PLATINUM | LIFE

Medical Health Plan | Application Form

VITA HEALTH

VITA HEALTH

Platinum / Life Medical Health Plan Application Form

Part A - Your Personal Details

Please complete the following details for yourself as the principal member

Company name:

Title: (Mr, Mrs, Miss, Other): Surname:

First name(s):

Nationality:

Passport no:

Date of birth: D D M M Y Y Y Y Sex at Birth: M F (tick as appropriate)

Country of residence:

Occupation:

Residential address:

Postal Code:

Postal address:

Postal Code:

Telephone: Mobile No:

Email (Home): Email (other):

Next of kin name: Relationship:

Next of kin address:

Postal Code:

Principal

The VitaHealth Membership Plans are underwritten by International Reinsurers who is authorised and regulated.

Membership Administrator

VitaCap Benefit Limited is the appointed Administrator of the VitaHealth Platinum & Platinum Life Membership plans.

Part A - Your Personal Details (continued)

Do you and/or any applicant participate in any competitive sporting activities? Yes ☐ No ☐

Competitive sporting activities include (but are not limited to): parachuting, gliding, paragliding, parascending, scuba diving, hang gliding, bungee jumping, polo, motor sports, equestrian events, hunting, or any other high-risk activity.

If yes, please give full details of any sporting activities you participate in, and how often:

Have you previously held a membership, or do you currently hold a membership with VitaCap Benefit Limited? Yes ☐ No ☐

Previous/Current Membership No:

Date of Expired Membership/s: D D M M Y Y Y Y

Have you previously been insured, or are you currently insured, with another health insurer? Yes ☐ No ☐

Previous/Current Policy No:

Please explain:

Part B - Health Plan Applied For

Platinum ☐ Platinum Life ☐ Platinum Life Benefit Amount in US$

Platinum Life is similar to Platinum in benefits and includes a Life Benefit.

Part C - Members Details

Please enter the names and details of all dependents for whom benefits is required. You may include your partner and children, up to age 18 (or up to age 25 if in full-time education - proof will be required) if the dependants are eligible to be part of the corporate policy.

Partner details

First Name(s): Surname:

Occupation:

Passport no:

Date of birth: D D M M Y Y Y Y Sex at Birth: M F (tick as appropriate)

Country of residence: Nationality:

Part C - Members Details (continued)

Child 1 details

First Name(s): Surname:

Occupation:

Passport no:

Date of birth: D D M M Y Y Y Y Sex at Birth: M F (tick as appropriate)

Country of residence: Nationality:

Child 2 details

First Name(s): Surname:

Occupation:

Passport no:

Date of birth: D D M M Y Y Y Y Sex at Birth: M F (tick as appropriate)

Country of residence: Nationality:

Child 3 details

First Name(s): Surname:

Occupation:

Passport no:

Date of birth: D D M M Y Y Y Y Sex at Birth: M F (tick as appropriate)

Country of residence: Nationality:

Child 4 details

First Name(s): Surname:

Occupation:

Passport no:

Date of birth: D D M M Y Y Y Y Sex at Birth: M F (tick as appropriate)

Country of residence: Nationality:

Part D - Health Declaration

The Principal is not obliged to provide benfits for any pre-existing or past conditions for which you have previously received medication, advice or treatment or experienced symptoms, whether the condition has been diagnosed or not, at any time before the start of your membership, unless stated otherwise in writing, as stated below. A related condition is any disease, illness or injury that is caused by a pre-existing condition or result from the same underlying cause as a pre-existing condition.

Should the Principal accept, in writing, pre-existing or past conditions, then special terms, exclusions or loading may apply, at the Principal's discretion. Should treatment for any pre-existing or related condition be required, and has not been declared on this application, or the full details disclosed, The Principal is not obliged to pay these associated claims.

The Principal has the right to refuse membership or apply special terms, exclusions or loading for any new application or renewal. Please, therefore, take the greatest care to ensure that this application form is completed fully and accurately. If you are uncertain if any particular fact needs to be disclosed, you must include it. If, after completing your application form, any changes occur that may affect the information provided by you on this form, such as a change in your state of health or the state of health of any of your dependents, please inform the Principal in writing about the change. The Principal reserves the right to decline or accept an application with special terms, exclusions or loading on receipt of any further health information.

PLEASE NOTE:
Failure to disclose all current and previous medical conditions on each new application or renewal, renders the membership void.

Part E - Medical History

This section asks for health and medical details, past and present, about the applicant/s named in section C.
Please complete every question for each individual.

If the answer to a question is yes, please give full details in section F on the next page. If you are unsure of the relevance of any details, please include them.

Have you ever:

- Seen a GP or other health care professional?
- Received treatment?
- Experienced symptoms?

	Principle Member		Partner		Child 1		Child 2		Child 3		Child 4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Heart or cardiovascular disorders: e.g coronary artery disease, chest pains, circulation problems, varicose veins, high blood pressure, venous ulcers, cholesterol, deep vein thrombosis.												
2. Glandular disorders: e.g diabetes, thyroid, hormonal problems.												
3. Breathing or respiratory disorders: e.g asthma, bronchitis, shortness of breath, chest infections, TB, Emphysema, Pulmonary Embolism.												
4. Ear, nose, throat or eye problems: e.g hay fever, tonsillitis, sinusitis, cataracts, eye infections, deafness, ear infections.												
5. Stomach, intestines, liver or gallbladder: e.g ulcer, colitis, repeated indigestion, irritable bowel, change in bowel habits, hepatitis, piles, rectal bleeding.												
6. Cancer, tumors, growths, cysts or moles that itch or bleed.												
7. Skin problems: e.g eczema, rashes, psoriasis, and acne.												
8. Brain or nervous system disorders: e.g stroke, migraines, repeated headaches, MS, epilepsy, nerve pains, fits, chronic fatigue syndrome.												
9. Muscle or skeletal problems: e.g arthritis, cartilage and ligament problems, back and neck problems, sprains, joint replacements, gout, sciatica.												
10. Urinary problems: e.g bladder, kidney or prostate problems, urinary infections, incontinence.												
11. Blood disorders: e.g anaemia, hepatitis, HIV, abnormal blood tests												
12. Reproductive system disorders: e.g pregnancy and/ or childbirth problems, heavy or irregular periods, fibroids, endometriosis, infertility, abnormal smears, menopause.												
13. Allergies.												
14. Psychological disorders: e.g. depression, schizophrenia, anorexia, bulimia, compulsive disorders, stress, anxiety, addiction												
15. Auto-immune disorders: e.g. sjorgens syndrome, lupus, multiple sclerosis, rheumatoid arthritis.												
16. Any other medical condition not mentioned above or any other previous surgery.												
17. Are you, or any prospective member, taking any chronic medicines, prescribed or otherwise?												

Part E - Medical History (Continued)

	Principle Member		Partner		Child 1		Child 2		Child 3		Child 4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
18. Are you, or any prospective member, receiving any treatment of any kind?												
19. Current smoker/ex-smoker.												
20. To the best of your knowledge are you currently pregnant?												

	Principle Member	Partner	Child 1	Child 2	Child 3	Child 4
Height (cm)						
Weight (kg)						
Alcohol consumption per week 1 unit = 1 tot/small glass wine / 1 bottle of beer						

Part F - Additional Information

If you have answered YES to any questions, please give full details below. Please continue on a separate sheet if necessary.

Question No: _____ Name person who suffered the illness / injury: _____

Date(s) on which the illness / injury occured: D D M M Y Y Y Y

Diagnosis: _____

Treatment / test performed and results (please attach medical report):

Date you last suffered symptoms or received treatment relating to this condition: D D M M Y Y Y Y

Name and contact details of treating physician: _____

Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: _____ Name person who suffered the illness / injury: _____

Date(s) on which the illness / injury occured: D D M M Y Y Y Y

Diagnosis: _____

Treatment / test performed and results (please attach medical report):

Date you last suffered symptoms or received treatment relating to this condition: D D M M Y Y Y Y

Name and contact details of treating physician: _____

Give details of any foreseeable need for further consultation or treatment for this condition:

Part F - Additional Information (Continued)

Question No: ______ Name person who suffered the illness / injury: ______

Date(s) on which the illness / injury occured: D D M M Y Y Y Y

Diagnosis: ______

Treatment / test performed and results (please attach medical report):

Date you last suffered symptoms or received treatment relating to this condition: D D M M Y Y Y Y

Name and contact details of treating physician: ______

Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: ______ Name person who suffered the illness / injury: ______

Date(s) on which the illness / injury occured: D D M M Y Y Y Y

Diagnosis: ______

Treatment / test performed and results (please attach medical report):

Date you last suffered symptoms or received treatment relating to this condition: D D M M Y Y Y Y

Name and contact details of treating physician: ______

Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: ______ Name person who suffered the illness / injury: ______

Date(s) on which the illness / injury occured: D D M M Y Y Y Y

Diagnosis: ______

Treatment / test performed and results (please attach medical report):

Date you last suffered symptoms or received treatment relating to this condition: D D M M Y Y Y Y

Name and contact details of treating physician: ______

Give details of any foreseeable need for further consultation or treatment for this condition:

Part F - Additional Information (Continued)

Question No: ____ Name person who suffered the illness / injury: ____

Date(s) on which the illness / injury occured: D D M M Y Y Y Y

Diagnosis: ____

Treatment / test performed and results (please attach medical report):

Date you last suffered symptoms or received treatment relating to this condition: D D M M Y Y Y Y

Name and contact details of treating physician: ____

Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: ____ Name person who suffered the illness / injury: ____

Date(s) on which the illness / injury occured: D D M M Y Y Y Y

Diagnosis: ____

Treatment / test performed and results (please attach medical report):

Date you last suffered symptoms or received treatment relating to this condition: D D M M Y Y Y Y

Name and contact details of treating physician: ____

Give details of any foreseeable need for further consultation or treatment for this condition:

Question No: ____ Name person who suffered the illness / injury: ____

Date(s) on which the illness / injury occured: D D M M Y Y Y Y

Diagnosis: ____

Treatment / test performed and results (please attach medical report):

Date you last suffered symptoms or received treatment relating to this condition: D D M M Y Y Y Y

Name and contact details of treating physician: ____

Give details of any foreseeable need for further consultation or treatment for this condition:

Part F - Additional Information (Continued)

Please give details of the doctor who is most familiar with the medical history of each person named in this application.

Applicant

Name of Doctor: | Telephone:

Email: | Lenght of time treating applicant:

Partner

Name of Doctor: | Telephone:

Email: | Lenght of time treating applicant:

Child 1

Name of Doctor: | Telephone:

Email: | Lenght of time treating applicant:

Child 2

Name of Doctor: | Telephone:

Email: | Lenght of time treating applicant:

Child 3

Name of Doctor: | Telephone:

Email: | Lenght of time treating applicant:

Child 4

Name of Doctor: | Telephone:

Email: | Lenght of time treating applicant:

Part G - Disclosure by Applicant

1. I have made full and complete disclosure about the medical history of each person included on this application and fully understand that this membership will not cover pre-existing conditions.

2. To the best of my knowledge and belief, each person included on this application is in good physical health and free from physical defect or infirmity, except where the condition has been disclosed herein on the medical questionnaire.

3. I am not aware of any reason for the above benefit to be cancelled or curtailed and I have not withheld any material facts. I understand and accept that failure to disclose a fact or the giving of false information may give the Principal the right to cancel from inception any Membership issued as a result of this application and may invalidate any future claim.

Signature of Applicant | Date: D D M M Y Y Y Y

***Please supply passport copies for all individuals included in this application form.**

Part H - Legal Declaration

1. This application is my/our official request to enter into a contract with the principle through VitaCap Benefit Limited providing the foregoing Membership. I understand and accept that the contract will be on Principle's standard Terms and Conditions for the Platinum & Platinum Life Health Membership Plan.

2. I understand and accept that Vitacap Benefit Limited is subject to the supervisory arrangements and laws of Guernsey; and that the VitaHealth Membership Plan is governed by the laws of Guernsey; and that all disputes relating to this Policy shall be subject to the jurisdiction of the courts of Guernsey; except as otherwise expressly agreed by the parties in writing. I understand and accept that this application can only be accepted by employees of VitaCap Benefit Limited and that no other parties have the necessary authority to create a binding contract.

3. I acknowledge that, in the event of any premium tax or withholding tax being levied in my/our country of residence, it will be my/our responsibility to settle such tax liabilities directly with the relevant tax authorities; or where there are any statutory reporting requirements by any authority in my/our country of residence related to any premiums paid or insurance contracts owned, it will be my/our responsibility to make such reports as may be required directly to the relevant authorities.

4. I confirm that I have not been subject to a sequestration order, declared insolvent, or unfit to enter into contracts. I also confirm that I have contracting capacity in respect of this Membership.

5. I understand and accept the Principal and/or the Membership Administrator may require sight of my medical records to consider a claim. I authorise any doctor, physician, practitioner, hospital, clinic, insurance or reinsurance company, employer, other individual organisation or government office that has any records or knowledge of me or my health to disclose to the Principal and/or the Membership Administrator, any information for the purpose of considering a claim. This authorisation shall irrevocably bind my successors and assignees and remain valid, notwithstanding my death or incapacity, and a copy of this authorisation shall be as effective and valid as the original.

6. I understand that information given to the Principal and/or the Membership Administrator, in connection with this application may be used by them in their consideration of any claim in future, and may be shared with a third party, e.g. a medical examiner, to help in the assessment of a claim against this Membership.

7. I understand that the Terms and Conditions and a copy of this completed application are available on request.

8. I understand and accept that where I am applying on the advice of a Financial Adviser or Agent, that Financial Adviser or Agent is acting on my behalf and not as an agent of the Principal and/or the Membership Administrator.

9. I have read all the information contained in this application and checked my answers to the questions in this application and declare that, to the best of my knowledge and belief, all the information I have given is true and that no fact has been withheld.

10. I understand I must ensure that all facts I have disclosed to my Financial Adviser or Agent in answer to the questions in this application are accurately recorded in this application.

11. I understand that I must inform the Membership Administrator without delay of any changes in my health or circumstances which occur between the date of this application and the Start Date of the Membership, which would have resulted in me providing different answers to the questions in this application. I also understand that I must notify the Membership Administrator of any changes in the details contained on this application form, including a change in the state of health of any person named on it, or contact information.

12. I accept that if I am required to undergo a medical examination, the replies to the medical examiner's questions will form part of this application.

13. I understand and agree that the Principal will use the information I give (as well as information about me relating to any existing Membership I may have with the Principal for administration, underwriting, claims, research and statistical purposes. I authorise the Principal and/or the Membership Administrator to pass information, including medical information, to medical examiners and practitioners, underwriters, claims investigation companies, life insurance or reinsurance companies, data processors, and to any company or agency appointed for these purposes. (These companies or agencies may be located in countries that do not have laws to protect your information.) The Principal and/or the Membership Administrator will remain responsible for making sure that the information is held securely.

14. I also agree that the Principal and/or the Membership Administrator may pass the information to third parties for the prevention of crime or detection of fraud, enabling assets to be rightfully claimed or where required by law or regulation.

15. I agree to the Principal and/or the Membership Administrator asking any doctor I have consulted about my physical or mental health to provide medical information so they may asses this application. I agree they may gather relevant information from other insurers about any other applications for life, critical illness, sickness, disability, accident or private medical insurance on my life for which I have applied. I authorise those asked to provide medical and benefit information when presented with a copy of this consent form.

16. I understand that the VitaHealth Health Plans will not cover pre-existing conditions, unless stated otherwise in writing.

Part H - Legal Declaration (Continued)

17. I understand that the Principal and/or the Membership Administrator will hold and process my personal data for the purpose of processing my Membership, processing any claims submitted under my Health Plan and providing other related services, which may include sharing my personal data with doctors and other medical professionals involved in my treatment or care (or the treatment or care of the persons benefited on my membership). I understand that this may include the transfer of personal data to countries worldwide and in signing this form I consent to such transfer and use. The Principal and/or the Membership Administrator employees are bound by patient confidentiality and data protection processes.

18. I understand that on receipt of my VitaHealth Membership Plan documents, if I am not entirely satisfied, I can cancel this application and receive a full refund of the fees I have paid minus an administration fee, provided that I have not submitted any claim and that I return my documents to the company within 30 days of the start of the membership.

19. I declare that I have been provided with a copy of the Membership Terms and Conditions which I have read for myself and on behalf of the persons/beneficiaries on my membership. I understand that this Health Plan starts from the date of the membership benefit and, therefore, no refund of premium will be allowed after 30 days if this membership benefit is cancelled.

20. I understand that, in the event that an excess is applicable, that excess is deductible for each claim I make on my Health Plan Benefit, and that the Principal and/or the Membership Administrator have the right to collect the excess.

21. I declare that to the best of my knowledge and belief, all the information I have given on this application form is true and complete and that I have confirmed the family details with the respective family members, and that, in the event of fraud or suspected fraud my Health Membership will be annulled immediately by the Principal and/or the Membership Administrator, and my personal data may be disclosed to other parties, including, but not limited to, the appropriate law enforcement agencies.

22. I understand that the Membership Administrator will give me reasonable notice on renewal and premiums which may vary each year.

23. I understand that the Principal and/or the Membership Administrator cannot be liable if my membership benefit has lapsed should the credit / debit card be declined and if I do not respond to requests for alternative methods of payment.

24. I agree that I will inform the Membership Administrator if any of the details given on this application form change..

Signature of Applicant

Date: D D M M Y Y Y Y

How did you hear about the VitaHealth Medical Health Plans

☐ Social Media ☐ Website ☐ Friend ☐ Brochure ☐ Other

For Office Use

Application Approved? ☐ If not, reason why:

Exclusions:

Group name: Total membership fee (USD):

Membership No: Receipt No:

Start date: D D M M Y Y Y Y Renewal date: D D M M Y Y Y Y