CHOICES APPLICATION FORM
For Individuals

Please use BLOCK CAPITALS and Black Ink when completing the form.
Please contact us on +44 (0) 1344 233950 if you have any queries. Please send your application form to us by:

- Email to info@expacare.com
- Alternatively, please send the form to your insurance broker

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 Choices 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

2. FAMILY MEMBERS TO BE INCLUDED ON COVER

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
Child Dependant 1							
Child Dependant 2							
Child Dependant 3							
Child Dependant 4							

3. LIFESTYLE QUESTIONNAIRE

	Main Applicant / Policyholder	Spouse or Partner	Child Dependant 1	Child Dependant 2	Child Dependant 3	Child Dependant 4
Height: (Please specify cm or inches)						
Weight: (Please specify kg or pounds)						
Have you smoked any tobacco products in the last year? If yes, please specify how much you smoke per week:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Do you consume alcohol? If yes, please specify how many units you consume per week? e.g. 1 pint of beer = 2.5 units, 1 bottle wine = 10 units	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Approximately how many hours do you exercise per week?						
Number of days absent from work due to ill health in the last year?						

4. 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:

5. 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.

6. BROKER DETAILS

Broker name: Broker code (if known):

7. AREA OF COVER

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

Area 3 - Worldwide (not available for US nationals) ☐

Area 4 – South East Asia (including Brunei, Cambodia, Christmas island, E. Timor, Indonesia, Laos, Malaysia, Myanmar, Philippines, Thailand and Vietnam) ☐

8. CHOICES CORE PLAN

	MUST BE SELECTED
Choices Core Plan	☑ SELECT

9. CHOICES OPTION 1 - CANCER TREATMENT AND CHRONIC CARE

Please SELECT ONE of the levels of cancer and chronic cover below. Please note that restrictions on this benefit may apply subject to the level of out-patient benefit selected (if any).

	SELECT ONE ONLY
No cover required	☐ SELECT
Treatment for in-patient and out-patient cancer and chronic conditions: restricted cover	☐ SELECT
Treatment for in-patient and out-patient cancer and chronic conditions: full cover	☐ SELECT

10. CHOICES OPTION 2 - OUT-PATIENT TREATMENT

Please SELECT ONE of the levels of out-patient treatment below.

	SELECT ONE ONLY
No cover required	☐ SELECT
Basic out-patient	☐ SELECT
Intermediate out-patient	☐ SELECT
Extended out-patient	☐ SELECT
Advanced out-patient	☐ SELECT

11. CHOICES OPTION 3 - ADDITIONAL BENEFITS

Please SELECT from the additional benefits listed below.

Dental, Wellness and Optical Treatment

	SELECT ONE ONLY
No cover required	☐ SELECT
Dental treatment and wellness benefit	☐ SELECT
Dental treatment, wellness benefit and optical	☐ SELECT

Maternity Care

	SELECT ONE ONLY
Maternity Basic	☐ SELECT
Maternity care level 1	☐ SELECT
Maternity care level 2	☐ SELECT

12. POLICY EXCESS LEVEL (OPTIONAL)

Excesses are not available for Middle East plans.

	SELECT ONE ONLY
Nil Excess	☐ SELECT
GBP 100 / USD 170 / EUR 150	☐ SELECT
GBP 250 / USD 425 / EUR 375	☐ SELECT
GBP 500 / USD 850 / EUR 750	☐ SELECT
GBP 1,000 / USD 1,700 / EUR 1,500	☐ SELECT
GBP 2,000 / USD 3,400 / EUR 3,000	☐ SELECT
GBP 5,000 / USD 8,500 / EUR 7,500	☐ SELECT

Excess applies per person, per policy period

13. CO-PAY (OPTIONAL) ONLY AVAILABLE FOR MIDDLE EAST PLANS

	SELECT ONE ONLY
20% co-pay subject to a max of AED 50 per visit (applies to Consultations and diagnostic services with doctors or specialists only)	☐ SELECT
20% co-pay subject to a max of AED 100 per visit (applies to Consultations and diagnostic services with doctors or specialists only)	☐ SELECT
10% co-pay applying to all outpatient services and prescription drugs	☐ SELECT
20% co-pay applying to all outpatient services and prescription drugs	☐ SELECT

14. PAYMENT DETAILS

a) Payment Currency (please note this will determine the currency of the policy): GBP ☐ USD ☐ EUR ☐
Plans in the Middle East and Indonesia are only available in 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.*

15. 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 6.

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 ☐

16. 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
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 ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2. 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 ☐
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 ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	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 ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
5. 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 ☐
6. 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 ☐
8. Ear, Nose, Throat or Eye Problems. e.g. cataracts, glaucoma, blepharitis, ear infections, hearing problems, vertigo, tinnitus, tonsillitis, wisdom teeth or sinus problems.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
9. 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 ☐
10. 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 ☐
11. 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 ☐
13. 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. 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 ☐

16. 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 ☐

16. 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?

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

17. 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.

18. AUTHORISATION 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.

19. AUTHORISATION AND DECLARATION

I am applying to be covered under the Expacare Choices 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 (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):

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

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