Norbert Fuss

William Russell

Personal Health Plans

Application form for individuals & families (full medical underwriting)

Please complete this form in **BLOCK CAPITALS** using black ink, and return it to us by email or post. You can find our contact details at the end of this form.

Broker/intermediary details

If you were introduced to us through a broker or intermediary, please state their name and company.

Norbert Fuss

Your personal details

First name: ..... Surname: ..... Title: .....

Address: .....

Mobile number: ..... Home number: .....

Email: ..... Occupation: .....

Nationality: ..... Date of birth: ..... ◯ Male ◯ Female

Country where you will be living/working: ..... How long have you lived there? ..... years

About your occupation and other pursuits

1 Is your occupation and that of your partner 100% office-based? ◯ Yes ◯ No

If **NO**, please provide a job description, or full details of any non-office-based activities and how often they are undertaken:

.....

.....

2 Do you or your partner participate in any hazardous activities? ◯ Yes ◯ No

If **YES**, please provide full details of any hazardous activities and how often you and/or your partner participate in them:

.....

.....

Examples of hazardous activities include: off-piste or freestyle skiing/snowboarding; scuba diving; rock climbing; mountaineering, pot-holing or caving; hang-gliding or parachuting (including tandem); bungee jumping; kite surfing or windsurfing; hunting or competitive horse-riding; driving or riding a motorised vehicle in any kind of race or competition; riding or riding pillion a motorcycle, motor scooter, moped or quad bike; flying other than as a passenger in a commercial aircraft aeroplane; competitive and/or offshore sailing; contact sport or any other activity that places you in a similar degree of danger as any of those mentioned here.

Depending on your occupation and any hazard activities you particpate in, your policy may be subject to a premium loading or special terms, or we may decline to offer cover.

Dependants to be insured on your health plan

Please enter the details for all dependants to be insured on your health plan. You may include your partner provided they are under 76 years of age, and your children provided they are under 18 years of age (or 25 years of age if they are in full-time education). Any children aged 18 and over who are not in full-time education must apply for their own health plan.

	Partner	Child 1	Child 2	Child 3
First name				
Surname				
Date of birth				
Gender				
Nationality				
Relationship to you				
Country where they will be living				
Occupation/full-time education				

Start date of your health plan

When would you like your health plan to start? ◯ On acceptance of your application ◯ Specific date: .....

Please note that your application for a health plan is only valid for 28 days from the date we receive it. Cover cannot be backdated.

Previous/current insurance plans

1 Has anyone named on this form ever applied for a health plan or been insured with William Russell? ◯ Yes ◯ No

If **YES**, please state the policy number: ..... Date of expiry of plan: .....

2 Has anyone named on this form ever had an application for insurance declined or accepted with special terms, or had an insurance plan cancelled by any insurance provider? ◯ Yes ◯ No

If **YES**, please provide details: .....

3 Does anyone named on this form currently have any other health insurance? ◯ Yes ◯ No

If **YES**, please state the name of insurer: .....

Policy number: ..... Date of expiry of plan: .....

Choose your health plan

Please choose your health plan and excess combination from the table below, along with the optional benefits you require. The excess options and optional benefits available with each plan are shown in the column for the plan you select.

If you have one, please state the reference for the quote you wish to accept: .....

Bronze	Silver*Lite*	Silver	Gold
Excess options			
◯ Nil	◯ Nil	◯ Nil	◯ Nil
Per claim options			
◯ $800/£530/€750	◯ $50/£33/€45	◯ $50/£33/€45	◯ $50/£33/€45
◯ $1,600/£1,060/€1,500	◯ $100/£67/€90	◯ $100/£67/€90	◯ $100/£67/€90
	◯ $800/£530/€750	◯ $800/£530/€750	◯ $800/£530/€750
	◯ $1,600/£1,060/€1,500	◯ $1,600/£1,060/€1,500	◯ $1,600/£1,060/€1,500
Per annum options			
◯ $250/£167/€225	◯ $250/£167/€225	◯ $250/£167/€225	◯ $250/£167/€225
◯ $500/£330/€450	◯ $500/£330/€450	◯ $500/£330/€450	◯ $500/£330/€450
◯ $1,000/£660/€1,000	◯ $1,000/£660/€1,000	◯ $1,000/£660/€1,000	◯ $1,000/£660/€1,000
◯ $2,500/£1,660/€2,500	◯ $2,500/£1,660/€2,500	◯ $2,500/£1,660/€2,500	◯ $2,500/£1,660/€2,500
◯ $5,000/£3,330/€5,000	◯ $5,000/£3,330/€5,000	◯ $5,000/£3,330/€5,000	◯ $5,000/£3,330/€5,000
◯ $10,000/£6,600/€10,000	◯ $10,000/£6,600/€10,000	◯ $10,000/£6,600/€10,000	◯ $10,000/£6,600/€10,000
Bronze	**Silver*Lite***	**Silver**	**Gold**
Optional benefits			
◯ Medevac Plus	◯ Medevac Plus	◯ Medevac Plus	◯ Medevac Plus
◯ Private hospital room	◯ Private hospital room	◯ Enhanced well-being	◯ Enhanced well-being
	◯ Enhanced Out-patient treatment†	◯ Dental Basic	◯ Dental Plus
		◯ Dental Plus	◯ Direct billing*
	◯ Dental Basic	◯ Direct billing*	
	◯ Direct billing*		

†Select the option you require from the table on the page below.

Direct billing is free of charge, but is only available if you are resident in certain Asian countries and you have selected a **nil or **$50/£33/€45 per claim excess**. You will also need to submit an application form for direct billing..*

Choose your health plan (continued)

Enhanced out-patient treatment

You need only complete this table if you have selected the enhanced out-patient treatment option on the previous page. This option is only available with a Silver*Lite* plan.

◯ **Option A**
Cover up to US$7,500 or £5,000 or €5,625 per period of cover

◯ **Option B**
Cover up to US$10,000 or £6,600 or €7,500 per period of cover

Area of cover

You can find out more information about the areas of cover on our website.

◯ **Zone 1** Worldwide, excluding the USA.

USA cover options

The following two options provide limited cover in the USA. They are not available with Silver*Lite*.

◯ **USA-45** We will cover you in the USA for temporary trips of up to 45 days' duration from the date on which you enter the country. Any trip of longer than 45 days will not be covered, but there is no limit to the number of temporary trips you can make to the USA during any one period of cover.

The overall maximum amount we will pay in respect of treatment you receive in the USA is US$250,000 per insured person, per period of cover. Within this amount, we will pay: -

- up to US$100,000 for elective treatment; and
- up to US$250,000 for accident & emergency treatment of a condition that you have not previously suffered from prior to commencing your temporary trip.

We do not cover emergency evacuation to, from or within the USA, even if you select the USA-45 option.

◯ **USA-90** We will cover you in the USA for temporary trips of up to 90 days' duration from the date on which you enter the country. Any trip of longer than 90 days will not be covered, but there is no limit to the number of temporary trips you can make to the USA during any one period of cover.

The overall maximum amount we will pay in respect of treatment you receive in the USA is US$250,000 per insured person, per period of cover. This overall maximum amount includes both elective treatment and accident & emergency treatment that you receive.

We do not cover emergency evacuation to, from or within the USA, even if you select the USA-90 option.

Optional plan

The following optional plan is available with all health plans.

Personal accident plan ◯ You ◯ Partner

Please select your personal accident benefit.

◯ US$75,000 or £50,000 or €75,000 ◯ US$150,000 or £100,000 or €150,000 ◯ US$225,000 or £150,000 or €225,000

◯ US$300,000 or £200,000 or €300,000 ◯ US$375,000 or £250,000 or €375,000

The personal accident plan does not cover accidents as a result of hazardous activities/occupations. Cover for hazardous activities and occupations may be subject to a premium loading or special terms, or we may decline to offer cover.

Paying for your health plan

Please select the currency in which you would like to pay your premium. The benefits for your health plan and your excess will be denominated in this currency.

◯ US dollars ◯ Pounds sterling ◯ Euros

Please select your payment method and the frequency with which you wish to pay your premium:

Credit/debit card	◯ Annually	◯ Half-yearly[2]	◯ Quarterly[3]	◯ Monthly[3]
Direct debit[1]	◯ Annually	◯ Half-yearly[2]	◯ Quarterly[3]	◯ Monthly[3]
Bank transfer	◯ Annually			

[1] Direct debit payments are only available when you pay in pounds sterling from a UK bank account.
[2] Half-yearly premiums are subject to a 3% surcharge.
[3] Quarterly or monthly premiums are subject to a 5% surcharge.

Health declaration

Your health plan will be underwritten on a full medical underwriting basis. Please complete the following health declaration and provide us with full details of any medical conditions existing before the start date of your plan. Pre-existing medical conditions and related conditions will not be covered unless you have told us about them and we have agreed to cover them. This includes conditions arising between the time you submit this application form and the start date of your plan, so please contact us immediately if the information provided changes.

Please answer the following questions for each person named on this form fully, accurately, and to the best of your knowledge and belief. If you answer **YES** to any question, please supply full details in the spaces provided. If you require more space, please continue on a separate sheet of paper. If you do not answer the questions fully and accurately, your plan may be cancelled, claims may be rejected or special terms may be applied retroactively. If you are in any doubt as to whether you should tell us anything, please tell us anyway.

	You	Partner	Dependants over age 18
Height (cm)			
Weight (kg)			
Have you smoked cigarettes/cigars in the last 12 months?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
If **YES**, how many do you smoke on average a day:	.....	.....	.....
Do you drink alcohol?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
If **YES**, how many of the following do you drink each week?			
• Pints of regular-strength beer/cider	.....	.....	.....
• Pints of strong beer or cider	.....	.....	.....
• 175ml glasses of wine	.....	.....	.....
• 250ml glasses of wine	.....	.....	.....
• 35ml measures of spirits	.....	.....	.....

Health declaration (continued)

Medical questions for EACH person named on this form

1 Has any person named on this form **ever** experienced any of the following conditions?

a) **Brain or nervous system conditions?** ◯ Yes ◯ No
For example: stroke/transient ischemic attack (TIA), epilepsy, migraines or repeated headaches, multiple sclerosis, meningitis, shingles, nerve pain.

b) **Cancer, tumours or growths?** ◯ Yes ◯ No
For example: polyps, benign growths or cysts, lymphomas, any cancers or pre-cancerous conditions.

c) **Heart or circulatory conditions?** ◯ Yes ◯ No
For example: high blood pressure, angina/chest pains, heart attacks or failure, abnormal heartbeat, varicose veins, raised cholesterol, stroke, deep vein thrombosis.

d) **Psychiatric, psychological conditions or sleep disorders?** ◯ Yes ◯ No
For example: depression, anxiety, stress, anorexia nervosa, autism, bipolar disorder, insomnia, narcolepsy, sleep apnoea.

e) **Joint replacements?** ◯ Yes ◯ No

2 In the last **five** years, has any person named on this form seen a doctor, or experienced any symptoms, or been admitted to a hospital or medical facility for an operation or procedure, or undergone any tests or investigations, for any of the following conditions:

a) **Auto-immune disorders?** ◯ Yes ◯ No
For example: HIV/AIDS, rheumatoid arthritis, systemic lupus erythematosus, scleroderma.

b) **Back, joint, muscular or skeletal problems?** ◯ Yes ◯ No
For example: back or joint pain, whiplash, sciatica, degenerative changes, osteoarthritis, osteoporosis, gout, bunions, fractures, cartilage or ligament problems.

c) **Breathing or upper and lower respiratory conditions (including allergies)?** ◯ Yes ◯ No
For example: asthma, chronic obstructive pulmonary disease (COPD), shortness of breath, chest infections, pneumonia, bronchitis, tuberculosis (TB), allergies to food substances and animals.

d) **Diabetes, thyroid or any other endocrine disorder?** ◯ Yes ◯ No
For example: diabetes type 1, 2 or gestational, overactive or underactive thyroid, pituitary or adrenal problems, obesity.

e) **Eyes, ear, nose and throat or oral/dental conditions?** ◯ Yes ◯ No
For example: glaucoma, cataracts, retinal detachment, macular degeneration, hearing difficulties, repeated ear infections, tonsillitis, sinusitis, dental problems, wisdom teeth problems, gingivitis.

f) **Gynaecological or breast conditions?** ◯ Yes ◯ No
For example: complications of pregnancy (ectopic pregnancy, miscarriage, pre-eclapsia, pre-term labour or emergency c-section), heavy or irregular periods, fibroids, endometriosis, ovarian cysts, abnormal smear tests, pre- and post-natal complications, breast lumps/cysts.

g) **Skin conditions (including allergies)?** ◯ Yes ◯ No
For example: eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed or allergic reactions.

h) **Stomach, liver/gall bladder, or digestive system conditions?** ◯ Yes ◯ No
For example: ulcers, irritable bowels, Crohn's disease, colitis, reflux/heartburn abdominal pain, anaemia, hepatitis, cirrhosis, gallstones, hernias, haemorrhoids/piles.

i) **Urinary, kidney or prostate conditions?** ◯ Yes ◯ No
For example: kidney infections, kidney stones, incontinence, prolapse, prostate problems, recurrent bladder or urine infections.

j) **Any alcohol and/or drug dependency problems?** ◯ Yes ◯ No

k) **Any physical defect, infirmity or congenital condition?** ◯ Yes ◯ No

l) **Any other medical condition not mentioned above?** ◯ Yes ◯ No

3 Has any person named on this form experienced any signs or symptoms of any medical condition in the last six months, whether or not a doctor has been consulted? ◯ Yes ◯ No

4 Is any person named on this form currently taking any medication, prescribed or otherwise? ◯ Yes ◯ No

5 Is any person named on this form currently undergoing any treatment or periodic reviews for a medical condition, physical impairment, disability or recurrent illness not already mentioned? ◯ Yes ◯ No

6 Is anyone named on this form currently pregnant? ◯ Yes ◯ No

Health declaration (continued)

If you have answered YES to any of the above questions, please give full details

Question no: ..... Name of person affected: .....

Date(s) on which the injury or condition first occurred: .....

Date symptoms were last experienced: .....

Please state what diagnosis was made: .....

.....

.....

.....

.....

.....

What treatment was received: .....

.....

.....

.....

Is any future treatment required, including consultations with a doctor or periodic tests or reviews? ◯ Yes ◯ No

If **YES**, please give details: .....

.....

.....

.....

Question no: ..... Name of person affected: .....

Date(s) on which the injury or condition first occurred: .....

Date symptoms were last experienced: .....

Please state what diagnosis was made: .....

.....

.....

.....

.....

.....

What treatment was received: .....

.....

.....

.....

Is any future treatment required, including consultations with a doctor or periodic tests or reviews? ◯ Yes ◯ No

If **YES**, please give details: .....

.....

.....

.....

Your doctor's details

Please provide details of the doctor who is most familiar with the medical history of all those named on this form. If any of your dependants regularly see a different doctor, please provide this information on a separate piece of paper.

Name of doctor: ..... Title: .....

Address: .....

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

How long have you been known to this doctor? .....

How we use your information

Please read this section carefully.

- We will use the information that you have given us on this application form for the purposes of administering your health plan, processing your claims, identifying and preventing fraud, complying with our legal and regulatory obligations, and carrying out research and statistical analysis to help us improve our services. We will not retain your information for longer than is necessary.
- We may share your information with other organisations in relation to the above purposes, *eg* the insurer of your health plan, payment service providers, and our emergency medical assistance service providers. This may involve transferring your information to countries outside the European Union.
- Telephone calls to and from William Russell may be recorded for training and monitoring purposes.
- We will process the personal information of each person named on this form, including sensitive information such as details about your/their health, in accordance with our privacy policy.
- Our privacy policy also contains information about who to contact if you have any questions about how we use your information, or if you would like to request a copy of the information we hold about you. For full details of our privacy policy, please visit our website or consult your plan agreement.

Communication preferences

We'd like to stay in touch with you in ways we think you might find helpful. Every now and then, we share information about international healthcare and expat life, plus other useful content we think could be of interest to you. We also send occasional emails that promote our products and services.

We won't spam you or share your details with third parties, and you can unsubscribe at any time. You can read our privacy policy on our website.

Please tick the box to opt into our marketing communications:

- ◯ Email
- ◯ Newsletter
- ◯ Telephone
- ◯ Text message/SMS

Declaration for your health plan

Please read this section carefully and sign on the following page.

- I understand that my application for a health plan is subject to written acceptance by William Russell.
- I declare that I have taken reasonable care to answer every question for all persons named on this form fully, accurately, and to the best of my knowledge. I also confirm that I have checked with each person that the information I have provided is a true representation of the facts.
- I understand that misrepresentation could result in claims being rejected or not fully paid, and/or my health plan being cancelled.
- I understand that the health plan I am applying for does not cover the medical conditions that existed before the proposed start date of the plan, unless I have provided full details of any such medical conditions to William Russell and William Russell has agreed to cover them. I also understand that my Certificate of Insurance will advise me of any medical conditions that are not covered by my health plan, based on the information I have provided on this form.
- I understand that I must inform William Russell, in writing, of any changes in the facts provided in my application, including any change in the health of any person named on this form, occurring before the start date of my health plan.
- In order to process my claims, I understand that William Russell may need to obtain details of my medical history and the medical histories of all persons named on this form.
- I authorise William Russell to send all insurance documents as PDF files to the email address I have provided on this form. If I have applied through a broker or intermediary, I understand that these documents may be sent via email to that broker or intermediary.

Declaration for your health plan (continued)

Some important notes

Please make sure that this form and all supplementary documents are legible. Your completed application form is valid for 28 days from the date you sign it. If your health plan has not commenced within 28 days, you may have to complete a new form. If the health of any person named on this form changes after you submit this form, but before your health plan starts, you must let us know immediately.

Please return this form to us by post or email using the contact details below. If you wish to use email, we can accept a printed, signed, and scanned copy of this form or we can accept a digitally-completed copy of this form saved and returned to us as a PDF. If you have completed this form digitally, please make sure that the email accompanying the return of this form contains the following text: -

"I, [your name], have completed and signed the application form myself and I am happy to be bound by the terms, conditions, and exclusions of the personal health plan agreement."

You must use the same email address to return the digitally-completed form that you provided on the first page of this form.

Name of applicant: .....

Signature of applicant: ..... **Date:** .....

Agency Norbert Fuss

Contact details
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