form to the Insurer or its authorised Claims Administrator or any Reinsurer for the purpose of assessing the risk and handling the reinsurance.

I authorise any doctor, physician or practitioner who has examined or observed me or any of the applicants for diagnosis, treatment, disease or ailment, to give to the Insurance Company full particulars of these, including any prior medical history and medical records.

By signing this application form, I authorise Expacare to deal with my broker, if one is appointed. I also agree that they have authority to see medical information that I have disclosed in this application and in addition any subsequent medical information that Expacare obtain in the course of dealing with my application and policy.

Signature of main applicant/policyholder:

DATE: (DD/MM/YY):

Signature of Spouse/Partner:

DATE: (DD/MM/YY):

Signature of Child Dependant 1:

DATE: (DD/MM/YY):

Signature of Child Dependant 2:

DATE: (DD/MM/YY):

Signature of Child Dependant 3:

DATE: (DD/MM/YY):

Signature of Child Dependant 4:

DATE: (DD/MM/YY):

Parents/guardians may sign the form on behalf of any dependants aged 0-17