Application Form

International Healthcare Plan

(effective 1st September 2007)

GOODHEALTH

Agent/Broker Name and Stamp

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

Please read through the following before completing this application and complete in BLOCK CAPITALS.

All information supplied will be treated in strict confidence. You must disclose all material facts. Failure to do so may invalidate the Policy. A material fact is one which is likely to influence the assessment and acceptance of this application. If You are in any doubt whether a fact is material it should be disclosed.

As the applicant You should answer all the questions and sign the declaration on behalf of all persons included in this application. A copy of this application can be supplied to You on request within three months of completion. You should keep a record of all information (including copies of all letters) supplied to Us for the purpose of entering into this contract.

1. Details of Applicant (First Person)

Family Name:

First Name(s): Title:

Marital Status: M/F: Date of Birth: day month year Height: m/ft Weight: kg/lb

Industry:

Occupation:

Nationality:

Country of Residence:

Residential Address:

Town/City:

Country/State:

Postcode:

Correspondence Address:

Town/City:

Country/State:

Postcode:

Home Telephone:

Mobile:

Home Email:

Business Telephone:

Fax:

Business Email:

2. Dependant's Details

Please note children to be included under this plan must be under 18 years of age, or 23 years or under if they are in full-time education and are fully dependant upon You.

Dependant 1

Family Name:

First Name(s):

Other Initials: Title: Sex: M/F Height: m/ft Weight: kg/lb

Relationship to Applicant: Date of Birth: day month year

Occupation:

Nationality:

Dependant 2

Family Name:

First Name(s):

Other Initials: Title: Sex: M/F Height: m/ft Weight: kg/lb

Relationship to Applicant: Date of Birth: day month year

Occupation:

Nationality:

Dependant 3

Family Name:

First Name(s):

Other Initials: Title: Sex: M/F Height: m/ft Weight: kg/lb

Relationship to Applicant: Date of Birth: day month year

Occupation:

Nationality:

Dependant 4

Family Name:

First Name(s):

Other Initials: Title: Sex: M/F Height: m/ft Weight: kg/lb

Relationship to Applicant: Date of Birth: day month year

Occupation:

Nationality:

If You have any further Dependants please provide details on a separate sheet.

3. Commencement Date

Subject always to Section 9 of this application form, the Commencement Date of this Policy will be the date on which this application is accepted in writing by Us. If You wish Your cover to start later, please indicate below.

Please note the Commencement Date can be no more than 30 days from the date of completion of this application by You. Under no circumstances will Policies be backdated.

Commencement Date: day month year

4. Product Options

This plan enables You to choose various options to suit Your personal requirements. Please clearly tick the option You have selected. Your Policy will be issued on this basis.

The table below is for guidance only, please refer to the full Benefit Schedule and Policy Wording for a detailed description of the Benefits of each plan option.

Benefits	Major Medical OPTION 001	Foundation OPTION 002	Lifestyle OPTION 003	Lifestyle Plus OPTION 004
Standard Excess	NIL	£65 or €/$100	£65 or €/$100	£65 or €/$100
Maximum Benefit per Insured Person per Period of Cover	£1,000,000 or €/$1,600,000	£1,000,000 or €/$1,600,000	£1,000,000 or €/$1,600,000	£1,000,000 or €/$1,600,000
In-Patient and Day-Patient care	■	■	■	■
Oncology, CT and MRI scans	■	■	■	■
Complications of Pregnancy	■	■	■	■
Parent Accommodation	■	■	■	■
Evacuation	■	■	■	■
Out-Patient care	◧	■	■	■
Emergency Dental Treatment	◧	■	■	■
Daily Hospital Cash Benefit	◧	◧	◧	◧
AIDS/HIV	◧	◧	◧	◧
Extended Evacuation	optional	optional	■	■
Routine Management of Chronic Conditions	□	□	◧	◧
Routine Pregnancy and Childbirth	□	□	□	◧
Routine and restorative dental care	□	□	□	◧
Your Selection – please tick Your choice	☐	☐	☐	☐

Currency of Policy - Please tick Your choice £ ☐ € ☐ $ ☐

Please note the currency of Your Policy will determine the Benefit limits and the Excess of Your Policy.

ALL limits and Excesses expressed in $ shall in all instances mean US$.

■ Full Refund ◧ Subject to Limits □ No Cover

Excess Options - Please select where You wish to change from the standard Excess applicable by ticking the appropriate box.

Nil	Standard	☐	☐	☐
£30/€50/$50	N/A	☐	☐	☐
£155/€250/$250	N/A	☐	☐	☐
£300/€500/$500	N/A	☐	N/A	N/A
£625/€1,000/$1,000	☐	☐	N/A	N/A
£1,250/€2,000/$2,000	N/A	☐	N/A	N/A
£3,000/€5,000/$5,000	☐	☐	N/A	N/A

Additional Options - Please tick Your choices.

USA Elective Treatment - [005]	N/A	☐	☐	☐
Semi-Private Room Restriction - [006] *Only available to residents of Hong Kong.*	☐	☐	☐	☐
China Private Room Restriction - [007] *Only available to residents of mainland China.*	☐	☐	☐	☐
Direct Settlement Network - [008] *Only available with standard Excess.* *Available in certain countries.* *Please check with Your local sales centre.*	N/A	☐	☐	☐
Extended Evacuation - [009]	☐	☐	N/A	N/A
Medical History Disregarded - [010] *Only available to compulsory group schemes of 10 employees or more.*	☐	☐	☐	☐
Extension to Lifestyle Plus - [011] *Only available to compulsory group schemes of five employees or more.*	N/A	N/A	N/A	☐

5. Premium Payment

Tick which payment method and payment frequency You require and complete all details relevant to that method.

☐ a) Cheque Payment (annual only). All cheques must be payable to "Goodhealth Worldwide". Please ensure that the name of the applicant (as declared in Section 1 of this form) is clearly stated on the reverse of the cheque.

☐ b) Bank Transfer (annual only). Please ensure the name of the applicant (as declared in Section 1 of this form) is clearly stated on any transfer. Our bank details for bank transfer are as follows:

Euro Account		Sterling Account		US Dollar Account	
Account Name:	Goodhealth Worldwide (Europe) Limited	Account Name:	Goodhealth Worldwide (Europe) Limited	Account Name:	Goodhealth Worldwide (Europe) Limited
Bank Address:	Citibank, PO Box 749, Dubai, UAE	Bank Address:	Citibank, PO Box 749, Dubai, UAE	Bank Address:	Citibank, PO Box 749, Dubai, UAE
Account Number:	500042265	Account Number:	500042354	Account Number:	500042257
Swift Code:	CITIAEAD	Swift Code:	CITIAEAD	Swift Code:	CITIAEAD

We cannot accept liability for any bank transfer which does not clearly identify the applicant.

☐ c) Credit Card (annual and monthly). VISA ☐ MasterCard ☐ AMEX (annual and monthly) ☐

Credit Card Number:

Cardholder's Name: Expiry Date: month year

Cardholder's Statement Address:

Currency of Payment: Euro ☐ Sterling ☐ Dollar ☐

Type of Payment: Annual ☐ Monthly ☐ If paying by monthly credit card please complete the Recurring Transaction Authority enclosed.

Cardholder's Authorisation Signature: Date: day month year

☐ d) Direct Debit (annual and monthly). Restricted to UK bank account holders, sterling accounts only.

Type of Payment: Annual ☐ Monthly ☐

If paying by Direct Debit please complete the enclosed Direct Debit form.

For payment method by c) and d), please note Your premium will be collected on receipt of this application, which may be in advance of the Commencement Date. If You opt for the monthly payment plan, We may in some circumstances, debit two month's premium in Your first month. This is dependent on what time of the month Your billing takes place.

6. Medical Practitioner Details

Please give the details, including name, address and qualifications of Your usual Medical Practitioner, and in respect of anyone else included in this application.

Please use a separate sheet if this space is insufficient.

7. Pre-existing Condition(s)

Benefits will not be available for any Medical Condition or Related Condition for which You have received medical Treatment, had symptoms of, or to the best of Your knowledge existed, or sought Advice prior to Your Date of Entry, until two consecutive years have elapsed, after the Date of Entry, during which no Treatment or Advice was given in respect of that Medical Condition or any Related Medical Condition.

8. Medical Questionnaire

Please reply to the following questions by ticking Yes or No. Where You have ticked Yes, please provide details.

	Yes	No
a) Have You, or anyone included in this application, been admitted to Hospital or other similar establishment in the last five years?		
b) Have You, or anyone included in this application, been prescribed with a course of any drugs or medication, or Treatments for a period in excess of seven days in the last two years?		
c) Have You, or anyone included in this application, any known or foreseeable need to consult with a Medical Practitioner or any other health care professional and/or to be required to be prescribed any drugs or medication and/or to be admitted to a Hospital or other similar establishment?		
d) Are You, or anyone included in this application, suffering from any disability, abnormality, recurrent illness, major illness or injury, not already noted above?		

Please use this space to provide any additional information, or a separate sheet of paper if there is insufficient space:

9. Declaration

I understand and accept Section 7 on Pre-existing Condition(s).

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.

I have declared all material facts which relate to this application.

I declare that I have read and understand the documents '*Key Facts*', '*Policy Wording*' and '*Benefit Schedule*' and agree to accept and conform to the terms of the Policy, unless I cancel this Policy within 15 days from the Commencement Date. I am satisfied that the product selected meets my requirements at this time.

I confirm and agree that the personal information collected or held by Goodhealth, whether contained in this application form or otherwise obtained may be used by Goodhealth, or disclosed to or transferred to any organisation in the World 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 Goodhealth or it's associated companies and 4) processing claims or analysing the insurance.

I authorise any doctor, physician or Specialist who I have attended in any capacity to provide Goodhealth, or their representatives, with any and all information in respect of such attendance and any known medical history.

I agree that where Medical Treatment is received within the Provider Network by myself or any of my Dependants and it is substantiated that the Treatment or Medical Condition is not refundable within the terms and conditions of the Policy, that I, as the Policyholder, shall be fully responsible for reimbursement to Goodhealth within 14 days of receipt of notice of such non-refundability of all funds expended in connection with any claim for such medical Treatment.

I understand and confirm that where I have not made repayment of funds disbursed by Goodhealth in respect of such medical Treatment not covered by the Policy, the Policy shall be suspended until the date of my full settlement of all outstanding amounts due from me to Goodhealth and in the event that funds so due from me to Goodhealth have been outstanding and unpaid for a period in excess of 14 days, exclusion 1 of the Policy Wording shall be re-applied to the Policy with effect from the date of full receipt by Goodhealth of the funds concerned in which event any suspension of the Policy pursuant to this subclause shall be lifted with effect from such full receipt date. In no event shall any claim for Treatment received during the period of suspension be made or met.

I further accept that where funds have been outstanding to Goodhealth for a period in excess of 15 days from notification, my Policy will be cancelled void ab initio, without refund of premium.

Signature of applicant:

Date: day month year

Contact Details for the Goodhealth Offices

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