CIGNA ACA GLOBAL HEALTH℠ PLAN

HELLO

We're glad you would like to join us.

A Global Individual Healthcare Plan Compliant with the Minimum Essential Coverage terms of the USA Patient Protection Affordable Care Act (PPACA).

Together, all the way.℠

Cigna®

Please complete this application form and return it to us, either by electronic mail, fax or post. See our contact information at the end of this form. Please complete this form in BLOCK CAPITALS.

SECTION A

APPLICATION DETAILS

Please complete this section for all persons to be covered under the policy, including the main policyholder and any dependents.

We will not provide cover to any anyone who has or is eligible to participate in any health insurance plan provided by their employer.				
Are you or any dependants eligible to participate in a health insurance plan provided by your employer?	**Yes**	◯	**No**	◯

POLICYHOLDER

You must notify us of any change of contact details so we can ensure that correspondence reaches you.

Title		First Name		Other Initials		Surname	
Gender (please tick)	Male	◯	Female	◯	Date of birth (DD/MM/YYYY)		
Occupation							
Correspondence address							
Daytime telephone number (Country code – Area code – Number)				Mobile telephone number (Country code – Number)			
Fax (Country code – Area code – Number)							
Email address							
Nationality (What is the nationality of the primary passport that you hold?)							
Location (The country in which you live/will live for the majority of your time for the period of cover)							
If you are not a US citizen and your primary country of residence is the USA, please provide your visa type or green card category							
What is the expiry date of your visa or green card? (DD/MM/YYYY)							
Do you have a USA social security number?	**Yes**	◯	**No**	◯	if yes, what is your social security number?		
I confirm I have attached a copy of the visa or green card for myself and all dependants					**Yes**	◯	**No** ◯
Height: Feet		Inches		Centimetres		**Weight:** Stones		Pounds		Kilogrammes	
Have you smoked or used any form of tobacco products in the last 6 months?					**Yes**	◯	**No** ◯

DEPENDANT 1

Title		First Name		Other Initials		Surname	
Relationship to policyholder			Gender (please tick)	Male	◯	Female	◯
Date of birth (DD/MM/YYYY)			Occupation				
Nationality (What is the nationality of the primary passport that you hold?)							
Location (The country in which you live/will live for the majority of your time for the period of cover)							
If you are not a US citizen and your primary country of residence is the USA, please provide your visa type or green card category							
What is the expiry date of your visa or green card? (DD/MM/YYYY)							
Do you have a USA social security number?	**Yes**	◯	**No**	◯	if yes, what is your social security number?		
Height: Feet		Inches		Centimetres		**Weight:** Stones		Pounds		Kilogrammes	
Have you smoked or used any form of tobacco products in the last 6 months?					**Yes**	◯	**No** ◯

DEPENDANT 2

Title		First Name		Other Initials		Surname					
Relationship to policyholder			Gender (please tick)	Male	◯	Female	◯				
Date of birth (DD/MM/YYYY)			Occupation								
Nationality (What is the nationality of the primary passport that you hold?)											
Location (The country in which you live/will live for the majority of your time for the period of cover)											
If you are not a US citizen and your primary country of residence is the USA, please provide your visa type or green card category											
What is the expiry date of your visa or green card? (DD/MM/YYYY)											
Do you have a USA social security number?	**Yes**	◯	**No**	◯	if yes, what is your social security number?						
Height: Feet		Inches		Centimetres		**Weight:** Stones		Pounds		Kilogrammes	
Have you smoked or used any form of tobacco products in the last 6 months?							**Yes**	◯	**No**	◯	

DEPENDANT 3

Title		First Name		Other Initials		Surname					
Relationship to policyholder			Gender (please tick)	Male	◯	Female	◯				
Date of birth (DD/MM/YYYY)			Occupation								
Nationality (What is the nationality of the primary passport that you hold?)											
Location (The country in which you live/will live for the majority of your time for the period of cover)											
If you are not a US citizen and your primary country of residence is the USA, please provide your visa type or green card category											
What is the expiry date of your visa or green card? (DD/MM/YYYY)											
Do you have a USA social security number?	**Yes**	◯	**No**	◯	if yes, what is your social security number?						
Height: Feet		Inches		Centimetres		**Weight:** Stones		Pounds		Kilogrammes	
Have you smoked or used any form of tobacco products in the last 6 months?							**Yes**	◯	**No**	◯	

DEPENDANT 4

Title		First Name		Other Initials		Surname					
Relationship to policyholder			Gender (please tick)	Male	◯	Female	◯				
Date of birth (DD/MM/YYYY)			Occupation								
Nationality (What is the nationality of the primary passport that you hold?)											
Location (The country in which you live/will live for the majority of your time for the period of cover)											
If you are not a US citizen and your primary country of residence is the USA, please provide your visa type or green card category											
What is the expiry date of your visa or green card? (DD/MM/YYYY)											
Do you have a USA social security number?	**Yes**	◯	**No**	◯	if yes, what is your social security number?						
Height: Feet		Inches		Centimetres		**Weight:** Stones		Pounds		Kilogrammes	
Have you smoked or used any form of tobacco products in the last 6 months?							**Yes**	◯	**No**	◯	

SECTION B

APPLICANT DETAILS

When do you want your cover to begin? (DD/MM/YYYY)	

Choose your cost share option, this is what you will pay towards treatment. The out of pocket maximum is the most you could pay during your period of cover for your share of the cost of covered benefits and services as detailed in this plan. Once you have selected your coinsurance options, then select your deductible amount and corresponding out of pocket maximum. You tick only one box in the table below.

Cost share option		International coinsurance Beneficiaries residing in the USA*	International coinsurance Beneficiaries residing outside of the USA**	USA In-network provider coinsurance	USA Out of network provider coinsurance	Deductible	Annual Out of pocket maximum	Select your option
Option 1	◯	0%	20%	20%	40%	$0	$2,000	
						$500	$3,000	
						$1,000	$4,000	
						$2,000	$6,850	
						$5,000	$6,850	
Option 2	◯	0%	10%	10%	30%	$0	$1,000	
						$500	$2,000	
						$1,000	$3,000	
						$2,000	$4,000	
						$5,000	$6,850	
Option 3	◯	0%	0%	0%	20%	$0	$1,000	
						$500	$1,000	
						$1,000	$2,000	
						$2,000	$3,000	
						$5,000	$6,850	

* This is the amount of coinsurance you will pay for treatment that takes place when you are on a visit outside of the USA.
** Beneficiaries who are USA citizens. This is the amount of coinsurance you will pay for treatment that takes place outside of the USA (typically your country of residence).

OPTIONAL BENEFITS

International Vision and Dental	**Yes**	◯	**No**	◯
International Medical Evacuation	**Yes**	◯	**No**	◯

Please note that the International Vision and Dental and International Medical Evacuation options can only be purchased in conjunction with the Core plan.

Please note each optional module chosen, will apply to all dependents. Your plan selection can only be amended at policy renewal. If you wish to increase your level of cover at renewal, additional premium will be payable.

SECTION C

PAYMENT DETAILS (YOUR PREMIUM IS PAYABLE IN US DOLLARS)

Payment frequency					**Quarterly**	◯	**Annually**	◯	
Payment method	**Credit/debit card**	◯			**Bank wire transfer (Annual payment only)** (We will call you on receipt of your application to provide the relevant details)			◯	
Credit/debit card number									
Type of card	**MasterCard**	◯	**Visa**	◯	**Visa Debit**	◯	**Visa Electron**	◯	**Delta** ◯
	American Express	◯	**Solo**	◯	**Maestro (UK Domestic)**	◯	**Maestro International)**		◯
Name as it appears on the card									
Start date of the card (mm/yy)					Expiry date of the card (mm/yy)				
Security code (This is the 3 digit number on the reverse of most cards. For American Express cards, this is the 4 digit number found on the front of the card on the right hand side)									
Is the billing address the address you have provided for your policy?					**Yes**	◯	**No**	◯	
If no, please provide the full billing address									

Credit card authorisation: I authorise Cigna to charge my credit/debit card account with my healthcare premium (of which I will be notified upon acceptance of cover/renewal). This will continue until the instruction is cancelled, and I will provide written notice to Cigna according to my Policy Rules documentation.

Cardholder's signature	
Date (DD/MM/YYYY)	

SECTION D

CONFIDENTIAL HEALTH QUESTIONNAIRE

At Cigna we want to provide you with the best clinical care and to help us do that we are going to ask you and each person named in Section A a few questions about your health. This information will NOT affect your policy acceptance or the terms of your policy but will help us to offer you expert clinical assistance for many routine and chronic conditions and will not be used for any other purpose.

	Have you been diagnosed with or had treatment for any of the following (please circle the appropriate answer):	POLICYHOLDER		DEPENDANT 1		DEPENDANT 2		DEPENDANT 3		DEPENDANT 4	
1	Cancer	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
2	Cardiovascular (heart) disease including heart attack, angina, heart failure and narrow or blocked arteries	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
3	Stroke or neurological conditions such as Parkinson's disease, multiple sclerosis or epilepsy	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
4	Diabetes, obesity, kidney or liver disease	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
5	Arthritis, back or joint pain	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
6	Respiratory disease such as asthma, emphysema and chronic obstructive pulmonary disease	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
7	Any mental health conditions, any eating or addiction disorders or any psychiatric conditions requiring inpatient admission	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
8	Hepatitis, any blood conditions, HIV or AIDS	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
9	Any congenital or hereditary conditions, or any condition which has existed from birth	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
10	Multiple trauma; head injury, multiple fractures or other serious accident	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
11	Organ Transplant	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
12	Are you taking any medication or being treated for a medical condition which you have had for more than 6 months or expect to require long term?	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
13	Have you had any previous surgeries? (If yes, please confirm the name of the condition for which you had the surgery in Section E)	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○
14	Is any applicant currently pregnant?	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○	Yes ○	No ○

SECTION E

ADDITIONAL HEALTH INFORMATION

If you have answered 'Yes' to any questions in Section D, please tell us what condition you are suffering from.

POLICYHOLDER	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4

SECTION F

DECLARATION FOR ALL CUSTOMERS

I hereby declare that I have taken reasonable care to answer all questions accurately, honestly and completely.

I confirm that each covered person is aware of their duty to take reasonable care to answer your questions accurately, honestly, completely and to the best of their knowledge.

Please note that if you are declaring the above on another person's behalf, it is your obligation to keep evidence of the consent you are providing hereto of your covered family members' actual declarations and consents. I hereby propose to Cigna for cover to begin on the cover date or such other agreed date. I have carefully read, understood and agree to abide by the Policy Rules and Customer Guide as they form part of my contract of insurance.

Signature	
Date (DD/MM/YYYY)	

If you are signing for on behalf of the Main policyholder please sign below where you are warranting and representing to us that you have read the above declaration and have the authority to enter into this application:

Signature					
Date (DD/MM/YYYY)					
Select the relationship to main policyholder	**Broker**	◯	**Agent**	◯	
			Other (please specify)	◯	

FRAUD NOTICE

Any person who, dishonestly and with intent to make a gain for himself or cause loss to another, or to expose another to a risk of loss: (1) makes an application for insurance or makes a claim under a policy containing any information he knows to be untrue or misleading ; or who (2) in making an application for insurance or a claim under a policy dishonestly and with intent to make a gain for himself or cause loss to another, or to expose another to a risk of loss fails to disclose information which has been asked for, commits fraud. We will investigate any claims or applications for insurance which we have grounds to believe may be fraudulent. Committing fraud may result in your policy being terminated and any claims you make under not being paid. We may, for the purposes of the detection and prevention of fraud, share information relating to suspected fraud with other insurance companies and/or with law enforcement authorities.

HOW WE USE YOUR INFORMATION

We will collect, use, store, and disclose your personal information, including sensitive information (in particular, information relating to your medical history and any medical treatment you may have or have had), in accordance with relevant data protection legislation. We collect and will use your personal information, including sensitive information, for the purpose of carrying out our obligations under this plan.

We may share your information, including sensitive information, with other Cigna companies and authorised healthcare providers, where necessary to carry out our obligations under this plan. This statement also applies to personal information of any beneficiaries detailed on this application form.

You have the right to request a copy of your personal information held by us, and beneficiaries under your policy have the request to request a copy of personal information we hold about them. We may charge a fee to provide this information.

I consent to the collection, use and disclosure of my personal and medical data by Cigna for the purposes required by the contract of insurance I have entered into.	☐

SPECIAL OFFERS, PROMOTIONS, PRODUCTS AND SERVICES

We would like to keep in touch with you to keep you updated about our special offers, promotions, products and services which we think will interest you. We will not release your information to any third parties.

If you would like to receive this information, please tick here	☐			
If yes, how would you like us to contact you?	**Email**	☐	**Telephone**	☐

Please return your fully completed form by email or by post to:

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United Kingdom

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Together, all the way.℠