



Worldwide Healthcare Plan - Employer Application Form

Please complete in **BLOCK** capitals ensuring all relevant fields are completed

1. Company Details

Company Name:	
Nature of Business:	
Address:	
Zip/Postcode:	
Tel No:	Fax No:

2. Contact Details

Please provide the name and contact details of the person(s) responsible for running your company's group medical scheme.

Primary contact person:

Title Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/>	First names:
Surname:	
Job title:	
Tel No:	Email Address:
Fax:	

Secondary contact person:

Title Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/>	First names:
Surname:	
Job title:	
Tel No:	Email Address:
Fax:	

3. Cover Requirements

Please indicate your requirements by ticking the relevant boxes below

1. Plan Type

Programme 1

Programme 2

Programme 3

2. Geographical Area

Area 1

Area 2

Area 3

Covers Europe

Covers all countries worldwide
except USA, Canada and Caribbean

Cover all countries worldwide
with **no** exceptions

3. Currency

What currency would you like the benefits of your group scheme to be denominated in?

US \$

GBP £

Euros €

4. Basis and value of Deductible

Please note that if you require a deductible it must be in the same currency as in 3. above

a) No deductible to apply

b) Deductible on an annual basis i.e. per period of insurance per insured member basis

Please indicate below the required value

\$300 \$600 \$1200

£165 £330 £660

€250 €500 €1000

c) Deductible on a per medical condition basis

Please indicate below the required value

\$60 \$120 \$300

£35 £70 £165

€50 €100 €250

4. Definition of staff to be insured

Please indicate who is to be covered by the group scheme

Employees only **OR** Employees and their eligible dependants

Please attach a census of everyone to be covered including their date of birth, nationality and country of residence together with a completed application form for each employee.

5. Start Date

From what date would you like insurance cover to start from?

Day Month Year

Please note that this date is not guaranteed and is subject to agreement by Europ Assistance.

Declaration

I declare that I am authorised by the Company to enter into this Contract of Insurance. I further declare that after full and reasonable enquiry and to the best of my knowledge and belief that the statements made by me on this application form together with any supplementary information forming part of this application are full, true and correct. I understand that any changes to the information I have provided which take place between the time this form is completed and the time coverage becomes effective, must be notified in writing to the Insurer prior to the effective date of this coverage and that failure to do so may result in the rejection of a claim or cancellation of the Policy.

Important Note

Please ensure that prior to entering into this Contract of Insurance you have been provided with, and have read, the terms and conditions that will apply to you as the Policyholder and any eligible insured person enrolled on this policy. If you do not understand any aspect of the terms and conditions you should contact **Europ Assistance International Health Solutions S.A.S.** at the address given below before signing this application.

Signature:**Position:**

Date

/

/

Signed for and on behalf of;

Please seal with company stamp

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For further information or for any queries, please contact: Europ Assistance, International Health Solutions S.A.S., PO Box 637, Sussex House, Perrymount Road, Haywards Heath, West Sussex RH16 1WR, United Kingdom.

Website: www.ea-ih.com