Fax or e-mail Enrollment Form to:
Integra Global Ltd.
E-mail: ig-contact@integraglobal.com
Fax: +1 800 774 3608
Questions: + 1 888 753 1377

ENROLLMENT FORM

Primary Insured Details:

Last Name: **First Name:**

☐ **Male** ☐ **Female** **Date of Birth:** **Citizenship:**

Country of Residence Outside the U.S. **Job Title:**

Email address:

Tel: **Fax:**

Height: **Weight:**

Correspondence Mailing Address:

Country of Assignment Address (if different from above)

Coverage Details

Coverage is for:

☐ Myself only ☐ Myself plus Spouse ☐ Myself plus Children ☐ Myself and Family

Choose your health cover:

☐ **Personal Health** ☐ **Premier Personal Health**

Geographical Cover:

☐ Plan I - Worldwide Coverage Including the US and Canada
☐ Plan II - Worldwide Coverage Excluding the US and Canada

Currency: ☐ $USD ☐ €EUR ☐ £GBP

Deductible: ☐ Nil (Premier only) ☐ $100/€75/£65 (Premier only) ☐ $200/€150/£125 ☐ $500/€400/£300 ☐ $1,000/€750/£650 ☐ $5,000/€4,000/£3,000

Options:

Dental ☐ Yes ☐ No

AD&D Cover:

☐ $50k/40k/£35k ☐ $100k/€80k/£70k ☐ $150k/€120k/£105k ☐ $250k/€200k/£175k

Requested Effective Date *(for Plan I - 1st, 11th and 21st of each month only)*: ______________________

Payment Method: ☐ Annual ☐ Semi-annual ☐ Quarterly

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MEDICAL HISTORY for Primary Insured

Have you at any time been treated for or been told that you had trouble with any of the following within the last ten years?

	Yes	No
1. Heart / Blood vessels	☐	☐
2. Mental / Nervous Disorders	☐	☐
3. Stroke / Blood Pressure / Hypertension	☐	☐
4. Cancer	☐	☐
5. Respiratory Problems (Asthma)	☐	☐
6. Diabetes(Related problems)	☐	☐
7. HIV/AIDS or related diseases	☐	☐
8. Ortho Problems & Arthritis (Back, Joints, etc)	☐	☐
9. Urological Problems (Kidney Stones)	☐	☐
10. Neurological Disorder	☐	☐
11. Stomach / Intestines	☐	☐
12.Hernia	☐	☐
13. Ears / Eyes	☐	☐
14. Immune System Disorders	☐	☐
15. Sexually Transmitted Infections	☐	☐
16. Skin	☐	☐
17. Thyroid	☐	☐
18. Are any inpatient or outpatient medical /surgical or dental procedures or oral surgery (including diagnostic testing) recommended / contemplated	☐	☐
19. Have you been examined by or consulted with a physician in the last five years	☐	☐
20. Are you currently taking any medication	☐	☐
21. Do you use tobacco products	☐	☐
22. If female, are you pregnant? (If yes, please give due date)	☐	☐
23. Have you ever had an application or an application for reinstatement of Life, Accident, or Health Insurance declined, postponed, rated or modified? (If yes, please give details)	☐	☐

If you have answered YES to any of the above questions, please explain the details in full below.

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DEPENDENT DETAILS

(to be completed by Primary if requesting insurance for dependents)

Full Name	Relationship	Date of Birth	Height	Weight

Dependent's Address (if different from Primary Insured)

Medical History - Dependents Have you at any time been treated for or been told that you had trouble with any of the following within the last ten years?

	Yes	No
1. Heart / Blood vessels	☐	☐
2. Mental / Nervous Disorders	☐	☐
3. Stroke / Blood Pressure / Hypertension	☐	☐
4. Cancer	☐	☐
5. Respiratory Problems (Asthma)	☐	☐
6. Diabetes(Related problems)	☐	☐
7. HIV/AIDS or related diseases	☐	☐
8. Ortho Problems & Arthritis (Back, Joints, etc)	☐	☐
9. Urological Problems (Kidney Stones)	☐	☐
10. Neurological Disorder	☐	☐
11. Stomach / Intestines	☐	☐
12.Hernia	☐	☐
13. Ears / Eyes	☐	☐
14. Immune System Disorders	☐	☐
15. Sexually Transmitted Infections	☐	☐
16. Skin	☐	☐
17. Thyroid	☐	☐
18. Are any inpatient or outpatient medical /surgical or dental procedures or oral surgery (including diagnostic testing) recommended / contemplated	☐	☐
19. Have you been examined by or consulted with a physician in the last five years	☐	☐
20. Are you currently taking any medication	☐	☐
21. Do you use tobacco products	☐	☐
22. If female, are you pregnant? (If yes, please give due date)	☐	☐
23. Have you ever had an application or an application for reinstatement of Life, Accident, or Health Insurance declined, postponed, rated or modified? (If yes, please give details)	☐	☐

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If you have answered YES to any of the above questions, please explain the details in full below.
Give the question number with the relevant details.

Name of Dependent	Please state Condition and Details	Duration of Disability	Complete Recovery or Ongoing? Month / Year	Name and Address of Physicians / Hospitals

Declaration

- I hereby apply for membership to the Integra Global Healthcare Plan.
- I accept the benefits, terms, conditions and limits provided for in the terms of the insurance policy and I agree to be bound by such terms.
- I understand that this application is subject to written acceptance by LAMP Insurance Company Ltd.
- I confirm the correctness of the statements and information contained in this application and confirm the correctness of all other documents submitted now or in the future concerning this application. This clause will constitute a condition precedent to the payment of the benefits provided for in the terms of the Plan. We accept that LAMP Insurance Company Ltd will be relying on such statements and information when agreeing to accept this application. LAMP Insurance Company Ltd reserves the right to investigate where uncertainty exists about the validity of information provided.
- I, the applicant and the listed dependents, agree to being called upon to submit such medical examinations and tests as LAMP Insurance Company Ltd deems necessary.
- I acknowledge that LAMP Insurance Company Ltd reserves the right to cancel the membership of this Plan if any amount due is not paid by or on the due date concerned.
- I agree to give LAMP Insurance Company Ltd immediate written notice should any changes material to the assessment of this application occur before the date upon which LAMP Insurance Company Ltd grants written acceptance. This will give LAMP Insurance Company Ltd the opportunity to reconsider the terms of acceptance.
- AUTHORISATION: To all physicians/hospitals/healthcare institutions/insurers/medical or hospital service providers/employers: You are authorised to provide LAMP Insurance Company Ltd information concerning healthcare, advice, treatment, supplies, absence (including those relating to mental illness and/or AIDS/ARC/HIV) relating to me or any other members of my family for whom coverage has been requested. This information will be used to determine eligibility for coverage. This authorisation will be valid for twenty four months from the date of confirmation of this application.

Primary Applicant's Signature   Date

Expatriate Insurance Services Ltd
11a Forge Business Centre, Upper Rose Lane
Palgrave, Diss, Norfolk, IP22 1AP