

Freedom Healthnet

WORLDWIDE INDIVIDUAL APPLICATION FORM (Moratorium)

Each of the following parts should be completed by you and the completed form returned to: **Freedom Healthnet Ltd, Bourne Gate, 25 Bourne Valley Road, Poole, BH12 1DY, United Kingdom.** Please use **BLOCK CAPITALS**.

Maximum age of entry 65.

About you

Title:

Forename(s):

Surname:

Country of Residence:²

How long have you lived there?

Home country:

Nationality on passport:

Date of birth:

Occupation:

Residential Address:³
Postcode:

Telephone numbers: *(inc. area code)* Daytime: Evening:

Mobile number:

E-mail address:

Start date: *(We cannot backdate cover under any circumstances)*

²Your country of residence will determine the value of Insurance Premium Tax that is added to your premium. Please speak to your adviser or contact us if you are unsure whether your premium will be affected.

³All correspondence will be sent to this address unless you have completed the correspondence address details below. It is very important that you tell us immediately of any changes to your contact or personal details. A change in circumstances could affect your cover.

Correspondence Address (if different from above)

Residential Address:³
Postcode:

Telephone numbers: *(inc. area code)* Daytime: Evening:

Mobile number:

E-mail address:

About your family

If you require further dependants to be covered please use a separate sheet

Surname:	Forename:
Date of birth (dd/mm/yyyy):	Gender:
Country of Residence:	Nationality on passport:
Occupation:	Relationship to you:

continued overleaf >

Surname:	Forename:
Date of birth (dd/mm/yyyy):	Gender:
Country of Residence:	Nationality on passport:
Occupation:	Relationship to you:

Surname:	Forename:
Date of birth (dd/mm/yyyy):	Gender:
Country of Residence:	Nationality on passport:
Occupation:	Relationship to you:

Surname:	Forename:
Date of birth (dd/mm/yyyy):	Gender:
Country of Residence:	Nationality on passport:
Occupation:	Relationship to you:

The cover you require

Select the area of cover from the descriptions below based upon the location of your country of residence and your home country if you require the option of returning to your home country for treatment. Please see eligibility section in the Policy Document for restrictions on US Citizens. You and your dependants must have the same area of cover.

Area 1 – Europe Area 2 – Worldwide excluding USA Area 3 – Worldwide

Please indicate the plan type that you require. Please be sure that you have read the policy summary and details of cover before making your selection to ensure the product meets your requirements. Please contact us if you require copies of these documents.

	Category 1
Freedom Diamond – 2,000,000 (€/£/\$) overall limit	<input type="checkbox"/>
Freedom Platinum – 1,000,000 (€/£/\$) overall limit	<input type="checkbox"/>
Freedom Gold – 750,000 (€/£/\$) overall limit	<input type="checkbox"/>
Freedom Silver – 500,000 (€/£/\$) overall limit	<input type="checkbox"/>
Freedom Bronze – 500,000 (€/£/\$) overall limit	<input type="checkbox"/>

Excess

Do you require an excess?

Yes No

If Yes, please choose appropriate selection from the table:

Note: An excess does not apply to the Dental Benefit.

Excess Per Year €/£/\$	Premium Reduction %	Please Select
Nil Excess	n/a	
50	5%	
100	10%	
250	15%	
500	20%	
1000	25%	
2500	30%	
5000	40%	

Doctor's/Medical Practitioners Details

Please provide the contact details of your family doctor(s) or medical practitioner(s) who last treated you or your family in the last 2years. Failure to provide this information may cause a delay in processing any claims submitted.

Name:	<input type="text"/>		
Hospital/Clinic/Practice:	<input type="text"/>		
Address:	<input type="text"/>		Postcode:
Telephone number:	<input type="text"/>	Fax number:	<input type="text"/>
Email address:	<input type="text"/>		

Pre-existing Medical Conditions

Please read the (Moratorium Explained) that can be found in the Freedom Worldwide brochure.

You must sign this section to show that you understand and accept our Moratorium underwriting. We will not process your application unless this section is signed as well as the Declaration on this application form.

If you would like a copy of our policy document please contact us.

It is important that you read, understand and accept all of the paragraphs in the following declaration of your Freedom Healthnet worldwide application to be underwritten under this moratorium clause.

This declaration applies equally to you and to any eligible dependant(s) you have included within the application form.

Moratorium means we exclude any conditions for which you have received medication, advice or treatment or you have experienced symptoms whether the condition has been diagnosed or not in the two years before the start of your cover (pre-existing conditions).

Related conditions (those which are medically considered to be associated with a pre-existing condition) will also not be covered.

However, if you have not had any such symptoms, treatment, medication or advice for a pre-existing condition or any related condition for a continuous period of 2 (two) years after the start date of your Policy for a particular condition, the condition will become eligible for cover under this Policy.

Pre-existing means any medical or related medical condition which has one or more of the following characteristics:

- was foreseeable,
- manifested itself,
- the person had signs or symptoms of,
- the person sought advice for,
- the person received treatment for, or,
- to the best of the person's knowledge, was aware existed.

After a period of twenty-four (24) months continuous cover under the policy/plan, pre-existing medical conditions may become eligible for benefit, if the person concerned has not:

- experienced symptoms,
- sought advice,
- required treatment, medication, or special diet, or,
- received treatment, medication, or special diet.

If the person concerned has experienced any of the above, he/she will be required to wait a further twenty-four (24) months from the last date of treatment and must meet the above criteria, before being eligible to claim benefit for the pre-existing medical condition in question.

I confirm that I have read, understood and accept this Moratorium Underwriting Clause relating to pre-existing medical conditions and that it applies equally to any eligible dependant(s) included within the application form.

Signature:

Date:

D	D	M	M	Y	Y	Y	Y
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Declaration

I hereby apply to be covered under the selected Freedom Healthnet Worldwide Plan(s) together with the dependants listed in this application.

I declare that to the best of my knowledge and belief the information given in this application is true and complete. I have read, understood and agree to be bound by the terms and conditions detailed in the policy, along with all eligible dependants included in this application or any subsequent dependants enrolled after the commencement date of the plan. It is agreed that this declaration and information supplied in this application shall form the basis of the contract between me, my dependants and Freedom Healthnet Ltd. After reading all the terms & conditions and documents provided to me, I am satisfied that the product selected meets my requirements at this time.

I authorise and request the doctor named in this application and/or any other medical establishment, including any other health professional who has attended me and any of my dependants included under this plan for treatment of a medical condition, to provide Freedom Healthnet Limited with the information they may need in connection to any claim made under this plan.

I accept, if I do not provide the information required in the medical practitioner section that, in the event of a claim being made by me, or any of my dependants included under this plan, which is deemed as being treatment for a pre-existing medical or related medical condition by Freedom Healthnet Limited such claim will be rejected.

I confirm and agree that any personal information collected or held by Freedom Healthnet Limited, whether contained in this application or otherwise obtained may be used by Freedom Healthnet Limited, or disclosed to or transferred to any organisation for the purpose of i) assessing this application and providing on-going insurance cover, customer service and the processing of claims, ii) processing and effecting premium payments, iii) providing marketing communications in respect of Freedom Healthnet Limited, its related products and services and those of its associated companies. (If you do not wish us to use your details in this way, please let us know in writing to the address).

Freedom Healthnet Limited may use organisations who may be located in the EEA or elsewhere. Where an organisation is located outside the EEA, Freedom Healthnet Limited will take all necessary steps to ensure the organisation provides appropriate guarantees in respect of the technical and organisational security measures and the transfer and processing complies with all relevant data protection and privacy laws.

Data Protection Act 1998: We, Freedom Healthnet Ltd will use the information you have given to provide and administer the policy you have applied for. The use of personal data and description of the general categories of person and organisations to whom we may disclose it can be found in the Data Protection Register. You are entitled to request a copy of the personal data held in reference to you on our computer, but we reserve the right to charge a small fee.

We, our agents or intermediaries and any member of Freedom Healthnet Ltd, may use the information that you have provided for marketing purposes or for general market research. We may also use some of the information to advise you of other products and services, offered by Freedom Healthnet. Please tick if you do not wish to receive this information.

Signature:

Date:

Methods of payment

Euros (€)

GB Pounds (£)

US Dollars (\$)

Methods of Payment

Annual Cheque

Please attach the annual cheque payment

Credit Card or Annual Debit Card

Please complete section 1 below

Direct Debit - Monthly or Annually

Please complete a separate direct debit mandate

1. Credit Card or Debit Card

Credit/Debit Card authorisation form (Mastercard and Visa only)

Please complete these instructions if you wish to pay premiums by Credit Card

Type of card:

Mastercard

Visa

Payment time period:

Monthly

Quarterly

Annually

Name on card:

Card number:

Security number:

Expiry date:

To Freedom Healthnet Limited

I authorise you, until further notice in writing to charge my Mastercard/Visa account with unspecified amounts in respect of premiums as and when they become due.

Signed:

Date:

Please complete these instructions if you wish to pay premiums by Annual Debit Card

Payment time period:

Annually

Name on card:

Card number:

Issue Number:

Security number:

Valid from date:

Expiry date:

To Freedom Healthnet Limited

I authorise you, until further notice in writing to change my Mastercard/Visa account with unspecified amounts in respect of premiums as and when they become due.

Signed:

Date:

(For office use only)

Agent/Broker Name:

Agent Broker Number:

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