

# SHORT-TERM INTERNATIONAL HEALTH PLAN



## APPLICATION FORM

Insurance made easy.

For Office Use: Inception Date:   /   /     Policy Number:       Broker Code:

### HOW TO APPLY

1. Complete all sections in full and sign the declaration ensuring you have understood all aspects of the application.
  2. Complete the Method of Payment details.
  3. Submit the application form to APRIL International UK.
- Insurance Premium Tax will be added to the premium if you and/or your dependants will be resident in a country where we are required to charge tax.
- All correspondence from us (your Certificate of Insurance, Policy Guide, Claims Reimbursements etc.) will be sent via email.

### PLEASE WRITE IN CAPITAL LETTERS

#### YOUR PERSONAL DETAILS

Title:  Mr  Mrs  Ms  Miss  Other.....

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

Address: .....

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

Postcode:       Country: .....

Telephone:                      Email: .....

Occupation: ..... Gender .....

Nationality\*: .....

\*used to establish the Home Country of the Applicant and Dependants

#### COVER REQUIRED (please tick)

| Plans   | Area of Cover   | Period of Cover  |
|---|---|--|
| <input type="radio"/> Short Term  | <input type="radio"/> Area 1: Worldwide excluding USA & Caribbean | <input type="text"/> <input type="text"/> months<br>(Cover can only be purchased in whole months for a minimum of 1 month to a maximum of 12 months) |
| <input type="radio"/> Short Term + Pre Existing Condition Cover<br>(Only available if the applicant is aged 50 years or less and selected a policy of 3 months or more) |   |  |
| <input type="radio"/> Short Term + Out of Area Cover<br>(30 days emergency cover is only available on policies of 3 months or more)                                     |   |  |
| <input type="radio"/> Short Term + Pre Existing Condition Cover + Out of Area Cover   |   |  |

#### REQUIRED START DATE (please tick)

On Acceptance  Other (please specify)   /   /

## PERSONS TO BE INSURED

Please give details of all the persons to be covered under the policy

|                | Surname | First Names | Date of Birth* | Gender | Country of Short-Term Residence |
|----------------|---------|-------------|----------------|--------|---------------------------------|
| Applicant      |         |             |                |        |                                 |
| Spouse/Partner |         |             |                |        |                                 |
| Child          |         |             |                |        |                                 |
| Child          |         |             |                |        |                                 |
| Child          |         |             |                |        |                                 |
| Child          |         |             |                |        |                                 |

## DOCTOR DETAILS

Please give details of the doctor(s) who is(are) most familiar with your/your dependant(s)' medical history

Doctor's Name:..... Doctor's Name: .....

Address:..... Address:.....

.....

City:..... City:.....

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

Postcode:         Postcode:

Country:..... Country:.....

Telephone:               Telephone:

## DECLARATION

I hereby apply to be enrolled in the Plan together with the persons to be insured listed above. 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 me and all eligible dependants included in my membership. I acknowledge on behalf of all the 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 unless specifically mentioned on the individual Certificates of Insurance.

By signing the declaration below you are confirming that you understand the English language and the terms of cover where they have been provided to you in English. If you are unsure of any terms conditions or exclusions please seek assistance from your insurance adviser before you sign.

Applicant's Signature

Date:   /   /

(On behalf of all persons to be insured)

Signing this application form does not bind you 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.

## METHOD OF PAYMENT

Premium amount:       .

Currency (delete as applicable): £GBP | \$USD | €EUR

Method of payment:

Bank Transfer  Credit/Debit Card

### Bank Transfer

Please make bank transfers to the following accounts, instructing your bank to make sure that the transfer identifies you as the source

**Account Name:** APRIL International UK | **Bank:** Barclays | **Address:** 1 Churchill Place, London E14 5HP

| Currency | Sort Code | Account No. | IBAN                   | SWIFT    |
|----------|-----------|-------------|------------------------|----------|
| £GBP     | 20-00-00  | 53869067    | GB03BARC20000053869067 | BARCGB22 |
| \$USD    | 20-00-00  | 76383566    | GB61BARC20000076383566 | BARCGB22 |
| €EUR     | 20-00-00  | 44928922    | GB97BARC20000044928922 | BARCGB22 |

## METHOD OF PAYMENT (CONTINUED)

### Credit Card Details

Credit/Debit Card:

Visa

Mastercard

Amex

I authorise APRIL International UK Limited to debit the following credit/debit card for the premium amount indicated:

Card No.

Expiry Date

Security Code

(Last 3 digits on back of card or if AMEX 4 digits on front of card)

Name of Cardholder: .....

Card Billing Address: .....

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

Postcode:

Country: .....

Signature of Cardholder

Date:  /  /

## SUBMITTING YOUR APPLICATION

By Post: APRIL International UK,  
Minster House, 42 Mincing Lane,  
London EC3R 7AE, United Kingdom

By Fax: + 44 (0) 20 7118 1178

By Email: [info@april-international.co.uk](mailto:info@april-international.co.uk)

## IMPORTANT INFORMATION

### Data Privacy

For full information about how we process and protect your personal information please refer to our Privacy Policy which can be viewed by clicking on the site terms and conditions on our website [www.april-international.co.uk](http://www.april-international.co.uk).

### How We Use Your Information

The personal information, provided by you (or anyone acting on your behalf), is collected by or on our behalf and may be used by us, our employees, agents and service providers acting under our instruction for the purposes of insurance administration, underwriting, claims handling, insurance mediation, research or for statistical purposes.

We may process your information for a number of different purposes. For each purpose we must have a legal ground for such processing. When the information that we process is classed as 'special category data, we must have a specific additional legal ground for such processing.

### Generally, we will rely on the following legal grounds:

- > It is necessary for us to process your personal information to provide this policy and services related to it. We will rely on this for activities such as providing you with information about your quote, assessing your application, managing your policy, handling claims and providing other services to you.
- > We have an appropriate business need to process your personal information and such business need does not cause harm to you. We will rely on this for activities such as maintaining our business records, developing,

improving our products and services, and providing information about our products and services to you.

- > We have a legal or regulatory obligation to use such personal information.
- > We need to use such personal information to establish, exercise or defend our legal rights.
- > You have provided your consent to our use of your personal information, including special category data.

### How we share your information

In order to sell, manage and provide our products and services, prevent fraud and comply with legal and regulatory requirements, we may need to share your information with the following types of third parties:

- > Insurers, Reinsurers, Regulators and Authorised/ Statutory Bodies
- > Fraud prevention agencies
- > Crime prevention agencies, including the police
- > Suppliers carrying out a service on our behalf
- > Other insurers, business partners and agents
- > Other companies within the APRIL Group

As we operate as part of a global business, we may transfer your personal information outside the European Economic Area (EEA) for these purposes where adequate protection is in place.

Continued over...

## IMPORTANT INFORMATION (CONTINUED)

### Marketing

We will not use your information or pass it on to any other person for the purposes of marketing further products or services to you unless you have consented to this.

### Fraud Prevention and Detection

In order to prevent or detect fraud and money laundering we may check your details with fraud prevention agencies and sanction websites, who may record a search. Searches may also be made against other insurers' databases. If fraud is suspected, information will be shared with those insurers. Other users of the fraud prevention agencies may use this information in their own decision making processes.

We may also conduct credit reference checks in certain circumstances. You can find further details in our full Privacy Policy explaining how the information held by fraud prevention agencies may be used.

### Automated Decisions

We may use automated tools with decision making to assess your application for insurance and for claims handling processes. If you object to an automated decision, we may not be able to offer you an insurance quotation.

### Contact Us

Please contact us if you have any questions about our privacy policy or the information we hold about you.

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april international | UK

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Insurance made easy.