Young Traveller
APPLICATION FORM

Please use BLOCK CAPITALS and Black Ink when completing the form.
Please contact us if you have any queries.
UK T: +44 (0) 1344 233 950 E: info@expacare.com
ZIM T: +263 (0) 86 7700 8964 E: marketing@healthintergrp.com

When selecting which benefit levels are required, please ensure that you are aware of any financial limits, cover restrictions or exclusions that may apply. Full details can be found either within the quotation that we provided, or alternatively within the Young Traveller membership guide, copies of which are available upon request.

1. MAIN APPLICANT / POLICYHOLDER

First name: Last name:

Nationality: Country of overseas residence:

Residential address:

Telephone: Email:

Occupation and Industry/nature of business:

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

PROOF OF IDENTITY AND PROOF OF ADDRESS:

Please send us a copy of your passport and a proof of address (eg utility bill, bank/credit card statement) dated within the last 3 months. If the proof of address is for a parent/guardian, please complete and sign the family declaration on page 6.

2. 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:

Email:

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

Please note that this may be subject to change if medical exclusions or further information is required. We will confirm details of any medical exclusions that will apply to your policy in our offer to you. Cover can only begin from the date that you confirm your acceptance of our offer in writing.

4. BROKER DETAILS

Broker name:

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5. AREA OF COVER

Area 2 - Worldwide excluding USA, Bermuda and all islands of the Caribbean ☑

6. PLAN

	SELECT ONLY ONE
Young Traveller	☐ SELECT
Young Traveller PLUS	☐ SELECT

7. PAYMENT DETAILS

a) Payment Currency (please note this determines the currency of the policy): ☑ USD

b) Payment method:

I will be paying by bank transfer ☐ I will be paying by credit card ☐

c) 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 or in the UK). 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.*

d) Who is paying the premium?

Policyholder ☐

Direct family member ☐

(Please state: Mother, father, brother, sister, son, daughter, grandparent, guardian, husband, wife) .....

Other (Please state) ☐ .....

Note: If Other, you will need to complete a separate Third Party Transaction Form and provide supporting KYC

8. NEXT OF KIN

First name: ..... Last name: .....

Relationship to Applicant: ..... Country of residence: .....

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

9. MEDICAL QUESTIONNAIRE

Do you or anyone to be covered currently have a health insurance policy with another insurance company? Yes ☐ No ☐

If yes, please specify which company: .....

Have you or anyone to be covered ever had a health insurance policy? Yes ☐ No ☐

If yes, please specify which company and confirm how long you were on cover: .....

Have you or anyone to be covered ever been declined or had exclusions applied on another health care policy? Yes ☐ No ☐

If yes, please provide details for each applicant in the Medical History Section, Part 3 on page 4.

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10. MEDICAL HISTORY - PART 1

Have you or any named dependant in the last 5 years:

- seen a doctor, specialist or healthcare professional;
- experienced any signs or symptoms;
- been admitted to hospital, had any operations or investigations; including x-rays, biopsies and blood tests; For any of the following? (If 'Yes' for any question please provide full details in Medical History - Part 3)

		Main Applicant / Policyholder
1.	**Heart and Circulatory Disorders.** e.g. chest pain (angina), abnormal heart beat, varicose veins, high blood pressure, circulation problems, blood lipid or cholesterol problems.	Yes ☐ No ☐
2.	**Respiratory Disorders.** e.g. asthma, bronchitis, COPD, pneumonia, tuberculosis, chest infections, cystic fibrosis.	Yes ☐ No ☐
3.	**Skeletal & Muscular Disorders.** e.g. back, shoulder or neck problems, disc disorders, osteoporosis, cartilage, tendon, or ligament disorders, joint replacements, fractures, bunions.	Yes ☐ No ☐
4.	**Digestive Disorders.** e.g. Crohn's disease, colitis, irritable bowel syndrome, changes in bowel habit, rectal bleeding, indigestion / reflux, hernia, cirrhosis, jaundice, liver / pancreas or gall bladder problems, haemorrhoids.	Yes ☐ No ☐
5.	**Blood Disorders.** e.g. anaemia, leukaemia, hepatitis, HIV, deep vein thrombosis (DVT), abnormal blood tests.	Yes ☐ No ☐
6.	**Neurological Disorders.** e.g. epilepsy, seizures, multiple sclerosis, meningitis, migraines, headaches, dementia.	Yes ☐ No ☐
7.	**Psychiatric Disorders.** e.g. depression, stress, anxiety, eating disorders, schizophrenia, addictions (including drug or alcohol dependency).	Yes ☐ No ☐
8.	**Ear, Nose, Throat or Eye Problems.** e.g. cataracts, glaucoma, blepharitis, ear infections, hearing problems, vertigo, tinnitus, tonsillitis or sinus problems.	Yes ☐ No ☐
9.	**Dental or Maxillofacial Problems.** e.g. wisdom teeth problems, gingivitis, dental / gum infections, abscesses.	Yes ☐ No ☐
10.	**Urinary Problems.** e.g. urinary tract infections, urinary / kidney stones, incontinence or urgency, renal failure, bladder or kidney problems.	Yes ☐ No ☐
11.	**Endocrine (glandular) Disorders.** e.g. diabetes, thyroid problems, pituitary, adrenal or hormonal problems.	Yes ☐ No ☐
12.	**Allergies or Skin Problems.** e.g. psoriasis, eczema, acne, moles, warts, lipomas, hypertrophic / keloid scars	Yes ☐ No ☐
13.	**Male Disorders.** e.g. abnormal PSA result, infertility, sexually transmitted infections, prostate or testicular disorders.	Yes ☐ No ☐
14.	**Female Disorders.** e.g. menstrual problems, fibroids, endometriosis, polycystic ovaries, abnormal smear test, menopausal symptoms, sexually transmitted infections, infertility, breast lumps, child birth or pregnancy problems.	Yes ☐ No ☐
15.	**Autoimmune & Infective Disorders.** e.g. myasthenia gravis, malaria, Lupus, Sjogrens syndrome.	Yes ☐ No ☐
16.	**For any medical condition not listed in questions 1-15 above.** Please provide full details in Medical History - Part 3.	Yes ☐ No ☐

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10. MEDICAL HISTORY - PART 2

Please answer the following question for you or any named dependant.
(If 'Yes' for any question please provide full details in Medical History - Part 3)

17.	Do you take any medication on a regular basis, prescribed or otherwise? Please list in Medical History - Part 3.	Yes ☐ No ☐
18.	Have you ever had any past history of any joint replacements, heart conditions or strokes?	Yes ☐ No ☐
19.	Have you ever been a) diagnosed with any conditions, or b) suffered symptoms for any undiagnosed condition, not mentioned in Medical History - Part 1?	Yes ☐ No ☐
20.	Have you ever been diagnosed with any cancerous or pre cancerous condition? If any please advise in Part 3.	Yes ☐ No ☐
21.	Are you currently pregnant?	Yes ☐ No ☐
22.	Are you undergoing any form of fertility treatment?	Yes ☐ No ☐
23.	Do you currently have any planned or pending check ups, investigations or treatment?	Yes ☐ No ☐

10. MEDICAL HISTORY - PART 3

If you have answered 'Yes' to any of the questions 1 - 23 please provide full details below.

Name	Question Number	Symptom or medical condition and area of body affected. e.g. skin rash on back	Date when symptoms started.	Date when symptoms finished.	What treatment did you receive and when? Please confirm dates and detail any medications provided.	What was the outcome? e.g. ongoing, still under review, complete recovery, recurrent or likely to recur?

ASTHMA - If you have answered 'Yes' to question 2 relating to asthma, please answer the following.

How many consultations have you had relating to Asthma in the last 24 months?	How many Asthma attacks have you experienced in the last 24 months regardless of whether hospital treatment was required?	Have you ever required emergency care, or been admitted to hospital for an event caused by, related to, or made worse by your Asthma? (Please provide details)	What are the triggers for your Asthma?	Do you have any planned or pending treatment or consultations relating to your Asthma?	What medication (name and dosage), are you prescribed for your Asthma?

If you need further space please include details on a separate sheet.

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11. 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 at info@expacare.com or refer to our Privacy Policy which can be found on our website.

12. AUHORISATION FOR RELEASE OF MEDICAL INFORMATION

Expacare Limited requires your authority for release of medical information about you as we may require further information to support your application, or for future claims.

I hereby authorise any organisation or person who has or may have information concerning my health to furnish Expacare or their respective representatives with:

1. All records of any treatment or discussion of my health
2. All information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment) and employment history
3. A medical certificate in the form attached completed by any health provider who Expacare may require.

13. AUTHORISATION AND DECLARATION

I am applying to be covered under the Expacare Young Traveller (Choices) plan as chosen on this application form.

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 (including pregnancy), 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): _____

Parents / guardians may sign the form on behalf of any main applicant / policyholder aged 12 - 17

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14. Family Declaration

PROOF OF RESIDENCE ADDRESS

(To be used for Dependents over 12 who reside with their parents / guardian)

Dear Sir / Madam,

Passport / I.D. Number:

I hereby confirm that the abovementioned person resides with me at:

and has resided at this address since .

I hereby sign in my personal capacity as:

☐ Parent / Guardian

Name:

Signature:

Date:

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