OPTIMUM GLOBAL
INTERNATIONAL INSURANCE SOLUTIONS

OG GEMS - MORATORIUM 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.

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? Yes ☐ No ☐

Do you wish to purchase the optional optical cover? 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.

Do you wish to purchase the optional Life & Critical Illness Cover top up. If yes please indicate amount Yes ☐ No ☐

USD $50,000 / GBP £50,000 / EUR €50,000 ☐ USD $100,000 / GBP £100,000 / EUR €100,000 ☐

Do you wish to purchase the optional travel cover? Yes ☐ No ☐

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 ☐

Do you wish to purchase the optional Life cover? (please note, this option is only available to members aged 18-64 yrs)

Please indicate which Life cover amount you are applying for along with the name of the applicant/s applying for this option:

Option a) $50,000 / €50,000 / £50,000 ☐ Name/s of applicant/s: _____

Option b) $100,000 / €100,000 / £100,000 ☐ Name/s of applicant/s: _____

Please note: If choosing this option, please complete the beneficiary nomination form.

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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.

6. DECLARATION

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 any agent thereof 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).

(a) I/We understand initially there is no cover at all for treatment of any medical condition which was in existence at any time during the five years immediately preceding the date on which the persons included on this application start their policy. This exclusion relates not only to those conditions for which a diagnosis has been received but also to any medical condition for which I/We actually had symptoms for, even though no diagnosis had been attached to those symptoms. All that matters is that the person knows, or ought reasonably to have known, that something was wrong even if they had not consulted a doctor. If a claim is made, therefore, I understand My/Our doctor may be asked for confirmation that I/We would have had no reason to know or believe, when I/We joined, that I/We might have the condition for which I/We are claiming treatment.

(b) In addition, I understand the persons covered by this application will not be covered for treatment of specified conditions where they have been diagnosed with diabetes, are currently undergoing treatment for blood pressure (hypertension), are under investigation, having treatment or undergoing monitoring as a result of a Prostate Specific Antigen (PSA) test.'

Treatment of all such conditions is completely excluded from cover for two years from the date of joining.

I/We understand that at the end of those two years the persons included in this application will be able to claim for treatment of those conditions or symptoms described in (a) above, but only if I/We have not had any medical treatment or any medical advice, or taken any drugs or medicines, or followed any special diets in respect of those conditions for the period of 24 consecutive months. If such treatment is received within the period of two consecutive years then the persons included in this application won't be able to claim for treatment of those conditions until such time as they have gone for a period of 24 consecutive months without any treatment or advice or help or drugs.

It follows that there are some medical conditions and specified conditions – those which continue or keep recurring as described in (b) above – for which it will never be possible to make a claim for treatment. This is because the person will always need to have medical advice or take medication and therefore will not be able to go for a period of 24 consecutive months without any treatment or advice or help or drugs.

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.

As regulations vary by country, we do not advise on local insurance requirements. Members are responsible for ensuring that this policy satisfies any applicable local laws and for obtaining any additional local coverage that may be required.

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.

Signature of Main Applicant: Date:

Signature of Spouse/Partner: Date:

Broker/Distributor details:

Distributor Number:

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LIFE INSURANCE BENEFICIARY DESIGNATION

Important notes:

- If more than one person is on the policy, please complete one beneficiary designation form per person
- Use this form to name the persons or entities you want to receive your life insurance proceeds after your death.

Medical Screening Questions:

- Do you have any known cancer? Yes ☐ No ☐
- Do you have any planned in-patient treatments or hospitalisations? Yes ☐ No ☐
- Do you have any terminal illness? Yes ☐ No ☐
- Have you ever been denied life insurance? Yes ☐ No ☐
- Have you been absent from work for 15 consecutive days or more in the last 6 months? Yes ☐ No ☐

If you have answered 'yes' to any of the above questions, please provide further details to **sales@optimumglobal.com**

1. Primary Beneficiaries

These parties are your first choice to receive the insurance proceeds after your death. If a primary beneficiary dies before you, we will divide their share(s) equally between the remaining primary beneficiaries.

You must name at least one (1) primary beneficiary.

Please complete the form fields below for each beneficiary you name. Having accurate information for your beneficiaries ensures that we distribute the proceeds the way you want.

Use the proceeds % field to tell us how you want us to distribute the proceeds. If you want a specific distribution, use whole numbers (no fractions or decimals) and make sure they add up to 100%.

THE BENEFICIARY FOR THE POLICY SHALL BE:

PRIMARY BENEFICIARY			
Name	Address	Relationship to the Covered Person	% of Death Benefit Payable to Beneficiary (must total 100%)

In the event, and only in the event, that all Primary Beneficiaries predecease me, then the proceeds shall be payable to the following Contingent Beneficiaries

2. About the Contingent Beneficiaries

Skip this section if you're not naming a contingent beneficiary. Contingent beneficiaries receive the insurance proceeds only if all the primary beneficiaries are deceased at the time of your death. If a contingent beneficiary dies before you, we will divide their share(s) equally between the remaining contingent beneficiaries.

Please complete the form fields below for each beneficiary you name.

Do not list the same person as both a primary and a contingent beneficiary.

Use the proceeds % field to tell us how you want us to distribute the proceeds. If you want a specific distribution, use whole numbers (no fractions or decimals) and make sure they add up to 100%.

CONTINGENT BENEFICIARY			
Name	Address	Relationship to the Covered Person	% of Death Benefit Payable to Beneficiary (must total 100%)

Please note, should all beneficiaries predecease the person covered, we will pay the life benefit to the estate of the deceased.

Insured's Signature: Insured's Printed Name: Date: