

# Pacific Prime International

## UltraCare Plan Individual & Family Application Form

If you have any questions or need any assistance in completing this form call us on +44(0) 1252 745 900 and one of our sales advisers will be happy to help.

Please complete clearly in **BLOCK CAPITALS**.

If you have received a quotation from us, please write the quote number here:

**Please note:** if any of the details that you write on this form are different from the details that you gave when you got your quotation, your premium may be different.

### A Your personal details

Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Other:	
Family Name:	First Names:	
Country of Residence: <sup>1</sup>	How long have you lived there?:	
Home country:	Nationality on Passport:	
Occupation:	Date of Birth (dd/mm/yy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F

<sup>1</sup> Your country of residence will determine the value of Insurance Premium Tax that is added to your premium. Please speak to your adviser or call us on +44 (0)1252 745 900 if you are unsure whether your premium will be affected.

### Residential Address <sup>2</sup>

Address:	
Town:	City:
Postal Code:	Country:
Telephone:	Fax:
Email:	

<sup>2</sup> All correspondence will be sent to this address unless you have completed the correspondence address details below. It is very important that you tell us immediately of any changes to your contact or personal details. A change in circumstances could affect your cover.

### Correspondence Address - if different from residential address above

Address:	
Town:	City:
Postal Code:	Country:
Telephone:	Fax:
Email:	

Please indicate your preferred communication channel  Email  Airmail  Fax  Telephone

### B Dependants to be Covered

#### Dependant 1

Family Name:	First Names:
Date of Birth (dd/mm/yy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Country of Residence:	Nationality on Passport:
Occupation:	Relationship to you:

Space for further dependants overleaf >>

## B Dependants to be Covered (continued)

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### Dependant 2

Family Name:	First Names:
Date of Birth (dd/mm/yy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Country of Residence:	Nationality on Passport:
Occupation:	Relationship to you:

### Dependant 3

Family Name:	First Names:
Date of Birth (dd/mm/yy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Country of Residence:	Nationality on Passport:
Occupation:	Relationship to you:

### Dependant 4

Family Name:	First Names:
Date of Birth (dd/mm/yy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Country of Residence:	Nationality on Passport:
Occupation:	Relationship to you:

If you have any further dependants to be covered please provide details on a separate sheet of paper and submit it along with this application.

## C Cover Start Date

Your cover will commence on the date when, subject to eligibility and the full completion of this form, we accept your application in writing. If you wish your cover to start at a later date please indicate this below. This date can be no more than 30 days after the date you complete this form. We cannot backdate cover under any circumstances.

Preferred Cover Start Date (dd/mm/yyyy):

## D Your Cover Options

### Area of Cover

Select the area of cover from the descriptions below based upon the location of your country of residence and your home country if you require the option of returning to your home country for treatment. Please see eligibility section in the Plan Guide for restrictions on US Citizens.

- Area 1 Europe
- Area 2 Worldwide, not including the USA
- Area 3 Worldwide
- Area 4 Australia and New Zealand

### Level of Cover / Plan Type

Please indicate the UltraCare plan type that you require. Please be sure that you have read the policy summary and table of benefits before making your selection to ensure the product meets your needs and demands. Please contact us if you require copies of these documents.

Plus <input type="checkbox"/>	Comprehensive <input type="checkbox"/>	Select <input type="checkbox"/>	Standard <input type="checkbox"/>
All the benefits of the Comprehensive Plan, but with higher limits and cover for restorative dental treatment.	As the Select Plan but with higher limits and cover for primary consultations, emergency dental and wellness benefits.	Full in-patient and daycare treatment with limited cover for specialist out-patient treatment - includes evacuation.	Full in-patient and daycare treatment - includes evacuation.

### Excess Options

If you wish to change the excess from the standard excess shown, please tick the appropriate box below.

	Plus	Comprehensive	Select	Standard
Nil Excess	<input type="checkbox"/> 10% Premium Loading	<input type="checkbox"/> 10% Premium Loading	<input type="checkbox"/> 10% Premium Loading	Standard
£25 / \$42.50 / €37.50	Standard	Standard	Standard	N/A
£50 / \$85 / €75	<input type="checkbox"/> 5% Premium Discount	<input type="checkbox"/> 5% Premium Discount	<input type="checkbox"/> 5% Premium Discount	N/A
£100 / \$170 / €150	<input type="checkbox"/> 10% Premium Discount	<input type="checkbox"/> 10% Premium Discount	<input type="checkbox"/> 10% Premium Discount	N/A
£250 / \$425 / €375	<input type="checkbox"/> 15% Premium Discount	<input type="checkbox"/> 15% Premium Discount	<input type="checkbox"/> 15% Premium Discount	N/A
£500 / \$850 / €750	<input type="checkbox"/> 20% Premium Discount	<input type="checkbox"/> 20% Premium Discount	<input type="checkbox"/> 20% Premium Discount	<input type="checkbox"/> 10% Premium Discount
£1,000 / \$1,700 / €1,500	<input type="checkbox"/> 25% Premium Discount	<input type="checkbox"/> 25% Premium Discount	<input type="checkbox"/> 25% Premium Discount	<input type="checkbox"/> 20% Premium Discount
£2,500 / \$4,250 / €3,750	<input type="checkbox"/> 30% Premium Discount	<input type="checkbox"/> 30% Premium Discount	<input type="checkbox"/> 30% Premium Discount	<input type="checkbox"/> 30% Premium Discount
£5,000 / \$8,500 / €7,500	<input type="checkbox"/> 40% Premium Discount	<input type="checkbox"/> 40% Premium Discount	<input type="checkbox"/> 40% Premium Discount	<input type="checkbox"/> 40% Premium Discount

The standard excess on medical out-patient treatment claims applies per medical condition per plan year.

If you have chosen a voluntary excess for the Plus, Comprehensive or Select plans to reduce your premium this will be applied to **all** (In-patient, Daycare and Out-patient) medical treatment. The Plus and Comprehensive plans also have a 25% co-insurance on out-patient dental treatment. This co-insurance cannot be removed.

If you have chosen a voluntary excess for the Standard plan this will be applied to all In-patient and Daycare medical treatment.

Discounts apply to main UltraCare Plan premiums only - not to optional add-on plan premiums.

## E Optional Add-on Benefits

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Do you want to add any of the following?

<b>Worldwide Personal Travel Plan</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If Yes, please indicate type	<input type="checkbox"/> Single	<input type="checkbox"/> Couple	<input type="checkbox"/> Family	<input type="checkbox"/> Single Parent Family
<b>Maternity Benefit Plan</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If Yes, please indicate level of co-insurance selected per person	<input type="checkbox"/> 10%	<input type="checkbox"/> 20%		

The maternity plan is only available for female members who are aged between 18 and 44. Cover only becomes available for pregnancies that are conceived 6 months after the commencement date of this optional add-on plan.

<b>Personal Accident Plan</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
If Yes, please circle the number of personal accident units required for each person on this application:					
Main Planholder:	1 2 3 4 5	Dependant 1:	1 2 3 4 5	Dependant 2:	1 2 3 4 5
		Dependant 3:	1 2 3 4 5	Dependant 4:	1 2 3 4 5

The Personal Accident Plan does not include accidents arising from manual or hazardous occupations, dangerous or winter sports, pursuits, or activities. If your occupation is not purely office-based or you take part in any dangerous or winter sports, pursuits or activities, please give full details on a separate sheet and include it with this Application Form. We may then be able to advise if we are able to cover the increased risk.

## F Paying Your Premiums

It is important that you keep your premiums up to date and notify us immediately of any changes to your payment details. Full payment details and information on unpaid or late payments are found in the UltraCare Plan Guide. **Please Note:** whilst premiums are outstanding all claims settlements will be suspended.

### Currency

In which currency do you wish to pay your premiums?

<input type="checkbox"/> GB pounds (£)	<input type="checkbox"/> US dollars (\$)	<input type="checkbox"/> euros (€)
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This selection will also determine the currency of your benefit limits and excess.

### Payment plans

Please select the frequency in which you wish to pay your premiums. Due to increased administration costs the annual total of any Monthly and Quarterly premium payments will be higher than the cost of paying Yearly.

	Cheque or Bank Draft	Bank Transfer	Credit Card	Direct Debit
Yearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quarterly	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>
Monthly	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>

### PLEASE FOLLOW INSTRUCTIONS FOR YOUR CHOSEN PAYMENT METHOD

**Note:** Direct Debits can only be accepted for clients who have a UK Bank Account and have elected to pay their premiums in GB Pounds.

### Payment Details

#### Cheque or Bank Draft

Please make all cheques and bank drafts payable to "InterGlobal Insurance Company Limited". Please ensure that your family name and date of birth are clearly shown on the reverse in case your payment becomes separated from this form.

#### Bank Transfers

Please ensure that your family name is clearly shown on any bank transfer and that the transfer is in the correct currency and sent to the correct details below:

GB Pound (£) Account	US Dollar (\$) Account	Euro (€) Account
Bank: HSBC Bank plc Address: 33 The Borough Farnham, Surrey GU9 7NJ United Kingdom	Bank: HSBC Bank plc Address: 33 The Borough Farnham, Surrey GU9 7NJ United Kingdom	Bank: HSBC Bank plc Address: 33 The Borough Farnham, Surrey GU9 7NJ United Kingdom
Account No: 41611593 Sort Code: 40.21.05 Swift Code: MIDLGB21 IBAN No: GBB4 MIDL 402105 41611593	Account No: 67348768 Sort Code: 40.05.15 Swift Code: MIDL GB22 IBAN No: GB68 MIDL 4005156 7348768	Account No: 67348776 Sort Code: 40.05.15 Swift Code: MIDL GB22 IBAN No: GB46 MIDL 400515 67348776

#### Credit Card

We can accept payments using the following Credit Cards - VISA, MasterCard and American Express. If your card is not in this list, please check with us as we may still be able to accept it. Please complete the Credit Card Authority Form attached to this application.

#### Direct Debit

We can only accept payments by Direct Debit if you have a UK Bank Account and have elected to pay your premiums in GB Pounds (£). Please complete the Direct Debit Form attached to this application.



# Direct Debit

We offer Direct Debit as an alternative form of payment to all planholders who take out a GB£ plan and currently hold a UK Bank or Building Society account. If you would like to take advantage of this facility for your regular payments please complete the following form.

Please note: We must receive the original of this form in order to set up your direct debit payments as banks will not accept copies.

## Instruction to your Bank OR Building Society to pay by DIRECT DEBIT

Please complete in BLOCK CAPITALS and send to:

InterGlobal Insurance Company Limited  
Woolmead House East  
The Woolmead  
Farnham  
Surrey GU9 7TX



Originator's Identification:

2	4	2	5	8	4
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Name(s) of Account Holder(s):

Bank/Building Society Account number:

Branch Sort Code:

Name and full postal address of your Bank or Building Society

To: The Manager

Bank/Building Society

Address:

Postcode:

Reference Number *(for InterGlobal Insurance Company Limited use only)*

## Instruction to your Bank/Building Society

Please pay InterGlobal Insurance Company Limited Direct Debits from the account detailed in this instruction subject to the safeguards assured by The Direct Debit Guarantee.

I understand that this instruction may remain with InterGlobal Insurance Company Limited and if so details will be passed electronically to my Bank/Building Society.

Signature(s):

Date (dd/mm/yy):

Banks and Building Societies may not accept Direct Debit Instructions for some types of accounts.

## The Direct Debit Guarantee



This guarantee should be detached and retained by the Payer

- This Guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by your own Bank or Building Society.
- If the amounts to be paid or the payment dates change InterGlobal Insurance Company Limited will notify you 10 working days in advance of your account being debited or as otherwise agreed.
- If an error is made by InterGlobal Insurance Company Limited or your Bank or Building Society you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us.

# Credit Card Authority

## To InterGlobal Insurance Company Limited

I hereby authorise the Card Account specified below may be debited with the current premium due, and all subsequent renewal premiums due as notified by InterGlobal until I give notice in writing that I wish to terminate this agreement. I understand that InterGlobal will give at least 4 weeks notice of renewal, and that the premiums may vary each year. I understand that InterGlobal cannot be held liable if my plan is lapsed should the credit card be declined and I do not respond to requests for alternative methods of payment.

Please complete in BLOCK CAPITALS.

Name *(as it appears on your card)*:

Please tick the appropriate:

MasterCard     Visa     American Express

My Card Number is:

Issue Date:    Expiry Date:

My Card billing address is:

Postcode:

Please charge the above card *(please tick)*

Yearly     Quarterly     Monthly

GB £     US \$     euros €

Signature(s):    Date (dd/mm/yy):