



APPLICATION FORM

Securus

IAIN APPLICANT						
rst name:		Last nam	e:			
ationality:		Country	of overseas resi	dence:		
esidential address:						
lephone:		Email:				
ccupation and Industry/na	ature of business:					
ame and address of Emplo	oyer:					
ale Female		Date of b	oirth: DD/M	M / YY		
AMILY MEMBERS TO bu may include your partner place of the property of the place of	ner/spouse and children.	Child dependant			as we receive v	vritten
ou may include your partn onfirmation from their plac	ner/spouse and children.	Child dependant	ation.	an join as long Occupation	as we receive v	Date of Birtl
ou may include your partnonfirmation from their place	ner/spouse and children. ce of study that they are	Child dependant e in full time educ	ation.			
ou may include your partnonfirmation from their place	ner/spouse and children. ce of study that they are	Child dependant e in full time educ	ation.			Date of Birtl
ou may include your partnonfirmation from their place	ner/spouse and children. ce of study that they are	Child dependant e in full time educ	ation.			Date of Birt
ou may include your partnonfirmation from their place ARTNER / SPOUSE First Name	ner/spouse and children. ce of study that they are	Child dependant e in full time educ	ation.			Date of Birt DD / MM / Y
ou may include your partnonfirmation from their place ARTNER / SPOUSE First Name HILD DEPENDANTS	ner/spouse and children. ce of study that they are Last Name	Child dependant in full time educ	Country of Residence	Occupation	Male / Female	Date of Birt DD / MM / Y Date of Birt
ou may include your partnonfirmation from their place ARTNER / SPOUSE First Name HILD DEPENDANTS	ner/spouse and children. ce of study that they are Last Name	Child dependant in full time educ	Country of Residence	Occupation	Male / Female	Date of Birt DD / MM / Y Date of Birt
ou may include your partnonfirmation from their place ARTNER / SPOUSE First Name HILD DEPENDANTS	ner/spouse and children. ce of study that they are Last Name	Child dependant in full time educ	Country of Residence	Occupation	Male / Female	Date of Birt DD / MM / Y Date of Birt
ou may include your partnonfirmation from their place ARTNER / SPOUSE First Name HILD DEPENDANTS	ner/spouse and children. ce of study that they are Last Name	Child dependant in full time educ	Country of Residence	Occupation	Male / Female	Date of Birt DD / MM / Y Date of Birt
ou may include your partnonfirmation from their place ARTNER / SPOUSE First Name HILD DEPENDANTS	ner/spouse and children. ce of study that they are Last Name	Child dependant in full time educ	Country of Residence	Occupation	Male / Female	Date of Birtl

Page 1 of 7 Application Form - Securus 2025 TMNF expacare.com

3.	YOUR DOCTOR Please give details of your regular physician or a phystwo years:	sician with whom you hav	e most recently consulted and	l preferably i	n the last
	Name:				
	Address:				
	Telephone:				
4.	PLAN				
	Securus Extensivecare				
	Securus Ultracare				
5.	AREA OF COVER:				
	Area 1 – Worldwide excluding USA, Bermuda a	nd all islands of the Caribb	pean		
	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*	Quarte	erly*
	* An administration charge of 2% on semi-annual and 4% or to policyholders in the EEA). If you do not live in the EEA an the Consumer Credit Act or the Consumer Credit Sourceboo	nd are paying for your insurance vi	a instalments then you will not benefi	•	
8.	MEDICAL QUESTIONNAIRE				
	Do you or anyone to be covered currently have a hea	alth insurance policy with a	nother insurance company?	Yes	No
	If yes, please specify which company:			<u></u>	<u></u>
	Have you or anyone to be covered ever had a health	n insurance policy?		Yes	No 🗌
	If yes, please specify which company and confirm h	ow long you were on cove	er:		
	Have you or anyone to be covered ever been declined	or had exclusions applied o	on another health care policy?	Yes ()	No (
	If yes, please provide details for each applicant in th	-	Part 3.		
	Are you opting for cover that includes dental treatme			Yes	No 📗
	If yes, please provide details of the last time you and ar	nyone else to be covered we	ent for a dental check-up.		
	Was all necessary work concluded?			Yes	No

Page 2 of 7 Application Form - Securus 2025 TMNF expacare.com

9. 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	Spouse or Partner	Child Dependant 1	Child Dependant 2	Child Dependant 3	Child Dependant 4
	NAME	NAME	NAME	NAME	NAME	NAME
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	Yes No	Yes No	Yes No	Yes No	Yes No
Respiratory Disorders. e.g. asthma, bronchitis, COPD, pneumonia, tuberculosis, chest infections, cystic fibrosis.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Skeletal & Muscular Disorders. e.g. back, shoulder or neck problems, disc disorders, osteoporosis, cartilage, tendon, or ligament disorders, joint replacements, fractures, bunions.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
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	Yes No	Yes No	Yes No	Yes No	Yes No
Blood Disorders. e.g. anaemia, leukaemia, hepatitis, HIV, deep vein thrombosis (DVT), abnormal blood tests.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Neurological Disorders. e.g. epilepsy, seizures, multiple sclerosis, meningitis, migraines, headaches, dementia.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
7. Psychiatric Disorders. e.g. depression, stress, anxiety, eating disorders, schizophrenia, addictions (including drug or alcohol dependency).	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Ear, Nose, Throat or Eye Problems. e.g. cataracts, glaucoma, blepharitis, ear infections, hearing problems, vertigo, tinnitus, tonsillitis, or sinus problems.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Dental or Maxillofacial Problems. e.g. wisdom teeth problems, gingivitis, dental/gum infections, abscesses.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Urinary Problems. e.g. urinary tract infections, urinary/ kidney stones, incontinence or urgency, renal failure, bladder or kidney problems.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Endocrine (glandular) Disorders. e.g. diabetes, thyroid problems, pituitary, adrenal or hormonal problems.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
12. Allergies or Skin Problems. e.g. psoriasis, eczema, acne, moles, warts, lipomas, hypertrophic/keloid scars.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Male Disorders. e.g. abnormal PSA result, infertility, sexually transmitted infections, prostate or testicular disorders.	Yes No	Yes No	Yes No	Yes No	Yes No	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	Yes No	Yes No	Yes No	Yes No	Yes No
15. Autoimmune & Infective Disorders. e.g. AIDS, myasthenia gravis, malaria, Lupus, Sjogrens syndrome.	Yes No	Yes No	Yes No	Yes No	Yes No	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	Yes No	Yes No	Yes No	Yes No	Yes No

9. 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)

	Main Applicant / Policyholder	Spouse or Partner	Child Dependant 1	Child Dependant 2	Child Dependant 3	Child Dependant 4
17. Do you take any medication on a regular basis, prescribed or otherwise? Please list in Medical History - Part 3.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
18. Have you ever had any past history of any joint replacements, heart conditions or strokes?	Yes No	Yes No	Yes No	Yes No	Yes No	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	Yes No	Yes No	Yes No	Yes No	Yes No
20. Have you ever been diagnosed with any cancerous or pre cancerous condition? If any please advise in Part 3.	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
21. Are you currently pregnant?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
22. Are you undergoing any form of fertility treatment?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
23. Do you currently have any planned or pending check ups, investigations or treatment?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

9. 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?

9. MEDICAL HISTORY - PART 3

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

Any Heart Disease or Autoimmune Diseases Diabetes/gestational of Thyroid Diseases Kidney Diseases Any placenta problem	5	Medical Condi	tion		YES/NO Yes No Yes No Yes No Yes No Yes No Yes No Yes No
Any Heart Disease or Autoimmune Diseases Diabetes/gestational of Thyroid Diseases Kidney Diseases	hypertension s diabetes	Medical Condi	tion		Yes No Yes No Yes No Yes No Yes No
Any Heart Disease or Autoimmune Diseases Diabetes/gestational of Thyroid Diseases	hypertension s		tion		Yes No Yes No Yes No Yes No
Do you have any Any Heart Disease or Autoimmune Diseases Diabetes/gestational of	hypertension s		tion		Yes No Yes No
Do you have any Any Heart Disease or Autoimmune Diseases	hypertension s		tion		Yes No
Do you have any Any Heart Disease or	hypertension		tion		Yes No
Do you have any			tion		
	y of the below condition		tion		YES/NO
	y of the below condition	ons?			
Please send a co					
	py of the latest ultrasc	ound report and specif	y if there are any abno	ormal findings or more	e than one foetus seer
Have you underg	gone any treatment or	taken any medication	s for infertility to achi	eve this pregnancy?	
maternity, till da	te? :				
Do you have ear	lier history of Caesarea	an Section, Premature	Delivery or Premature	babies? Or any other	complications related
Last Menstrual p	period date:				
Name of the Pre	gnant Female:				
Are you currently If you are current	ARY PREGNANCY of pregnant or showing tly pregnant please ans	signs and symptoms o		g to get pregnant?	Yes No
		Asthma?)Please provide details)			
	treatment was required?	or made worse by your			

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:

10. 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.

11. AUTHORISATION AND DECLARATION

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