MEDICARE LONG-TERM INTERNATIONAL HEALTH PLAN

ADDITION OF DEPENDANT FORM 2017 - 2018

Insurance made easy.

For Office Use: Inception Date: d d / m m / y y y y Policy Number: Broker Code:

PLEASE WRITE IN CAPITAL LETTERS

YOUR PERSONAL DETAILS

1

Surname: ..... First Name(s): .....

Certificate Number: .....

Address: .....

City: ..... State/Region/County: .....

Postcode: Country: .....

ADDITIONAL PERSONS TO BE INSURED

Please give details of all additional persons to be covered under your plan

2

	Surname	First Names	Date of Birth	Gender	Country of residence	Area of cover
Spouse/Partner						
Child†						
Child†						
Child†						
Child†						

†Any children to be included must be aged under 18, or 24 if still in full-time education. Evidence will be required. The cover provided for the above dependants will match that currently provided to you.

DECLARATION

3

I hereby apply for my eligible dependants listed above to be enrolled in the Plan. I/we declare that the information disclosed in this application form, is to the best of my/our knowledge and belief both accurate and complete. I/we have taken care not to make any misrepresentation in the disclosure of this information and understand that all information provided is relevant to the acceptance and assessment of this insurance. For my benefit and protection, I have read the Policy Guide carefully and requested further information on any points I do not understand. I understand the Policy Guide to be part of any contract of insurance issued as a result of this Application. I agree that they will be binding on all eligible dependants included in my membership. I acknowledge on behalf of all additional persons to be insured that benefits will not apply to treatment arising from any pre-existing conditions as more fully defined in the Policy Guide.

Applicant's Signature

Date: d d / m m / y y y y

(On behalf of all persons to be insured)

Signing this application form does not bind your eligible dependants to be insured to enter into this insurance. No cover is in force until this application form is accepted by the insurer and the premium is paid. The insurer reserves the right to decline any insurance application or to offer different premium and terms from those quoted dependent on the information you have provided.

DATA PROTECTION ACT Any information you have provided will be dealt with by APRIL International UK and the Insurer of the plan in compliance with the provisions of the Data Protection Act 1998. For the purpose of providing this insurance and handling of any claims or complaints which may arise under it, APRIL International UK and the Insurer of the plan may need to transfer certain information which you have provided to other parties. By signing this proposal you agree that such transfer(s) may be made.

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