

Individual/Family Application Form I



Proposer's Details:

Name (last, first, middle): _____

Location and Contact Details:

Residential Address (must be filled in)

Correspondence Address

(if different from residential address)

Address: _____

Address: _____

City: _____ Postal Code: _____

City: _____ Postal Code: _____

Country: _____

Country: _____

Telephone: _____

Telephone: _____

Facsimile: _____

Facsimile: _____

Email: _____

Email: _____

Plan Requested	'A'	'AA'	'AAA'
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan Options	'A'	'AA'	'AAA'
North American Exclusion	N/A	<input type="checkbox"/>	<input type="checkbox"/>
Maternity Exclusion	N/A	<input type="checkbox"/>	<input type="checkbox"/>
Out-patient	<input type="checkbox"/>	N/A	N/A
Dental	N/A	<input type="checkbox"/>	<input type="checkbox"/>
Accidental Death & Disablement – Sum Assured	US\$100,000	US\$250,000	US\$500,000
(All Sum Assured limits are available to each Plan level)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Requested Effective Date	_____		

Dependents to be Insured – Name (last, first, middle)

(Please use a separate sheet if necessary. Note, the Proposer and each Dependand must complete an Application Form II – Medical Questionnaire)

Declaration by Proposer

I/we hereby apply for a policy to be issued based on the statements contained in Forms I & II and declare that all answers to the foregoing questions are correctly recorded, and that they are full, complete and true. Except as declared herein, all persons to be insured are currently in good health. I/we agree that the policy as issued including all schedules, endorsements, and this application shall form the whole contract and that no insurance shall be in force until and unless the application has been accepted, and the appropriate premium paid.

Printed Name/Title _____ Signature _____ Date _____

DATA PRIVACY: It is hereby declared that as a condition precedent to the liability of Liberty International Insurance Limited ("the Company"), the Insured Person(s) has agreed that any personal information collected or held by the Company is provided and may be held, used and disclosed by the Company to individuals/organizations associated with the Company or any selected third party (within or outside Hong Kong) for the purpose of processing the application and providing subsequent services for this and other financial products and services, direct marketing, data matching, and to communicate with the Insured Person(s) for such purposes. The Insured Person(s) has the right to obtain access to and to request correction of any personal information held by the Company concerning the Insured Person(s). Such request can be made to the Company's Data Privacy Officer, proMedico Unit, Liberty International, 13F DCH Commercial Centre, 25 Westlands Rd, Quarry Bay, Hong Kong.

Please send completed Application Forms I & II, any relevant medical reports and your premium payment to GlobalHealth Asia Limited, Suite 1401-3, Chinachem Hollywood Centre, 1-13 Hollywood Road, Hong Kong.



(Please see reverse side for important premium payment information)

Premium Payment

A. Cheque Payment or Money Order.

Please make your US Dollar cheque or money order made payable to "GlobalHealth Asia Limited".

B. Bank Transfer.

For direct premium remittances, please send full payment (inclusive of all bank charges) to:

Intermediary Bank

ABA No.: 026009593
 Reclpent Bank: Bank of America N.A., New York,
 USA CHIPS UID 009953
 Account No.: 6550-4-90452
 Swift Address: BOFAUS3N

Beneficiary Bank

Bank: The Bank of East Asia, Limited, Hong Kong
 Account Holder: GlobalHealth Asia Limited
 Account No.: 015-521-50-00072-4 (USD Account)
 Swift Address: BEASHKHH (SWIFT MT103)

- Note:
1. All bank charges will be borne by the remitter
 2. Please indicate your Policy Number as payment details to your bank
 3. Please fax (852 2526 0769) or email the bank remittance advice or instruction slip with your Policy Number to GlobalHealth for our accounting records and to issue an Official Receipt.

C. Credit Card.

Premiums may be paid by Visa or MasterCard using the Credit Card Authorization below:

Credit Card Payment Authorization

I/we, the undersigned, authorize you to charge my credit card for payment of GlobalHealth insurance premiums as stated below:

Policyholder : _____

Policy Number (if known) : _____

Visa MasterCard

Card Number : - - -

Name of Issuing Bank : _____

Card Holder's Name : _____

Expiry Date : /
m m y y

For US\$ _____

Signature _____ Date _____

- Please note:
1. Card payment and effectiveness is subject to the credit card centre's approval.
 2. All charges will be made in Hong Kong dollars at the exchange rate(s) then in force.

Producer Name: _____	Producer Code: _____
Address: _____	
Phone Number: _____	Fax Number: _____
Email address: _____	

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