

Proposer's Details:

Name (last, first, middle / Company): _____

(A separate Form II must be completed for each Applicant and submitted with Form I)

Applicant's Details:

Name (last, first, middle): _____

Date of Birth: _____ Sex: M F Height (cm): _____ Weight (kg): _____ Smoker: Yes No

Occupation (specific nature of business & duties): _____

Residential Address: _____ Email: _____

Citizen of: _____ Passport/ID No.: _____

Relationship to Policyholder: (Employee, Self, Spouse, Dependant Child) _____

Important note about filling in this form:

The answers you give to the questions contained in this Application will form the basis of any insurance policy issued, and will be incorporated into the contract. It is essential that you give accurate, truthful, and complete information for all persons to be insured, as inaccuracies may jeopardize coverage or invalidate a claim.

1. Does this person reside outside of the Usual Country of Residence shown on Form I? If yes, please state which country. Yes No

2. Does this person's occupation include any activities involving offshore, underwater, underground, or manual work, or work in a remote location? If yes, please give details. Yes No

3. Has this person previously applied for or held a GlobalHealth policy? If "Yes", please provide policy number. Yes No

4. Does this person have health insurance with another insurance company? If "Yes", please attach a copy of the policy and benefit schedules, and indicate if the other coverage will be continued if the GlobalHealth application is approved. Yes No

5. Has this person ever had a policy or application for life, sickness, accident disability, critical illness or medical insurance refused, postponed, declined, withdrawn or had any special terms (including extra premium or exclusions) imposed? If "Yes", please provide full details. Yes No

6. Has this person been in a hospital for treatment or observation or undergone any surgical procedure? If "Yes", please provide the date, diagnosis and nature of treatment. Yes No

7. Within the last five years, has this person suffered from, been treated for, sought advice on, or had symptoms relating to any of the following conditions:
- a) Cancer, leukaemia, tumour of any kind (benign or malignant) or blood disorder? Yes No
- b) Asthma, chronic bronchitis, chronic sinusitis, allergies, deviated nasal septum, tuberculosis, or any disease or disorder of the lungs? Yes No
- c) Chest pain, raised blood pressure, heart condition, rheumatic fever, varicose veins or circulatory disorder? Yes No
- d) Indigestion, gastric or duodenal ulcer, hernia, haemorrhoids or any disease or disorder of the bowel? Yes No
- e) Kidney stones, urinary tract infections or complaint, venereal disease, or any disease or disorder of the kidney, bladder, prostate or genitor-urinary tract? Yes No
- f) Diabetes or any disease or disorder of the gall bladder, pancreas or liver, including Hepatitis B or Hepatitis C? Yes No
- g) Disease of the brain, nervous system, stroke, epilepsy? Yes No
- h) Mental health disorder, depression, anxiety, nervous condition, stress, post traumatic stress disorder, behavioural problem, alcohol or drug addiction? Yes No
- i) Back or neck pain or strain, spinal condition, sciatica, whiplash, arthritis, bone fracture, joint injury e.g. knee, elbow, wrist, shoulder, hallux valgus (hammer toes) or experienced any symptoms of a muscle disorder or gout? Yes No
- j) Malaria, dengue fever, typhoid or any other tropical disease? Yes No
- k) HIV, AIDS (acquired immune deficiency syndrome), AIDS related condition or had any positive blood test for the HIV (also called AIDS or HTLV-III) virus? Yes No
- l) Pregnancy or any complications of pregnancy, abnormal smear test or any gynaecological disorder? (female only) Yes No
- m) Psoriasis, eczema, dermatitis or other skin condition or any disease or disorder of the eyes or ears? Yes No
- n) Any other ailment, impairment, injury or condition(s) not mentioned above? Yes No
- If yes to any of the above questions, please provide full details and include all relevant up-to-date medical reports. (Attach separate sheet if necessary)

8. Is this person taking any medication or receiving any form of treatment at the present time? If "Yes", please provide the medical condition, name of medication and dosage, and/or treatment. Yes No
- _____
- _____

9. Has this person been advised to have or do they intend to seek any medical advice, test, investigation, surgical procedure, hospitalization, or treatment in the near future? If "Yes", please provide the medical condition, attending physician, and recommended treatment. Yes No
- _____
- _____

10. Please provide the following information about this person's current usual doctor/personal physician/medical centre or hospital:
- Name: _____
- Address: _____
- Tel: _____ Facsimile: _____ Email: _____
- How long has this person been under this physician's care: _____
- Date of last attendance & reason: _____

Declaration by Applicant

I/we hereby apply for a policy to be issued based on the statements contained herein 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 if the health status of the above intended insured person changes after this application is signed and before the Company issues a policy I/We shall immediately notify the Company of the change. 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

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