CIGNA CLOSE CARE℠ APPLICATION FORM

HELLO

We’re glad you would like to join us.

Together, all the way.℠

Cigna®

Please complete this application form in BLOCK CAPITALS, and return to us. See our contact information at the end of this form.

To satisfy certain regulatory requirements, you must state in Section A below whether you or any other person receiving cover under the policy is a Politically Exposed Person. A Politically Exposed Person is an individual who holds or has previously held a prominent position in a public function, such as a member of any royal family, a head of state, a judiciary official, a politician, a military officer etc. This requirement is only applicable if your policy is arranged through our Dubai International Finance Centre office.

SECTION A

APPLICATION DETAILS

Please complete this section for all persons to be covered under the policy, including the main policyholder and any dependents.

POLICYHOLDER

You must notify us of any change of contact details so we can ensure that correspondence reaches you.

Title		First Name		Other Initials		Surname	
Gender		Male	○	Female	○	Date of birth (DD/MM/YYYY)	
Are you a Politically Exposed Person? (see explanatory notes above)		Yes	○	No	○	Occupation	
Are you currently in the US?		Yes	○			No	○
		If yes, please identify state:				**If no, please proceed to Nationality question**	

Please provide your US address below if you are currently located in one of the following states: AZ, CA, CT, DC, FL, IL, IN, KS, LA, MI, NH, OH, SC, TN, TX, UT, VA.
If not located in one of the above states, please proceed to Nationality question

Address					
City		State		Zip/Postal Code	
Nationality (What is the nationality of the primary passport that you hold?)					
Location (The country in which you live/will live for the majority of your time for the period of cover)					
Address in location country (if known)					
Address line 1					
Address line 2					
Address line 3					
Country				Zip/Postal Code	
Correspondence address (If applicant is a US National, address must be outside the United States)					
Address line 1					
Address line 2					
Address line 3					
Country				Zip/Postal Code	
Daytime telephone number (Country code – Number)		Mobile telephone number (Country code – Number)		Fax (Country code – Number)	
Email address					

Height:	Feet		Inches		Centimetres		**Weight:**	Stones		Pounds		Kilogrammes	
Have you smoked, or used tobacco or nicotine replacement products in the last 12 months?									Yes	○	No	○
If yes, how many per day?	**Less than 20 per day**	○	**20 or more per day**	○	**Nicotine replacements**	○						

DEPENDENT 1

Title		First Name		Other Initials		Surname	
Relationship to policyholder		Gender	Male ◯	Female ◯			
Are you a Politically Exposed Person? (see explanatory notes above)			Yes ◯	No ◯			
Date of birth (DD/MM/YYYY)		Occupation					
Nationality (What is the nationality of the primary passport that you hold?)							
Location (Your country of habitual residence, this must be the same as the policyholder's)							
Height: Feet		Inches		Centimetres		**Weight:** Stones	
Pounds		Kilogrammes					
Have you smoked, or used tobacco or nicotine replacement products in the last 12 months?			Yes ◯	No ◯			
If yes, how many per day?	**Less than 20 per day** ◯	**20 or more per day** ◯	**Nicotine replacements** ◯				

DEPENDENT 2

Title		First Name		Other Initials		Surname	
Relationship to policyholder		Gender	Male ◯	Female ◯			
Are you a Politically Exposed Person? (see explanatory notes above)			Yes ◯	No ◯			
Date of birth (DD/MM/YYYY)		Occupation					
Nationality (What is the nationality of the primary passport that you hold?)							
Location (Your country of habitual residence, this must be the same as the policyholder's)							
Height: Feet		Inches		Centimetres		**Weight:** Stones	
Pounds		Kilogrammes					
Have you smoked, or used tobacco or nicotine replacement products in the last 12 months?			Yes ◯	No ◯			
If yes, how many per day?	**Less than 20 per day** ◯	**20 or more per day** ◯	**Nicotine replacements** ◯				

DEPENDENT 3

Title		First Name		Other Initials		Surname	
Relationship to policyholder		Gender	Male ◯	Female ◯			
Are you a Politically Exposed Person? (see explanatory notes above)			Yes ◯	No ◯			
Date of birth (DD/MM/YYYY)		Occupation					
Nationality (What is the nationality of the primary passport that you hold?)							
Location (Your country of habitual residence, this must be the same as the policyholder's)							
Height: Feet		Inches		Centimetres		**Weight:** Stones	
Pounds		Kilogrammes					
Have you smoked, or used tobacco or nicotine replacement products in the last 12 months?			Yes ◯	No ◯			
If yes, how many per day?	**Less than 20 per day** ◯	**20 or more per day** ◯	**Nicotine replacements** ◯				

DEPENDENT 4

Title		First Name		Other Initials		Surname	
Relationship to policyholder		Gender	Male ◯	Female ◯			
Are you a Politically Exposed Person? (see explanatory notes above)			Yes ◯	No ◯			
Date of birth (DD/MM/YYYY)		Occupation					
Nationality (What is the nationality of the primary passport that you hold?)							
Location (Your country of habitual residence, this must be the same as the policyholder's)							
Height: Feet		Inches		Centimetres		**Weight:** Stones	
Pounds		Kilogrammes					
Have you smoked, or used tobacco or nicotine replacement products in the last 12 months?			Yes ◯	No ◯			
If yes, how many per day?	**Less than 20 per day** ◯	**20 or more per day** ◯	**Nicotine replacements** ◯				

SECTION B

APPLICANT DETAILS

When do you want your cover to begin? (DD/MM/YYYY)

CORE COVER

Choose your deductible

	$0 ◯	$375 ◯	$750 ◯	$1,500 ◯	$3,000 ◯	$7,500 ◯	$10,000 ◯
	€0 ◯	€275 ◯	€550 ◯	€1,100 ◯	€2,200 ◯	€5,500 ◯	€7,400 ◯
	£0 ◯	£250 ◯	£500 ◯	£1,000 ◯	£2,000 ◯	£5,000 ◯	£6,650 ◯

Then, select your cost share percentage

No cost share ◯	10% ◯	20% ◯	30% ◯

Choose your out of pocket maximum
(This is the maximum amount of cost share under the Core Cover you must pay in the event of a claim or claims per period of cover).

$2,000 ◯	$5,000 ◯
€1,480 ◯	€3,700 ◯
£1,330 ◯	£3,325 ◯

OPTIONAL BENEFITS

Do you wish to upgrade your plan with any of the following options

Outpatient and Wellness Care

Yes ◯ No ◯

Deductible

$0 ◯	$150 ◯	$500 ◯	$1,000 ◯	$1,500 ◯
€0 ◯	€110 ◯	€370 ◯	€700 ◯	€1,100 ◯
£0 ◯	£100 ◯	£335 ◯	£600 ◯	£1,000 ◯

Cost share after deductible (a $3,000 / €2,200 / £2,000 out of pocket maximum is applied to cost shares on the Outpatient and Wellness Care option)

No cost share ◯	10% ◯	20% ◯	30% ◯

Dental Care and Treatment Yes ◯ No ◯

USA coverage (applicable to US nationals only) Yes ◯ No ◯

If you are a US national and do not select to purchase USA coverage, you will not be covered for temporary trips home.

Please note that the Outpatient and Wellness Care, Dental Care and Treatment and USA coverage options can only be purchased with your Core cover.

Please note that each plan chosen will apply to all dependents.

Your plan selection can only be amended at policy renewal. Should you wish to increase your level of cover at renewal, full medical underwriting and waiting periods may apply and an additional premium amount will be payable.

SECTION C

CONFIDENTIAL HEALTH QUESTIONNAIRE

You now need to provide information about the medical history of yourself and each person named in Section A. If you tick Yes to a question, please provide full details in Section D.

Once you've done this we can finalise your application. It may help to have any relevant medical documentation to hand when you are filling out this form. Depending on the medical history, we might need some further information before we can finalise your cover.

Please read the following questions very carefully. Please take reasonable care to answer all questions honestly and fully. Careless misrepresentation could result in Cigna reducing the amount of any claims proportionately; whereas deliberate or reckless misrepresentation could result in Cigna rejecting claims, and/or cancelling cover. If you need help completing your application, please contact us.

If you are unsure about the answer to any question you should make the enquiries necessary to allow you to provide an accurate answer.

YOUR PLAN

	Has any applicant received treatment, tests or investigations for, or been diagnosed with, or had any signs or symptoms of:	POLICYHOLDER	DEPENDENT 1	DEPENDENT 2	DEPENDENT 3	DEPENDENT 4
1	**Diabetes and other endocrine (glandular) disorders** e.g. any thyroid disorder, weight problems, gout, pituitary or adrenal gland conditions?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
2	**Heart or circulatory disorders** e.g. chest pain, heart attack, high blood pressure, vascular disease, coronary artery disease, angina, irregular heartbeat, aneurysm or heart murmur.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
3	**Cancer, tumours or growths** including polyps, cysts or breast lumps.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
4	**Muscle or skeletal problems** e.g. back pain, whiplash, arthritis, joint pain or problems, gout, fractures, cartilage, tendon or ligament problems.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
5	**Asthma, allergies, breathing or respiratory disorders** e.g. chest infections, pneumonia, bronchitis, shortness of breath, rhinitis, TB, emphysema or chronic obstructive pulmonary disease.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6	**Gall bladder, stomach, intestinal, gastric or liver problems** e.g. irritable bowel disease, colitis, Crohn's disease, gastric or peptic ulcers, reflux, indigestion, heartburn, gall stones, hernia, haemorrhoids or hepatitis.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
7	**Brain or neurological disorders** e.g. multiple sclerosis, epilepsy or seizures, stroke, migraines, recurring or severe headaches, meningitis, shingles or nerve pain.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
8	**Skin problems** e.g. eczema, acne, moles, rashes, allergic reactions, cysts, dermatitis or psoriasis	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
9	**Blood, infective or immune disorders** e.g. high cholesterol, anaemia, malaria, HIV or systemic lupus erythematosus.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
10	**Urinary or reproductive disorders** e.g. urinary tract infections, kidney problems, fibroids, painful, irregular or heavy periods, fertility problems, polycystic ovarian syndrome, endometriosis, testicular or prostate problems.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯

YOUR PLAN (CONTINUED)

Has any applicant received treatment, tests or investigations for, or been diagnosed with, or had any signs or symptoms of:		POLICYHOLDER	DEPENDENT 1	DEPENDENT 2	DEPENDENT 3	DEPENDENT 4
11	**Anxiety, depression, psychiatric or mental health issues** including eating disorders, post-traumatic stress disorder, alcohol or drug issues.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
12	**Ear, nose, throat, eye or dental problems** e.g. ear infections, sinus problems, tonsils and adenoids, cataracts, glaucoma, wisdom teeth problems.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
Please also answer the following questions:						
13	Does anyone have any illness, condition or symptom not already mentioned? Please include details of any known or suspected issues whether or not medical advice has been sought or a diagnosis reached.	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
14	Does anyone take any medication, receive any treatment of any kind or expect to have a review or follow up for any current or past medical problem not already mentioned?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯

SECTION D

ADDITIONAL HEALTH INFORMATION

Please tell us more if you have answered 'Yes' to any questions in Section C. If you are unsure if any details are relevant, please include them anyway. If you run out of space, please use a separate sheet.

	Section C Question Number	**The name of the illness or medical problem. Where applicable state the area of the body affected** (e.g. left arm, right foot).	**When did the symptoms occur and when did you last have symptoms?**	**What treatment was provided?** (Include details of medication and dates of when treatment started and ended.)	**What is the current status of the illness or medical problem?** (E.g. ongoing, complete, recovery, recurrent or likely to recur.)
POLICYHOLDER					
DEPENDENT 1					
DEPENDENT 2					
DEPENDENT 3					
DEPENDENT 4					

SECTION E

DECLARATION FOR ALL CUSTOMERS

I hereby declare that I have taken reasonable care to answer all questions accurately, honestly and completely. I acknowledge that if I do not answer all questions accurately and completely as a result of my carelessness that could result in Cigna reducing the amount of any claims proportionately. I also acknowledge that if I deliberately or recklessly provide inaccurate or incomplete information in answer to questions that could result in Cigna rejecting claims, and/or cancelling cover.

The duty to answer our questions accurately, honestly and completely applies in respect of each person who is covered by this policy. Although failure to fulfil this duty by one covered person may affect coverage or payment of their claims, it will not affect coverage or payment of claims in relation to any other covered person, unless that person has also made careless, deliberate or reckless misrepresentations in relation to our questions. I warrant and represent that I have each covered person's consent to disclose the personal information, including the sensitive personal information (e.g. medical information) contained in this form to you. I confirm that each covered person is aware of their duty to take reasonable care to answer your questions accurately, honestly, completely and to the best of their knowledge.

(Please note that if you are declaring the above on another person's behalf, it is your obligation to keep evidence of the consent you are providing hereto of your covered family members' actual declarations and consents.)

I hereby propose to Cigna for cover to begin on the cover date or such other agreed date. In the event that it is found that I, or any covered person, have deliberately or recklessly provided any information which is false or inaccurate, Cigna may void the contract of insurance as it relates to me or the covered person and refuse all claims and need not return any premiums paid in, except for where it would be unfair for the premiums to be retained. I have carefully read, understood and agree to abide by the Policy Rules and Customer Guide as they form part of my contract of insurance.

Signature	
Date (DD/MM/YYYY)	

If you are signing for, or on behalf of, the Main policyholder please sign below where you are warranting and representing to us that you have read the above declaration and have the authority to enter into this application:

Signature				
Date (DD/MM/YYYY)				
Select the relationship to main policyholder	**Broker** ◯	**Agent** ◯		
	Other (please specify) ◯			

FRAUD NOTICE

Any person who, dishonestly and with intent to make a gain for himself or cause loss to another, or to expose another to a risk of loss: (1) makes an application for insurance or makes a claim under a policy containing any information he knows to be untrue or misleading ; or who (2) in making an application for insurance or a claim under a policy dishonestly and with intent to make a gain for himself or cause loss to another, or to expose another to a risk of loss fails to disclose information which has been asked for, commits fraud. We will investigate any claims or applications for insurance which we have grounds to believe may be fraudulent. Committing fraud may result in your policy being terminated and any claims you make under not being paid. We may, for the purposes of the detection and prevention of fraud, share information relating to suspected fraud with other insurance companies and/or with law enforcement authorities.

HOW WE USE YOUR INFORMATION

We will collect, use, store, and disclose your personal information, including sensitive information (in particular, information relating to your medical history and any medical treatment you may have or have had), in accordance with relevant data protection legislation. We collect and will use your personal information, including sensitive information, for the purpose of carrying out our obligations under this plan.

We may share your information, including sensitive information, with other Cigna companies and authorised healthcare providers, where necessary to carry out our obligations under this plan. This statement also applies to personal information of any beneficiaries detailed on this application form.

You have the right to request a copy of your personal information held by us, and beneficiaries under your policy have the right to request a copy of personal information we hold about them. We may charge a fee to provide this information.

I acknowledge the collection, use and disclosure of my personal and special category data by Cigna for the purposes required by the contract of insurance I have entered into.	☐

SPECIAL OFFERS, PROMOTIONS, PRODUCTS AND SERVICES

We would like to keep in touch with you to keep you updated about our special offers, promotions, products and services which we think will interest you.

If you would like to receive this information, please tick here	☐			
If yes, how would you like us to contact you?	**Email**	☐	**Telephone**	☐

SECTION F

PAYMENT DETAILS

This page, including your card details, will be securely disposed of once your application has been processed and the payment details have been securely stored.

PAYMENT DETAILS FOR YOUR PREMIUM

Payment currency			**US Dollar**	○	**Euro**	○	**Sterling**	○	
Payment frequency			**Monthly**	○	**Quarterly**	○	**Annually**	○	
Payment method	**Credit/debit card**	○			**Bank wire transfer (Annual payment only)** (We will call you on receipt of your application to provide the relevant details)	○			
Credit/debit card number									
Type of card	**MasterCard**	○	**Visa**	○	**Visa Debit**	○	**Visa Electron**	○	**American Express** ○
Name as it appears on the card									
Start date of the card (MM/YY)			Expiry date of the card (MM/YY)						
Security code (This is the 3 digit number on the reverse of most cards. For American Express cards, this is the 4 digit number found on the front of the card on the right hand side)									
Please confirm that the payment card is that of the policyholder?							**Yes** ○		**No** ○
If the cardholder is not the policyholder, please state the relationship to the policyholder	**Other beneficiary**	○	**Employer**	○	Company name				
	Spouse/partner	○	**Other**	○	Relationship				
	Family member	○							
Date of birth of cardholder (DD/MM/YYYY)									
Nationality of cardholder									
Is the billing address the residence address you have provided for your policy?							Yes ○		No ○
If no, please provide the full billing address									

Credit card authorisation: I authorise Cigna to charge my credit/debit card account with my healthcare premium (of which I will be notified upon acceptance of cover/renewal). This will continue until the instruction is cancelled, and I will provide written notice to Cigna according to my Policy Rules documentation.

Cardholder's signature		Date (DD/MM/YYYY)	

Upon completion of the application, please contact our Broker Sales Team for support.

Email: cgi.sales@cigna.com

Telephone: +44 (0) 1475 788 682
Toll free from US: 1-877-539-6296

Together, all the way.℠

Cigna®

Cigna Close Care℠ Application Form Broker 11/2021