Cigna Global Health Options *Advance*

Application form

Please note that you can apply by calling our Sales Team on +44 (0)1475 492119. Otherwise, please complete this application form and return it to us, either by electronic mail, fax or post. Please see our contact information at the end of this form.

Please complete this form in BLOCK CAPITALS.

APPLICANT DETAILS

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

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 (please tick)	**Male** ☐ **Female** ☐	Date of birth (DD/MM/YYYY)	/ /
Occupation			
Correspondence address			
Daytime telephone number (Country code – Area code – Number)			
Mobile telephone number (Country code – Area code – Number)			
Fax (Country code – Area code – Number)			
Email address			
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)			
Height:	**Feet**	**Inches**	**Centimetres**
Weight:	**Stones**	**Pounds**	**Kilogrammes**

BENEFICIARY 1

Title	First Name	Other Initials	Surname
Relationship to policyholder		Gender (please tick)	**Male** ☐ **Female** ☐
Date of birth (DD/MM/YYYY)	/ /	Occupation	
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)			
Height:	**Feet**	**Inches**	**Centimetres**
Weight:	**Stones**	**Pounds**	**Kilogrammes**

BENEFICIARY 2

Title	First Name	Other Initials	Surname
Relationship to policyholder		Gender (please tick)	**Male** ☐ **Female** ☐
Date of birth (DD/MM/YYYY)	/ /	Occupation	
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)			
Height:	**Feet**	**Inches**	**Centimetres**
Weight:	**Stones**	**Pounds**	**Kilogrammes**

BENEFICIARY 3			
Title	First Name	Other Initials	Surname
Relationship to policyholder		Gender (please tick)	**Male** ☐ **Female** ☐
Date of birth (DD/MM/YYYY) / /		Occupation	
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)			
Height:	**Feet**	**Inches**	**Centimetres**
Weight:	**Stones**	**Pounds**	**Kilogrammes**

BENEFICIARY 4			
Title	First Name	Other Initials	Surname
Relationship to policyholder		Gender (please tick)	**Male** ☐ **Female** ☐
Date of birth (DD/MM/YYYY) / /		Occupation	
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)			
Height:	**Feet**	**Inches**	**Centimetres**
Weight:	**Stones**	**Pounds**	**Kilogrammes**

BENEFICIARY 5			
Title	First Name	Other Initials	Surname
Relationship to policyholder		Gender (please tick)	**Male** ☐ **Female** ☐
Date of birth (DD/MM/YYYY) / /		Occupation	
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)			
Height:	**Feet**	**Inches**	**Centimetres**
Weight:	**Stones**	**Pounds**	**Kilogrammes**

BENEFICIARY 6			
Title	First Name	Other Initials	Surname
Relationship to policyholder		Gender (please tick)	**Male** ☐ **Female** ☐
Date of birth (DD/MM/YYYY) / /		Occupation	
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)			
Height:	**Feet**	**Inches**	**Centimetres**
Weight:	**Stones**	**Pounds**	**Kilogrammes**

APPLICANT DETAILS

Where do you want your cover? *(please tick)* Worldwide ☐ Worldwide excluding USA ☐

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

INTERNATIONAL MEDICAL INSURANCE PLAN

Chosen deductible option *(tick)*

£0 ☐	£250 ☐	£500 ☐	£1,000 ☐	£2,000 ☐	£5,000 ☐
$0 ☐	$375 ☐	$750 ☐	$1,500 ☐	$3,000 ☐	$7,500 ☐
€0 ☐	€275 ☐	€550 ☐	€1,100 ☐	€2,200 ☐	€5,500 ☐

CHOSEN COINSURANCE OPTION

First, select your coinsurance percentage: **No coinsurance** ☐ **10%** ☐ **20%** ☐

Then, if you have chosen a coinsurance option, select your chosen out of pocket maximum *(this is the maximum amount of coinsurance under International Medical Insurance plan you must pay in the event of a claim or claims)*

£1,500 ☐	£3,500 ☐
$2,000 ☐	$5,000 ☐
€1,750 ☐	€4,000 ☐

OPTIONAL BENEFITS

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

International Medical Insurance Plus — **Yes** ☐ **No** ☐

Deductible

£0 ☐	£100 ☐	£600 ☐
$0 ☐	$150 ☐	$1,000 ☐
€0 ☐	€110 ☐	€700 ☐

Coinsurance **No coinsurance** ☐ **10% coinsurance** ☐ **20% coinsurance** ☐

International Emergency Evacuation — **Yes** ☐ **No** ☐

International Health and Wellbeing — **Yes** ☐ **No** ☐

International Vision and Dental — **Yes** ☐ **No** ☐

Please note that International Medical Insurance Plus, International Emergency Evacuation, International Health and Wellbeing and International Vision and Dental plans can only be purchased in conjunction with the International Medical Insurance Plan.

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

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.

PAYMENT DETAILS

Payment currency **Sterling** ☐ **Dollar** ☐ **Euro** ☐

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: *(tick)* **Mastercard**

Visa ☐	**Visa Debit** ☐	**American Express** ☐
Maestro (UK Domestic) ☐	**Solo** ☐	**Delta** ☐
Maestro (International) ☐	**Visa Electron** ☐	

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)*

Is the billing address the address you have provided for your policy? *(please tick)* **Yes** ☐ **No** ☐

If no please provide the full billing address:

Address:

Postcode:

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) / /

MEDICAL HISTORY DECLARATION

Please tell us about past and present medical history for yourself and all other persons to be covered under the policy. 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 and answer each question accurately. Failure to take reasonable care to answer all questions honestly and to the best of your knowledge could affect payment of claims under your policy and may result in Cigna terminating your cover.

If you need help completing your application form, 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.

Please take reasonable care to answer all questions honestly and to the best of your knowledge. .

When answering the questions below, please answer them for yourself and ALL other persons to be covered by this policy.

Has anyone covered by this policy been treated for, or have a history of:

Number	Medical history questions Part 1	Yes	No	If you answered yes to any of the questions 1 to 14 please answer the questions below: Part 2	Yes	No
1	**Diabetes, thyroid and other endocrine (glandular) disorders** Including obesity, Type 1 and 2 Diabetes, over and underactive thyroid, pituitary or adrenal problems	☐	☐	Was the illness condition or medical treatment limited to one of the following?	☐	☐
				Nontoxic Goiter - resolved with treatment more than 1 year ago		
				Thyroid Nodule - successfully removed, no treatment needed, benign		
				Gout - single episode more than 2 years ago, no treatment or medication required		
2	**Heart or circulatory disorders** Including chest pains, angina, high blood pressure, heart attack, irregular heart beat, aneurysm or varicose veins	☐	☐	Was the illness or medical treatment limited to one of the following?	☐	☐
				Septal Defect - surgery or spontaneous closure more than 2 years ago, no symptoms, no follow up required		
				Innocent Heart Murmur - fully investigated and diagnosis confirmed		
				Varicose Veins - treated more than 5 years ago with no recurrence, fully recovered		
3	**Cancer, tumour or growth** *Including polyps or breast lumps*	☐	☐	Was the illness or medical treatment limited to one of the following?	☐	☐
				Basal Cell Carcinoma - removed more than 1 year ago, benign, no recurrence		
				Fibroadenoma Breast - removed/not present for at least 2 years		

		Yes	No		Yes	No
4	**Muscle or skeletal problems** *Including back pain, whiplash, arthritis, joint pain or problems, gout, fractures, cartilage or ligament problems*	☐	☐	Was the illness or medical treatment limited to one of the following?	☐	☐
				Back Surgery - more than 10 years ago, fully recovered, no residual problems		
				Fractured limb or rib - more than 6 months ago, no internal fixations e.g. pins, plates or wires, fully recovered		
				Sprain or strain of muscle, tendon or ligament - more than 2 years ago, fully recovered		
				Muscular back pain - more than 2 years ago, single, shortlived episode, treated with painkillers only, fully recovered		
5	**Asthma, allergies, breathing or respiratory disorders** *Including chest infections, pneumonia, bronchitis, shortness of breath, rhinitis, TB, emphysema or chronic obstructive pulminary disease*	☐	☐	Was the illness or medical treatment limited to one of the following?	☐	☐
				Hayfever		
				Flu		
				Laryngitis		
				Common Cold		
				Childhood Asthma - 'Grown out of it' - medication inhaler not required for more than 2 years		
				Sinusitis - single episode more than 1 year ago, no treatment or medication required		
				Tonsils - less than 1 episode per year or tonsils already removed		
6	**Gall bladder, stomach, intestinal, gastric or liver problems** *Including irritable bowel disease, colitis, Crohn's disease, gastric or peptic ulcers, reflux, indigestion, heartburn, gall stones, hernia, haemorrhoids or hepatitis*	☐	☐	Was the illness or medical treatment limited to one of the following?	☐	☐
				Appendix - removed more than 6 months ago, fully recovered		
				Gallbladder - removed more than 1 year ago, fully recovered		
				Gastroenteritis - single episode, fully recovered		
				Diarrhoea - mild, single episode, fully recovered		
				Hernia - surgically repaired more than 1 year ago, fully recovered		
				Haemorrhoids - treated more than 5 years ago with no recurrence, fully recovered		
7	**Brain or neurological disorders** *Including multiple sclerosis, epilepsy or fits, stroke, migraines, recurring or severe headaches, meningitis, shingles or nerve pain*	☐	☐	Was the illness or medical treatment limited to the following?	☐	☐
				Meningitis - more than 1 year ago, no ongoing or residual problems, full recovery		
8	**Skin problems** *Including eczema, acne, moles, rashes, allergic reactions, cysts, dermatitis or psoriasis*	☐	☐	Was the illness or medical treatment limited to the following?	☐	☐
				Pilonidal Sinus/Cyst - treated and fully recovered with no recurrencemore than 1 year ago		
				Acne - last episode more than 2 years ago		
				Basal Cell Carcinoma - removed more than 1 year ago, benign, no recurrence		
				Athletes Foot/Fungal Infections - treated and fully recovered		
				Skin Tag or Sebaceous Cyst - removed more than 2 years ago, no recurrence		

		Yes	No		Yes	No
9	**Blood, infective or immune disorders** *Including high cholesterol, anaemia, malaria, HIV or systemic lupus erythematosis*	☐	☐	Was the illness, condition or medical treatment limited to the following? *Infectious Hepatitis (Hepatitis A) - more than 1 year ago, normal liver function blood results, fully recovered*	☐	☐
10	**Urinary or reproductive disorders** *Including urinary tract infections, kidney problems, fibroids, painful, irregular or heavy periods, fertility problems, polycystic ovarian syndrome, endometriosis, testicular or prostate problems*	☐	☐	Was the problem related to one of the following? *Uncomplicated caesarian delivery - more than 1 year ago* *Hysterectomy - more than 1 year ago, not due to cancer, fully recovered* *Hydrocele - more than 6 month ago, treated, no longer present, not related to cancer, fully recovered* *Hernia - surgically repaired more than 1 year ago, fully recovered*	☐	☐
11	**Anxiety, depression, psychiatric or mental health issues** *Including eating disorders, post traumatic stress disorder, alcohol or drug issues*	☐	☐	Was the illness, condition or medical treatment limited to one of the following? *Post Natal Depression - not required medication or specialist advice for over 1 year, fully recovered* *Stress or Anxiety - single mild shortlived episode (6 months or less), not required medication or specialist advice for over 3 years, fully recovered*	☐	☐
12	**Ear, nose, throat, eye or dental problems** *Including ear infections, tonsils and adenoids, cataracts, glaucoma, wisdom teeth problems or sinuses*	☐	☐	Was the illness, condition or medical treatment limited to one of the following? *Long or short sightedness - corrected by glasses, contact lenses or laser surgery* *Wisdom teeth removal - removed with no complications, fully recovered* *Tonsils - less than 1 episode per year or tonsils already removed* *Sinusitis - single episode more than 1 year ago, no treatment or medication required*	☐	☐
13	**Has anyone smoked in the last 5 years?**	☐	☐	Is/was your smoking limited to the following? *Ex-smoker - Stopped smoking more than 2 years ago, previous consumption did not exceed 20 cigarettes per day* *Current smoker - maximum of 20 cigarettes per day, no respiratory/breathing problems*	☐	☐
14	**Has anyone's alcohol consumption ever exceeded 21 units per week if female or 28 units per week if male?** *(A unit of alcohol is roughly equivalent to a 1/2 pint (250 ml) of standard strength beer, lager or cider, a small glass (125ml) of wine or a single measure (25ml) of spirits)*	☐	☐			
15	**Does anyone have any illness, condition or symptom not already mentioned above? Please include details of any known or suspected issues whether or not medical advice has been sought or a diagnosis reached.**	☐	☐			
16	**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 above?**	☐	☐			
17	**Is anyone currently pregnant?**	☐	☐			
18	**Do you currently have or have you had a previous policy with Cigna?**	☐	☐			

If you answered NO to any of the questions 1 to 13 in Part 2 above or YES to questions 14 or 18 above, please provide details in the table below							
Question Number	**Name of the beneficiary this relates to**	**Symptoms/ Condition/ diagnosis**	**Date of onset**	**Frequency & severity of symptoms**	**Date of last episode/ symptoms**	**Details of any past or current medication or treatment**	**Current status (e.g. fully recovered/ ongoing)**

Data Protection

As Data Controller, we will process, disclose, use, store and retain all your personal and sensitive information in accordance with relevant data protection legislation. We will process your personal and sensitive information to allow us to carry out our obligations under this plan and we may share this information with authorised third parties to fulfil the contract. From time to time we may share this information with other insurers to help us to detect and prevent fraud. Telephone calls to and from our organisation may be recorded for the purposes of quality and training. Your application for cover and any future claims made under this plan may also include sensitive medical information. This will be kept confidential and only disclosed to authorised individuals.

Beneficiaries have a right to request a copy of any personal information held by us. We may charge a fee to provide this information.

In the above statement all reference to "your" shall be deemed to include the main policyholder and any beneficiaries detailed on this application form.

PRINCIPLE DECLARATION FOR ALL CUSTOMERS

I hereby declare that I have taken reasonable care to answer all questions honestly and to the best of my knowledge. I understand that failure to do this could affect payment of claims under my policy and may result in Cigna terminating my cover.

Where answering on behalf of another person (and their dependants or beneficiary) to be covered under the policy, I warrant and represent that I have that person's consent to disclose all their personal information including their medical history to you and they have advised me of all material information which has been asked in the application. I also have their consent to view any personal exclusions that Cigna may decide to apply to the policy and their consent that Cigna can process, disclose, use, store and retain all the personal information provided to them. I am fully aware that failure to take reasonable care to answer questions honestly and to the best of my knowledge may affect the coverage of all beneficiaries under this policy.

I hereby propose to Cigna for cover to begin on the cover date or such other agreed date and hold Cigna harmless in the event that any information disclosed is found to be deliberately false. Where Cigna has suffered any loss in this regard, I shall fully indemnify Cigna. I have carefully read, understand and agree to abide by the Policy Rules and Customer Guide as they form part of my contract.

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 principal's actual declarations and consents.

Main policyholder's signature:

Date: / /

If you are signing for 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:

Sign:

Date: / /

Select the relationship to main Policyholder:

Broker ☐ Agent ☐ other ☐ (please specify)

ADDITIONAL DECLARATION APPLICABLE FOR HONG KONG AND SINGAPORE NATIONALS LIVING IN THEIR HOME COUNTRY

If you are a customer whose nationality is either Hong Kong or Singaporean and you are resident and living in Hong Kong or Singapore under this insurance policy then under your local law and regulation you might be entitled to have a Needs Analysis conducted of your particular insurance needs and/or a Customer Protection form completed. I consent to purchase this insurance product without a Needs Analysis or a completed Customer Protection form.

☐ I confirm and agree with the above declaration

Policies issued by Cigna European Insurance Company Singapore Branch are covered under the Policy Owners' Protection Schemes Act 2011, Act No. 15 of 2011 of Singapore (the "Act") up to the limits prescribed by the Act.

Main policyholder's signature:

Date: / /

If you are signing for 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:

Sign:

Date: / /

State relationship to main Policyholder: Broker, Agent or other (please specify)

Please return your fully completed form by post to the following address:

Cigna Global Health Options *Advance*
220 St Vincent Street
Glasgow
G2 5SG
Scotland

Email: cignaglobal_sales.team@cigna.com
Tel: +44 (0) 1475 492119
Fax: +44 (0) 1475 492113

Broker Stamp:

FRAUD NOTICE: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing deliberately false information, commits a fraudulent insurance act, which is a crime.

We will not deal with any claims which we believe to be fraudulent. Committing fraud may result in your policy being terminated, or we will investigate any claims which we believe to be fraudulent.

Your relevant Cigna contracting entity from those listed below will be detailed in your Policy Rules and Certificate of insurance.

a) Cigna Global Insurance Company; or
b) Cigna Worldwide Life Insurance Company Limited; or
c) Cigna Europe Insurance Company S.A-N.V (Swiss Branch); or
d) Cigna Life Insurance Company of Europe S.A-N.V; or
e) Cigna Europe Insurance Company S.A-N.V (Singapore Branch)

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. We will not release your information to any third parties. If you would like to receive this information, please tick here: ☐

If yes, how would you like us to contact you?

Email: ☐ Telephone: ☐