GLOBALHEALTH EXPATRIATE INDIVIDUAL MEDICAL INSURANCE
INDIVIDUAL AND FAMILY APPLICATION FORM—SZ Use Only

POLICYHOLDER'S DETAILS

Name (last): _____

Name (first): _____

Name (middle): _____

ID/Passport No.: _____ Nationality: _____

Date of Birth (dd/mm/yy): ___/___/___ Height (cm): _____ Weight (kg): _____

Gender (M/F): _____ Smoker: Yes ☐ No ☐

Occupation (specify nature of duties): _____

Country of Residence: _____

Note: the Policyholder may not apply this insurance for any family member(s) unless he/she has applied the same for his/her self. Please fill in the details of family members to be insured in below sheet. The Insured Person(s) whenever referred to in this Application Form shall include the Policyholder.

CONTACT DETAILS

Email: _____

Telephone (Home): _____ (Work): _____

Mobile: _____ Fax: _____

Residential Address

(Line 1): _____

(Line 2): _____

(Line 3): _____ City: _____

State/Region: _____ Country: _____

Mailing Address (if different from residential address):

(Line 1): _____

(Line 2): _____

(Line 3): _____ City: _____

State/Region: _____ Country: _____

.

PLAN SELECTION

1. Level of Cover - Select your plan	☐ Advantage 100	☐ Advantage 200	☐ Advantage 300	☐ Advantage 400	☐ Advantage 500	
	Hospital only cover with sub-limits	Hospital only cover with sub-limits and option to add out-patient	A comprehensive hospital plan with extensive pre- and post-hospitalization	Strong hospital and out-patient coverage	Strong hospital and out-patient coverage with Maternity cover	
2. Deductible - Select your deductible (in US$)	☐ 500 ☐ 1,000 ☐ 2,000 ☐ 5,000	☐ NIL ☐ 500 ☐ 1,000 ☐ 2,000 ☐ 5,000	☐ NIL ☐ 500 ☐ 1,000 ☐ 2,000 ☐ 5,000	☐ NIL ☐ 500 ☐ 1,000 ☐ 2,000 ☐ 5,000	☐ NIL ☐ 500 ☐ 1,000 ☐ 2,000 ☐ 5,000	
3. Area of Cover - Upgrade to a Worldwide plan	NA	NA	☐ Yes	☐ Yes	☐ Yes	
4. Other Options	☐ Dental	☐ Dental ☐ Include out-patient cover	☐ Dental	☐ Dental	☐ Dental	
5. Personal Accident - Select your plan	☐ Classic		☐ Premier		☐ Supreme	
	Child Plan	Adult Plan	Child Plan	Adult Plan	Child Plan	Adult Plan
☐ Accidental Death, Burns and Dismemberment (US$)	15,000	75,000	15,000	150,000	15,000	300,000
☐ Hospital Income (Up to 90 days per policy year)*	NA	45	NA	80	NA	80

*Hospital Income benefit could only be chosen after choosing the Accidental Death, Burns and Dismemberment benefit.

Annual Premium (US$)	Age	Classic	Premier	Supreme
Accidental Death, Burns and Dismemberment	Adult Plan	150	300	600
	Child Plan	35	35	35
Hospital Income	18-29	55	90	90
	30-39	85	140	140
	40-49	115	190	190
	50-65	160	265	265

Remark: under the Policy, where foreign exchange conversion is involved, all compensation limit / Sum Insured and the premium shall be calculated in USD or RMB equivalent converted at exchange rate: USD/RMB 6.4.

Please choose the Policy currency (Claim settlement currency is same with Policy currency): ☐U.S. Dollar ☐RMB Yuan

Requested Policy Start Date (dd/mm/yyyy): I__I__I/I__I__I/I__I__I__I__I

FAMILY MEMBERS TO BE INSURED

Details	Dependant 1	Dependant 2	Dependant 3	Dependant 4
Last Name				
First, Middle Name				
Relationship to Policyholder				
Marital Status				
Nationality				
Passport/ ID Number				
Date of Birth (dd/mm/yy)				
Gender	☐M ☐F	☐M ☐F	☐M ☐F	☐M ☐F
Height (cm) & Weight (kg)				
Smoker	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Occupation				

MEDICARE (SOCIAL INSURANCE)

	Policyholder	Dependant 1	Dependant 2	Dependant 3	Dependant 4
Do you or any family member to be insured have Social Basic Medical Insurance?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
If any Insured Person has Social Basic Medical Insurance, are you willing to choose the use of the certificate of Social Insurance entitlement (including but not limited to Social Insurance card or Medicare Card) for such Insured Person to register treatment in Medicare Approved Hospital in Mainland China only and use of Medicare Social Insurance as primary insurance cover for such treatment?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

If you tick "Yes" on above box, then you may enjoy 5% discount on medical benefit premium under the Policy in respect of such Insured Person, provided that **AIG China will not liable for any medical costs incurred in hospital other than Medicare Approved Hospital in Mainland China or any medical costs incurred in Medicare Approved Hospital for any treatment: (1) that is not registered with the certificate of social insurance entitlement (including but not limited to social insurance card or medicare card) according to the agreement; or (2) for which Medicare Social Insurance is not applied as primary insurance cover.**

☐ Yes Has any proposed minor under 18 years of age been currently insured under any death benefit offered by AIG China and other insurance companies? (Note: if ticked, then AIG China will not accept the application for such minor to be covered under the optional plan of Personal Accident & Hospital Income; if not ticked, then it shall be deemed that such minor has not been insured under any death benefit offered by AIG China and other insurance companies.)

DEATH BENEFICIARY (Please fill in if any Personal Accident plan is selected)

	Name of Insured Person(s)	Name(s) of Beneficiary	Passport/ID No.	Proportion (%)	Date of Birth (dd/mm/yy)	Relationship to Insured Person
1						
2						
3						
4						

If death beneficiary is not named in the application form, the death benefit will be treated as heritage of Insured Person. If the proportion is not determined in the application form, the beneficiaries shall be entitled to equal shares of the death benefits.

MEDICAL QUESTIONNAIRE

Important Note about filling in this form:
The answers you give to the questions contained in this Application will form the basis of any insurance policy issued, and will be incorporated into the contract. It is essential that you give accurate, truthful, and complete information for all persons to be insured, as inaccuracies may jeopardize coverage or invalidate a claim.

1. Does any of the persons to be Insured reside outside the Usual Country of Residence as shown above? If "Yes", please state which country. ☐ Yes ☐ No

2. Does the occupation of any of the persons to be Insured include any activities involving offshore, underwater, underground, or manual work, or work in a remote location? If "Yes", please give details. ☐ Yes ☐ No

3. Have any of the persons to be Insured previously applied for or held a GlobalHealth policy? If "Yes", provide policy number. ☐ Yes ☐ No

4. Do any of the persons to be Insured have health insurance with another company? If "Yes", please attach a copy of the policy and benefit schedules, and indicate if the other coverage will be continued if the GlobalHealth application is approved. ☐ Yes ☐ No

5. Have any of the persons to be Insured ever had a policy or application for life, sickness, accident disability, critical illness or medical insurance refused, postponed, declined, withdrawn, or had any special terms (including extra premium or exclusions) imposed? If "Yes", please provide full details. ☐ Yes ☐ No

6. Within the last five years, have any of the persons to be Insured experienced, been treated for, sought advice on, or had symptoms relating to any of the following conditions? ☐ Yes ☐ No

If the answer is "Yes" to any of the following, **please write** the medical condition and complete the relevant questionnaire where indicated. For other medical conditions, please provide details in the table on page 4.

a) Cancer, leukemia, tumors, cysts or a growth of any kind? (If "Yes", please complete the Tumor/Cyst Questionnaire) ☐ Yes ☐ No

b) Asthma, persistent cough, coughing of blood, pneumonia, chest or breathing complaints, chronic bronchitis, chronic sinusitis, allergies, deviated nasal septum, tuberculosis, or any disease or disorder of the lungs? (If "Yes", please complete the Respiratory Questionnaire) ☐ Yes ☐ No

c) Chest pain, raised blood pressure, raised cholesterol, heart murmur or heart condition, breathlessness, abnormal heart rate, rheumatic fever, varicose veins, or circulatory disorder? (If "Yes", please complete the Cardiovascular Questionnaire) ☐ Yes ☐ No

d) Indigestion, gastritis, gastric or duodenal ulcer, blood in stools, fistula, hernia, haemorrhoids or any disease or disorder of the bowel? ☐ Yes ☐ No

e) Kidney stones, urinary tract infections or complaint, blood, protein or sugar in urine, or any disease or disorder of the kidney, bladder, prostate or genito-urinary tract? ☐ Yes ☐ No

f) Jaundice, hepatitis of any form or any disease or disorder of the gall bladder, pancreas or liver? ☐ Yes ☐ No

g) Diabetes, thyroid disorders or any other endocrine disorders? ☐ Yes ☐ No

h) Anaemia, thalassaemia, haemophilia, or any other disease or disorder of the blood? ☐ Yes ☐ No

i) Disease of the brain or nervous system, stroke, epilepsy, paralysis, weakness of a limb or prolonged headache? (If "Yes", please complete the Cerebrovascular/Nervous System Questionnaire) ☐ Yes ☐ No

j) Mental health disorder, depression, anxiety, nervous condition, stress, post traumatic stress disorder, behavioural problem, alcohol or drug addiction? ☐ Yes ☐ No

k) Back or neck pain or strain, spinal condition, sciatica, slipped disc, whiplash, gout, arthritis, bone fracture, joint injury e.g. knee, elbow, wrist, shoulder, hallux valgus (hammer toes) or any symptoms of a muscle disorder? (If "Yes", please complete the Musculo-Skeletal Questionnaire) ☐ Yes ☐ No

l) Malaria, dengue fever, typhoid or any other tropical disease? ☐ Yes ☐ No

m) HIV, AIDS (Acquired Immuno Deficiency Syndrome), AIDS related condition or had any positive blood test for HIV (also called AIDS or HTLV-III) virus? ☐ Yes ☐ No

n) Psoriasis, eczema, dermatitis, acne or any other skin condition? ☐ Yes ☐ No

o) Ear discharge, nose bleeds, double vision, impaired sight, hearing or speech or any other disease or disorder of the ear, eye, nose or throat? ☐ Yes ☐ No

p) (**Females only**) Pregnancy or any complications of pregnancy, abnormal smear test or any gynaecological disorder e.g. fibroid &/or cyst of the female reproductive system? (If "Yes", please complete the Gynaecological Questionnaire) ☐ Yes ☐ No

q) Any other ailment, impairment, injury, accident, condition(s), medical investigations, or hospital treatments not mentioned above? ☐ Yes ☐ No

If you answered "Yes" to any of the above questions that did not require a Medical Questionnaire , please give details of the condition in the table below.

Insured's concerned	Q.No.	Date of first consultation	Details of Medical condition, including nature of treatment, results and if you have fully recovered?	Name & Address of doctor, hospital or health professional consulted	Do you require any follow up treatment or consultation, if so when?

(Please use an extra sheet if more space is required)

7. Other than for those medical conditions mentioned above, has this person been admitted to hospital for treatment or observation or undergone any surgical procedure? If Yes, please provide full details, including the date, diagnosis and nature of treatment or surgical procedure.

☐ Yes ☐ No

8. Is this person taking any medication or receiving any form of treatment at the present time? If Yes, please provide the medical condition, name of medication and dosage, and/or treatment.

☐ Yes ☐ No

9. Has this person been advised to have or do they intend to seek any medical advice, test, investigation, surgical procedure, hospitalization, or treatment in the near future? If Yes, please provide the medical condition, attending physician and recommended treatment.

☐ Yes ☐ No

10. Please provide the following information about this person's current usual doctor/ personal physician/ medical centre or hospital:

Name: _____

Email: _____

Telephone (Work): _____ Fax: _____

Address

(Line 1): _____

(Line 2): _____ City: _____

State/Region: _____ Country: _____

How long has this person been under this physician's care: _____

Date of last attendance & reason: _____

IMPORTANT NOTICE:

1. **This Policy does not cover any Covered Charges incurred or any Disability suffered in Cuba, Myanmar, Iran, Sudan and Syria.**
2. **This policy will not cover any terrorist or member of a terrorist organization, narcotics trafficker, or illegal purveyor of nuclear, chemical or biological weapons defined by any country or international organization.**
3. In order to protect your own interests, before applying for the Policy, please read carefully the terms and conditions of this Policy, especially the exclusions. The policy wording is available from our salespersons or on our website at www.aiginsurance.com.cn. Please call 8009880898 or contact our salespersons to enquire the terms and conditions of this Policy. Please make sure that you fully understand the explanations of our salespersons. With no enquiry, you are deemed to have fully understood the terms and conditions of this Policy.
4. The Insurance Policy shall consist of policy wording, application form, quotation (if any), schedule, endorsements, remarks and any other relevant agreements.
5. If AIG China agrees to cover, the inception date of insurance shall be (1) expected inception date, provided that AIG China receives the agreed premium in full before such date; or (2) the day following receipt of the agreed premium in full, provided that AIG China receives the agreed premium in full on or after the expected inception date. If AIG China rejects the application, AIG China will refund the received premium in full without interest.
6. The English version of this Application Form is for reference only. Should there be any inconsistency between the Chinese and English versions, the Chinese version shall prevail.

DECLARATION BY POLICYHOLDER / INSURED PERSON(S)

I/We hereby apply for a policy to be issued based on the statements contained herein and declare in the Application Form that all answers to the foregoing questions are correctly recorded, and that they are full, complete and true. Except as declared herein, all persons to be insured are currently in good health. I/We agree that if the health status of the above intended insured person changes after this application is signed and before AIG Insurance Company China Limited ("AIG China") issues a policy I/we shall immediately notify AIG China of the change. I/We agree that the policy as issued including all schedules, endorsements, and this application shall form the whole insurance policy and that no insurance shall be in force until and unless the agreed premium has been paid and the policy schedule has been issued by AIG China.

I/We acknowledge that before applying for the insurance, I/we have read carefully the terms and conditions of this Policy, especially **the exclusions**, and fully understand your explanations and reminder. We understand that all insurance coverage is subject to the terms and conditions of this Policy.

I/We hereby declare and agree that our information and any personal information regarding the insured persons collected or held by AIG China (contained in this application form or otherwise obtained) may be held, used and disclosed by AIG China to individuals or organizations associated with AIG China (within or outside China) for the purposes of (i) processing this application and other insurance related matters, (ii) providing insurance services & (iii) communication with us or the insured persons.

I/We hereby agree that if currency conversion with USD/RMB is required in any claim settlement under the Policy, AIG China shall apply the RMB central parity rate as set by the People's Bank of China (PBOC) on the first day of the month in which AIG China has received the submitted claim.

I/We fully understand that any dispute arising from performance of this insurance contract shall be settled by litigation or arbitration to be chosen upon negotiation with AIG China when such dispute occurs or when the contract is concluded.

I/We hereby understand that the special notice should be given to AIG China where the death benefit offered by all the commercial insurance policies for any insured under 18 years old exceed the death benefit limit of RMB100,000 for person under 18 years old specified by China Insurance Regulatory Commission, otherwise, **AIG China may not be liable for any amount in excess of the regulatory limit.**

Cashless Out-patient Facility (Applicable only to the following plans with nil deductible: Advantage 400 and Advantage 500; however, if I, the Policyholder, has selected at the placement of the plans eligible for direct billing service the use of the certificate of Social Insurance entitlement (including but not limited to Social Insurance card or Medicare Card) for me/us to register treatment in Medicare Approved Hospital in Mainland China only and use of Medicare Social Insurance as primary insurance cover for such treatment, then I/we shall not be entitled to any direct billing service under such plan):
I/We authorize AIG China to release the names, dates of birth, sex, passport and/or identification number, any information provided on the Application and Employee & Family Enrolment Forms and any records AIG China may have regarding the Insured person(s) shown on the Namelist to hospitals, clinics, laboratories, physicians, specialists, dentists, chiropractors, acupuncturists, physiotherapists, or other medical practitioners for the purpose of providing direct bill paying services for the Insured Person(s). I/We hereby agree and acknowledge that the payment under the applicable Advantage Plan will be paid to relevant medical institution directly instead of paid to the Insured Person and that AIG China shall have discharged its obligations to make payment under the Policy after paying to such medical institution. By signing this Authority and Release Form, I/We also acknowledge the specific Policy term listed below:

Right of Recovery:
In the event of authorization of payment and/or payment is made by AIG Insurance Company China Limited for a claim which is not covered under this Policy or when the limit of liability of this insurance is exceeded, AIG China reserves the right to recover the said sum or excess from you. This recovery includes but is not limited to deducting the payments owed from other claims made by you during the Policy period. If the amount owed remains outstanding for more than 90 days, then AIG China reserves the right to suspend the direct billing service to you without further notice.

Signature of Policyholder	Signature of Insured Person(s) (if the Insured Person is a minor, then signature of his/her guardian)	Date

For enquiries/applications, please contact us

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