OPTIMUM GLOBAL
INTERNATIONAL INSURANCE SOLUTIONS

OG GEMS - CPME APPLICATION FORM

Please complete this form in block capitals. Payment must be submitted before any cover can be granted. You must disclose in this form, fully and faithfully, all material facts. A material fact is one that is likely to affect the assessment of this health insurance application. Failure to do so may result in you not receiving any benefit from your policy.

Company Name: _____ Group Number: _____

If you are applying as an employee of a company, please insert the name of the company above. If you are applying as an individual or a family, please leave it blank. Please complete in block capitals.

1. YOUR PERSONAL DETAILS (MAIN APPLICANT)

Title: _____ First Names: _____

Family Name: _____

Gender (please circle): M / F Nationality: _____ Date of Birth (dd mm yy): _____

Occupation: _____

Usual Country of Residence: _____ Passport/ID number: _____

2. CONTACT DETAILS

Residential address of the country where you spend more than 6 months per year:

Address: _____

_____

Country: _____ Postal Code: _____

Email Address: _____

	Country Code	Area Code	Number		Country Code	Area Code	Number
Home Telephone:				Work Telephone:			
Fax Number:				Mobile Telephone:			

3. ADDITIONAL MEMBERS TO BE COVERED

Title: _____ First Names: _____

Family Name: _____

Gender (please circle): M / F Nationality: _____ Date of Birth (dd mm yy): _____

Occupation: _____

Usual Country of Residence: _____

Relationship to main applicant: _____

1st Child

Title: _____ First Names: _____

Family Name: _____

Gender (please circle): M / F Nationality: _____ Date of Birth (dd mm yy): _____

Occupation: _____

Usual Country of Residence: _____

2nd Child

Title: _____ First Names: _____

Family Name: _____

Gender (please circle): M / F Nationality: _____ Date of Birth (dd mm yy): _____

Occupation: _____

Usual Country of Residence: _____

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3rd Child

Title: _____ First Names: _____

Family Name: _____

Gender (please circle): M / F Nationality: _____ Date of Birth (dd mm yy): _____

Occupation: _____

Usual Country of Residence: _____

4. YOUR CHOICE OF MEDICAL COVER

Please tick one box only

Core Plan (Please select): **Plan 1:** Emerald ☐ **Plan 2:** Sapphire ☐ **Plan 3:** Ruby ☐ **Plan 4:** Jade ☐ **Plan 5:** Diamond ☐

Area of Cover (Please select):
Option 1: Worldwide including USA ☐
Option 2: Worldwide excluding USA ☐
Option 3: Asia (Bangladesh - Bhutan - Brunei - Cambodia - East Timor - India - Indonesia - Japan - Laos - Malaysia - Maldives - Mongolia - Myanmar - Nepal - Pakistan - Philippines - Sri Lanka - Taiwan - Thailand - Vietnam) ☐
Option 4: Africa (including India & Pakistan) ☐
Option 5: Principal Country of Residence within the African Continent and pre-authorised Centres of Excellence on the African Continent ☐

Policy Currency (Please select): USD $ ☐ EUR € ☐ GBP £ ☐

Do you wish to purchase the optional dental cover? (Not available on Emerald or Sapphire) Yes ☐ No ☐

Do you wish to purchase the optional optical cover? (Not available on Emerald or Sapphire) Yes ☐ No ☐

Do you wish to purchase the optional maternity cover? (Not available on Emerald or Sapphire) Yes ☐ No ☐

Which female family members wish to benefit from the optional maternity cover : _____

Please note that remaining family members must choose the same Core Plan as those members opting for maternity cover.

Out-patient Co-Pay option (please select):
Option 1) Nil co-payment ☐
Option 2) 10% co-payment ☐
Option 3) 20% co-payment ☐

In-patient Deductible option (please select):
Option 1) Nil ☐
Option 2) USD $500 / EUR €400 / GBP £300 ☐
Option 3) USD $1,000 / EUR €800 / GBP £600 ☐
Option 4) USD $2,000 / EUR €1,600 / GBP £1,200 ☐
Option 5) USD $5,000 / EUR €4,000 / GBP £3,000 ☐
Option 6) USD $10,000 / EUR €8,000 / GBP £6,000 ☐

5. METHOD OF PAYMENT AND CONTRACT DETAILS

Contract Details

Date you want cover to commence (dd mm yy): _____ (Please note this date cannot be prior to the date we receive this application form)

Payment Option:

Premium Annual ☐ Semi-Annual ☐ Quarterly ☐

*Any charges made by the remitting bank and receiving bank in the course of submitting funds to Optimum Global Limited must be borne by the applicants. This may mean that it is necessary to pay an amount in excess of the contribution due to the plan to cover these charges.

Please indicate your name and invoice number when remitting payment.
Please remit the amount to the currency denominated bank account of **Optimum Global Limited** as shown on your invoice.

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6. SWITCH HEALTH DECLARATION

I,_____ date of birth_____ confirm that my/our existing health insurance policy,

Policy Number_____ is currently in force with the following insurance company:_____
, and that the terms offered by Optimum Global Insurance Company Limited are based on the premise that I/We have at the point of application an inforce Health Insurance policy with the above declared Insurance company.

I understand that claims may be rejected if at the point of claim it is revealed that I/We did not have an inforce health insurance policy with the above declared insurer at the point of switching coverage to Optimum Global Insurance Company Limited. This declaration is deemed to be part of the contract with Optimum Global Insurance Company Limited.

The information contained in this Declaration will form part of the application for cover. It is important that the questions are fully answered as non-disclosure may result in amended terms being applied to the policy or termination:

	Main Applicant		Spouse		1st Child		2nd Child		3rd Child	
Height (cm):										
Weight (kg):										
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Are any medical/surgical/dental consultations and/or procedures (including investigations or tests) recommended, scheduled or contemplated for anyone to be insured?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Has anyone to be insured ever been refused life or any other form of health insurance, or ever had a policy postponed, rated or accepted on special terms?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Has anyone to be insured been examined by, consulted with, or received medical treatment from a physician, specialist or consultant in the last 4 years?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Has anyone to be insured ever suffered from: any disease of the heart or circulatory system? stroke or high blood pressure? cancer, growth or other malignancy? any mental or nervous disorder?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Is anyone to be insured suffering from any medical condition which is likely to result in the need of an in-patient hospital stay within the next 6 months?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Is anyone to be insured suffering from an incurable medical condition that requires long-term treatment? For the avoidance of doubt this includes things like Asthma, Diabetes and any other chronic conditions.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. Is any person to be covered under this policy currently pregnant?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If the answer to any of the above is YES, please complete the section below:

Name	Nature of illness or injury	Details and dates of treatment	Present state of health/prognosis

Signature of Primary Applicant: Date(dd mm yy):

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7. DECLARATION

Benefits may not be payable if you do not fully disclose any material facts requested within this application form and any supplementary medical questionnaires which you may be required to complete as part of the application process. Material facts are those which could influence our assessment and acceptance of this application and, if you are in any doubt as to whether any facts are material, you should disclose them.

Personal Data provided in this application form will be used and processed by us in line with our Privacy Policy which can be found on our website, or which can be requested from us at any time.

I hereby give my consent to Optimum Global Insurance Company Limited or its agent to process the data supplied in this application form for the purposes of insurance intermediation, selection and/or compliance. I accept that this data may be sent and processed outside the UK in a country without specific data protection laws (this only applies if you have lived or worked overseas).

I/We declare that all the information on this application form is true and complete. I am/We are unaware of the existence of any medical condition or circumstance foreseeably requiring my/our hospitalisation in the future, and understand that benefits will not apply to treatment or expense arising from medical conditions which originated or were known to exist or for which treatment, medication, advice or diagnosis was sought or received prior to my/our enrolment in the Policy unless such conditions are fully disclosed to and accepted by Optimum Global Insurance Company Limited prior to the inception of the Policy. I/We consent to Optimum Global Insurance Company Limited seeking information from any doctor who has attended to me/us and I/we authorise the giving of such information. I/We further authorise Optimum Global Insurance Company Limited to give such information obtained or information contained herein for the purpose of obtaining insurance cover under this application to my insurance representative. I/We understand that Optimum Global Insurance Company Limited may require further medical information from my doctor and I/we am/are aware that I am/we are responsible for obtaining and paying for such information should I/we wish to continue my/our application. I am/We are aware that I/we can seek advice from a qualified adviser before I/we sign this application form. Should I/we choose not to, I/we take sole responsibility to ensure that this product is appropriate to my/our financial needs and insurance objectives. I/We have received Optimum Global Policy Conditions and the product benefit table and they have been explained to my/our satisfaction.

I/We agree that any cover which I/we may purchase for the USA shall terminate upon informing Optimum Global Insurance Company Limited that I/we have become a resident of the USA. I/We agree that this application shall be the basis of the contract of insurance between me/us and Optimum Global Insurance Company Limited. I/We understand that the insurance shall not become effective until it is accepted and confirmed in writing by Optimum Global Insurance Company Limited or its agent.

Signature of Main Applicant: Date:

Signature of Spouse/Partner: Date:

Broker/Distributor details:

Distributor Number: