Approved intermediary ExpatPlus

One Care International
24 rue de la Tour d'auvergne
75009 PARIS

EXPATPLUS APPLICATION FORM INDIVIDUALS

1. Policyholder details

Please use capitals to complete this form.

Last name	First name
Title	Date of birth (d - m - y) / /
Marital status	Sex ☐ M ☐ F
Occupation	Host country
Nationality	Passport no.

Home country address	
Postal code	Town / City
Country / State	

Host country address	
Postal code	Town / City
Country / State	

Home telephone	Business telephone
Mobile number	Fax
Home e-mail	Business e-mail

2. Company details (if applicable)

Company name	
Address	
Postal code	Town / City
Country / State	

3. Dependants to be included in the plan

Please enter the details of all dependants to be covered under this policy. This can include your spouse/partner and any children financially dependent on the policyholder and not more than 26 years old.

Last name	First name	Relation	Sex	Date of birth (d - m - y)
			☐ M ☐ F	/ /
			☐ M ☐ F	/ /
			☐ M ☐ F	/ /
			☐ M ☐ F	/ /
			☐ M ☐ F	/ /

4. Policy start date

START DATE (D - M - Y)

5. Plan details

Please tick your choice.

Area of cover	☐ WORLDWIDE	☐ WORLDWIDE EXCL. USA & CANADA		
Plan type		GLOBE	ORBIT	UNIVERSE
Deductible options Outpatient care	€ 0 / £ 0 / $ 0	☐	☐	NA
	€ 100 / £ 65 / $ 125	☐	☐	NA
	€ 300 / £ 200 / $ 375	☐	☐	NA
Additional options[1]				
Dental plan[2]	BASIC	☐	☐	☐
	COMPREHENSIVE	☐	☐	☐
Accidental death and disability[3]		☐	☐	☐
WITH INSURED CAPITAL OF € / £ / $				
Temporary incapacity[4]		☐	☐	☐
WITH MONTHLY ALLOWANCE OF € / £ / $				
Permanent disability[5]		☐	☐	☐
Settlement notes online in following language	☐ EN ☐ FR	☐ DE	☐ NL	☐ ES ☐ IT

[1] Please note that the optional covers can only be purchased in addition to a core plan, they cannot be purchased separately.
[2] The dental plan can only be taken out on family level.
[3] The minimum sum insured shall be € 50.000 / £ 32,500 / $ 62.500 and can be increased with amounts of € 5.000 / £ 3,250 / $ 6.250 up to a maximum sum insured of € 500.000 / £ 325,000 / $ 625.000.
[4] The minimum monthly allowance shall be € 1.000 / £ 650 / $ 1.250 up to a maximum of € 10.000 / £ 6,500 / $ 12.500. The monthly allowance cannot exceed 80% of the gross (monthly) salary of the insured.
[5] Permanent disability can only be taken out as complementary to temporary incapacity.

6. Nomination of beneficiaries (if optional cover accidental death and disability)

I declare that in the event of death, any indemnities to which I am entitled by virtue of the ExpatPlus insurance to be paid to the listed persons below or, failing this, to my legal heirs. The nomination of the beneficiaries in the event of death can only be modified by the undersigned.

LAST NAME	FIRST NAME	RELATION	PROPORTION OF CAPITAL (%)

7. Payment details

Please tick to indicate the payment frequency and method you will use.

Bank Transfer	☐ Annual	☐ Half yearly	☐ Quarterly
Credit card	☐ Annual	☐ Half yearly	☐ Quarterly
Currency of payment	☐ Euro	☐ Sterling	☐ US Dollar

8. Credit card authority

Credit card ☐ Mastercard ☐ VISA ☐ Eurocard ☐ AMEX

Credit card number Expiry date

Cardholder's name

Address cardholder (if different from address on p. 1)

I grant Vanbreda International, a power of attorney, as of today and until further notice, to collect all invoices in my name. I will advise you immediately if the card becomes lost, stolen or if I wish to close my card account or cancel the authority.

Date Cardholder's authorisation signature

9. Bank account information (for the reimbursement of medical expenses)

Account holder name

Account no.

Full bank name and address

Routing code (IBAN or ABA or Sort code or SWIFT code)

10. Declaration

1. I hereby apply for cover on behalf of all the persons named in this application form.
2. I declare that the answers given are to the best of my knowledge full, true and complete and have checked and found correct any answers and statements in this application that are not in my own handwriting.
3. I accept that this policy will be subject to the policy terms and conditions effective at the time of policy commencement. I confirm that I have read and understand the full definitions, benefits, exclusions and conditions of this policy.
4. I confirm and agree that the personal information collected or held by Vanbreda International, whether contained in this application form or otherwise obtained may be used by Vanbreda International, or disclosed to or transferred to any organisation for the purpose of 1) assessing this application and providing on-going insurance and customer service, 2) processing and giving effect to credit card payment, 3) providing marketing material in respect of insurance related services of Vanbreda International or it's associated companies and 4) processing claims or analysing the insurance.
5. I further accept that where funds have been outstanding to Vanbreda International for a period in excess of 15 days from notification my policy will be suspended automatically, without refund of premium.

Date Signature of applicant

Please send this form together with a medical questionnaire for each person to be insured to:

ExpatPlus c/o Vanbreda International NV
P.O. Box 69 - 2140 Antwerpen - Belgium
E-mail info@expatplus.com
Fax + 32 3 663 73 14

EXPATPLUS MEDICAL QUESTIONNAIRE

Please answer each of these questions fully and accurately, for each person included on your application. In case you have ticked 'Yes', please provide details in the additional information box on the last page.

	Policyholder	Partner	Child 1	Child 2
Name				
Date of birth (d - m - y)				
1. Height / weight	CM KG	CM KG	CM KG	CM KG
2. a. Do you currently have any health problems?	Yes No	Yes No	Yes No	Yes No
b. Is your capacity to work reduced?	Yes No	Yes No	Yes No	Yes No
c. Have you ever been unable to work for more than four consecutive weeks during the last five years?	Yes No	Yes No	Yes No	Yes No
3. Do you suffer from or have you suffered from any illnesses, disturbances or problems connected with:				
a. the **respiratory organs**, such as asthma, recurrent or chronic bronchitis, pneumonia, pulmonary tuberculosis or other disorders?	Yes No	Yes No	Yes No	Yes No
b. the **heart or vascular system**, such as high blood pressure, circulatory problems, heart attack, heart defect, heart failure, palpitations, apoplexy, phlebitis, varicose veins or other disorders?	Yes No	Yes No	Yes No	Yes No
c. the **nervous system or a mental disorder**, such as epilepsy, dizziness, paralysis, neuritis, depression or other disorders?	Yes No	Yes No	Yes No	Yes No
Have you ever attempted to commit suicide?	Yes No	Yes No	Yes No	Yes No
d. the **digestive system**, such as hiatus hernia, gastric or duodenal ulcers, or other disorders of the stomach or intestines, such as inflammations, haemorrhages, haemorrhoids, jaundice, diseases of the liver, gall bladder, pancreas?	Yes No	Yes No	Yes No	Yes No
e. the **urinary tract of sexual organs**, such as kidneys, ureters, bladder or prostate, urinary tract, blood or albium in the urine or other disorders?	Yes No	Yes No	Yes No	Yes No
f. the **metabolism or blood**, such as diabetes mellitus, elevated cholesterol, gout, thyroid gland or hormonal disturbances, anemia, coagulation disturbances or other disorders?	Yes No	Yes No	Yes No	Yes No
g. the **immune system or infectious diseases**, such as AIDS, HIV, sexually transmitted diseases, hepatitis, tropical diseases or other disorders?	Yes No	Yes No	Yes No	Yes No
h. the **skin**, such as eczema, allergies, psoriasis, fungal diseases, skin cancer or other disorders?	Yes No	Yes No	Yes No	Yes No
i. the **musculoskeletal system**, (bones, joints, spine, intervertebral discs, muscles, ligaments, tendons), such as disorders of the back, neck and shoulders, arthritis, rheumatism or other disorders?	Yes No	Yes No	Yes No	Yes No
j. the **eyes**, such as decreased visual acuity or refraction power, retinal disease or other disorders?	Yes No	Yes No	Yes No	Yes No

Name Date of birth (d - m - y)	Policyholder	Partner	Child 1	Child 2
k. the **ears**, hearing difficulties, inflammation or other disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l. **other illnesses**, disturbances or problems not listed above, such as congenital defects, deformities, tumours, cancers, etc?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you had any **accidents**, injuries or poisonings which necessitated a hospital stay or operation?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. a. Have you been examined, received treatment or been operated on in hospital or similar institution?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Have you been advised to take a rest, diet, withdrawal or other cure, or is such a cure planned?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c. Is a hospital stay or operation planned?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d. Have you been treated by or consulted any of the following in the last 5 years:				
- psychotherapist? (e.g. psychiatrist, psychologist)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
- chiropractors, physiotherapists?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e. Have you ever been given or prescribed a drug for a period in excess of 4 weeks?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f. Have you ever had radiation treatment (x-ray or radioactive substances)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. Have you undergone any **special examinations**/ tests during the last 5 years, such as x-rays, computed tomography, MRI (magnetic resonance imaging), ultrasound, echo, electrocardiogram, electroencephalogram, endoscopy or other tests?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Have you had an **AIDS** test that showed an HIV-positive or possibly positive result?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8. a. Do you practise sports?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Do you smoke?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c. Do you drink alcohol?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d. Do you take painkillers, sleeping tablets, tranquillisers or other medications?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e. Do you take or have you taken any narcotics (drugs)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9. a. Which **physician** did you last consult?				
b. Have you consulted any physicians in the last 5 years not already mentioned?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c. Which physician is most familiar with your medical history?				
10. For **female persons** only:				
a. are you pregnant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
if yes, has the pregnancy been normal to date?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. have you ever had a gynaecological disorder or a disease of the breast?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Additional information

If you answered 'Yes' to any of the questions above, please provide details here. Please provide the precise question number(s), name of the person, diagnosis, dates and duration of illness/injury/treatment and the names and addresses of attending physicians and medical facilities.

I certify that the statements made by me in answer to the above questions are true, complete and correct to the best of my knowledge and belief. I understand that nullity of the insurance or reduction of the insured capital sum might be applied in the event of claim if it were proved that the person to be insured had established a false declaration.

In view of a smooth administration of the contract and/or settlement of the insurance claim, and only for that purpose, the signatory hereby gives his/her special permission regarding the processing of the medical data concerning him/herself and/or the members of his/her family (article 7 of the Belgian law of December 8, 1992 concerning the private life).

DATE PLACE

SIGNATURE POLICYHOLDER SIGNATURE PARTNER

(Signature must be preceded by the handwritten words: 'Read and approved'.)

Please send this medical questionnaire back to:

ExpatPlus c/o Vanbreda International NV
P.O. Box 69 - 2140 Antwerpen - Belgium
E-mail info@expatplus.com
Fax + 32 3 663 73 14