Globalwide
WE KEEP OUR PROMISES

Enrollment Application
Health and Welfare Plans

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Erisa Enrollment Application

For company use – Representative details

Human Resource:	Fax number:
Contact name:	Email address:
Telephone number:	Official stamp:

Please complete this form in BLOCK CAPITALS or apply online at www.globalwidehealth.com

A deliberate or reckless misrepresentation by **You** may lead to **Us** voiding **Your Plan** with a loss of premium. Where **You** make a careless misrepresentation, **we** may void **Your Plan** or decline or reduce related claim payments. A misrepresentation is an untrue statement of fact relied on by one party, in this case **Us**, in establishing the terms of a contract (**Your Plan**). **You** should ensure that **You** complete **Your** application carefully, accurately, and fairly. If **You** are unsure about any matter, **you** should contact **Us**.

Please keep a record of all information **You** supply to **Us** in connection with this application.

Please enclose any medical reports or test results with **Your** application if they are available. **We** may ask **You** to complete a further medical questionnaire if **We** need more information. All the information **You** provide will be treated in strict confidence.

We rely on the information that **You** provide in this form (i.e. **Your** representations) to decide whether or not to accept **Your** application, and whether or not **We** need to apply special terms. Special terms are exclusions or conditions that **We** may apply to **Your** cover. If **You** submit a claim for the **Treatment** of any existing condition that **You** did not tell **Us** about here or did not tell **Us** everything about, **We** may refuse to pay that claim. **We** also have the right to void **Your Plan**, or **We** may impose special terms on **Your Plan** which **We** will apply retrospectively. Please take the greatest care to ensure that this application form is completed fully and accurately.

If, after completing **Your** application form and before the latest of either **Our** written acceptance, payment of premium or **Your Start Date**/**Entry Date**, anything occurs that affects the information **You** provided in this form, such as a change in **Your** state of health or the state of health of any of **Your Dependents**, **You** must tell **Us** in writing about the change.

If **You** have used an authorized insurance broker **You** understand, ack Globalwide edge and agree that by buying this **Plan**, **We** will pay the authorized insurance broker commission during the life of the **Plan** including renewals. **You** also understand that this agreement is necessary for **Us** to proceed with **Your** application.

We reserve the right to decline or accept **Your** application or to accept **Your** application form with special terms.

Please send **Your** completed application form along with a copy of **Your** government-issued identity document to **Us** via **Your** intermediary, or direct to GLOBALWIDE, 102 S TEJON ST STE 1100, Colorado Springs, CO 80903-2253, USA. **You** can also scan and email it to SALESTEAM@GLOBALWIDE.NET or fax it to +719 204 6364.

Section 1: Name of Plan holder

First name(s):	Family name:
What do **You** like to be called?	

*(If **Your** full name is John Andrew Smith, **You** might like to be called John or Mr Smith or Andy. **We** will address all correspondence to **You** in this way.)*

Section 2: Plan holder details

Address:				
Email address:				
Preferred telephone number *(including country code)*:				
Is this **Your**	Mobile ☐	Home ☐	Work ☐	*If You would like SMS notifications, please tell us Your mobile number:*
Gender:	Male ☐	Female ☐		Date of birth (dd/mm/yyyy): / /
Country of Residence:				Nationality:
Height (cm/ft):				Weight (kg/lbs):
Occupation:				Occupation industry:

Are **You** or any intended member of this policy, or any family member or close associate a politically exposed person? Yes ☐ No ☐
(If yes please provide further details)

Section 3: Spouse and Dependent details

Spouse details	
First name(s):	Family name:
What does he/she like to be called?	
Gender: Male ☐ Female ☐	Date of birth (dd/mm/yyyy): / /
Country of Residence:	Nationality:
Height (cm/ft):	Weight (kg/lbs):
Occupation:	Occupation industry:
Are **You** or any intended member of this policy, or any family member or close associate a politically exposed person? Yes ☐ No ☐ (If yes please provide further details)	

Dependent details	Dependent 1	Dependent 2	Dependent 3	Dependent 4
First name(s):				
Family name:				
What do they like to be called?				
Gender:	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Date of birth (dd/mm/yyyy):	/ /	/ /	/ /	/ /
Country of Residence:				
Nationality:				
Height (cm/ft):				
Weight (kg/lbs):				
Relationship to **Planholder**:				
Occupation (ages 16+):				

Section 4: Start Date

Date on which **You** wish **Your** Globalwide Enrollment **Plan** to start (dd/mm/yyyy): / /

Cover cannot start until **You** have accepted all **Our** terms and conditions following **Our** receipt of this application form and **We** have received the correct premium. **You** can apply for cover to start at a future date within 60 days of completion of this application form.

Section 5: Our environmental policy – Your document delivery settings

As an international organization, **we** are committed to reducing **Our** carbon footprint by working to minimize the impact of printing and shipping on the environment. To opt out of **Our** environmental policy and receive printed documents, please check this box. **You** will automatically receive a physical membership card for every **Person** on **Your Plan** no matter which option **You** choose, and **You** can access all of **Your** remaining **Plan** documents in **Your** secure online portfolio.

Section 10: Health declaration

If **You** have more than five **Dependants**, please use a separate sheet of paper and attach it to this application. **You** do not need to disclose matters related to common colds, **Vaccinations** or hay fever.

	Planholder	Dependent (Spouse)	Dépendent 1	Dépendent 2	Dependent 3	Dependent 4
10.1 Have **You** in the last five years ever undergone any **Surgical Procedure**, been a patient or been treated in a **hospital**, clinic, sanatorium, nursing home or other medical institution where **You** were off work for more than one week, and/or received more than 10 days **Treatment**?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
10.2 Are **You** currently taking any kind of medication (other than oral contraceptives), or is any **Treatment** or tests currently being performed or planned, or any day or **In-Patient** hospitalization scheduled?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
Have **You** ever received **Treatment**, tests or investigations for, been diagnosed with, or been hospitalized or had signs or symptoms of for:						
10.3 Asthma, bronchitis, tuberculosis, pneumonia, or any other respiratory conditions?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
10.4 Anxiety, depression, psychological, psychiatric, mental condition, drug or alcohol addiction or abuse?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
10.5 Blood disorders, anemia, hemophilia, thalassemia, or other abnormal blood tests? Have **You** ever been tested positive for HIV, Hepatitis B or C?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
10.6 **Cancer**, cyst, polyp, or any abnormal growth whether cancerous or benign?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
10.7 Digestive disorder including stomach, colon, rectum, hernia or any other bowel problems?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
10.8 Disorders of the kidneys, spleen, liver, pancreas, bladder, prostate, renal or recurrent urinary conditions?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
10.9 Diabetes, thyroid disorders or weight management problems?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
10.10 Epilepsy, multiple sclerosis or other neurological conditions?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
10.11 High blood pressure, heart or circulatory conditions, stroke or higher than normal cholesterol level?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
10.12 Knee, back or skin disorders, rheumatism, gout, arthritis or disease of the bone, spine, joint, muscle?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
10.13 Any type of disease, physical impairment, congenital or hereditary disorder, disability, recurrent illness, currently pregnant, termination of pregnancy, major injury or **Medical Condition** not already noted above?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
10.14 Females only Have **You** ever suffered from any breast or gynecological disorders?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐

Additional information

If **You** answered 'Yes' to any of questions 10.1 to 10.14, please provide details in the box below.
Please provide as much detail as possible, including the date and nature of diagnosis, frequency and severity of symptoms, date of last episode as well as details of any past, current or known future **Treatment**.

Member name	**Diagnosis** (If none made please describe the exact nature of symptoms suffered)	**Date of consultation**	**Treatment/ Medication received**	**Date of last treatment/ symptoms**	**Any underlying cause**	**Specific location on body including left or right**	**Outcome** (e.g. on-going complete recovery, likely to recur) or for smears, frequency (annually, 6-monthly)

Section 11: Doctor's contact details

Please give details of **Your** current usual doctor or the one who is most familiar with **Your** medical history.

Medical Practitioner's details

Name:	Telephone number:
Address:	
Date of last attendance and reason:	

Section 12: Important notes

Quotations are valid for 30 days subject to the above details remaining the same and are issued in accordance with Globalwide **Plan** terms, conditions, and exclusions.

The premiums quoted have been calculated based on each person's age at the date of the quotation. Premiums may be subject to change if the age of any person increases prior to the actual **Start Date** of **Your** Globalwide **Plan**. Cover cannot start until **You** have accepted all of **Our** terms and conditions following **Our** receipt of this application form and **We** have received the correct premium.

The premiums quoted have been based on Your Body Mass Index being within normal limits.

Data Privacy

We and **Your Underwriters** collect personal information about **You** and **Your Dependants** (including health, bank account and occupation) in the course of considering **Your** application and, if a **Plan** is issued to **You**, conducting **Our** relationship with **You**. This information will be processed for the purposes of underwriting **Your** insurance coverage, managing any **Plan** issued and administering claims. **Your** information may be passed to GLOBALWIDE Health group companies administering **Your Plan, Underwriters**, **Medical Practitioners**, Medical Assistance Companies and Claims Administrators for these purposes, including those located outside the USA. The same duty of confidentiality is required of any third parties to whom the administration of **Your Plan** may be subcontracted, including those based outside the USA. **Your** personal details will not be disclosed to other organizations without **Your** consent.

You have a right of access to, and correction of, information that **We** hold about **You**. Please contact **Us** if **You** would like to exercise either of these rights. Some of the information **We** collect about **You** may be classified as "sensitive" – that is information about racial or ethnic origin and physical or mental health. Data protection laws impose specific conditions in relation to sensitive information, including, in some circumstances, the need to obtain **Your** explicit consent before **We** process the information.

By signing this Application Form, **You** consent to the processing and transfer of information (including sensitive information) described in this notice. Without this consent **We** will not be able to consider **Your** application.

Globalwide group companies providing IPMI products may contact **You** by letter, SMS or email with details of other IPMI or related products and services, which may be of interest to **You**. If **You** do not wish this to happen, please tick this box. **You** may opt out of future marketing by contacting **Us** at any time. A list of Globalwide Health group companies, their contact details and **Our** Data Privacy Policy is available at www.globalwide.net

Section 13: Declaration and authorization

I hereby apply for cover on behalf of all the persons named in this application form for a Globalwide **Plan** as specified above.

I have received and read the **Benefit Schedule**, Terms and Conditions, Definitions, **Benefits** and exclusions of this **Plan**. I understand that the Application Form, **Certificate of Coverage**, **Benefit Schedule** and the Members' Handbook incorporating the **Plan** terms and conditions make up the contract between **Us** and all form part of the **Plan** Agreement. I am aware that cover shall be provided in accordance with the Agreement.

- I declare that the information given in this application is true and that disclosure in respect of each person included in this application is complete, even if some of the information provided is not in my own handwriting. I understand it is unlawful for me or my **Dependants** to GLOBALWIDE provide false, incomplete or misleading facts or information to Globalwide for the purpose of defrauding or attempting to defraud Globalwide. Penalties may include imprisonment, fines, denial of coverage, loss of premium, loss of **Benefits** and legal damages.
- I understand that I must notify Globalwide of any changes in the facts contained in this application form, such as a change in the state of health of any person named in it, before the latest of either written acceptance, payment of premium or the **Start Date**/**Entry Date**.
- For the purpose of this application I authorize any doctor who has ever treated or advised any of the persons named in this application to provide Globalwide with any information they may require in connection with **Treatment** related to any claim under this **Plan**. I have discussed the terms of this authorization with my partner and competent adult **Dependants**, and I have obtained their consent to the release of their healthcare information pursuant to this authorization.
- I declare that I have read and understood the following from the members' handbook: –
  cancellation and termination rights
  - complaints procedures
  - law and jurisdiction of the **Plan**
  - language of the **Plan** and **Our** service –

  compensation arrangements
  - Globalwide is acting on behalf of Globalwide Financial LLC for the purposes of issuing and administering **Plans**, receiving premiums and paying claims.
- I understand that Globalwide cannot be liable and therefore will not pay claims if my **Plan** is lapsed should Globalwide be unable to collect my premium for whatever reason and I do not provide Globalwide with an alternate method of payment within seven days of Globalwide requests for alternative methods of payment.
- I agree that where medical **Treatment** is received within the provider network by me or any of my **Dependants** and, except where previously agreed by Globalwide, it is determined that the **Treatment** or **Medical Condition** is not refundable within the terms and conditions of the **Plan**, I agree that I am liable to GLOBALWIDE for all claims settled for such medical **Treatment** in connection with any non-covered claim.
- I understand and confirm that where I have not repaid funds disbursed in good faith by Globalwide in respect of non-covered medical **Treatment**, valid claims may be offset against outstanding funds due to Globalwide and/or my **Plan** may be suspended until the outstanding amounts have been settled in full.
- I ack GLOBALWIDE ledge that if it is determined by Globalwide that a claim was fraudulent my **Plan** may be voided with immediate effect.
- I understand that if I am able to claim any costs from another insurance policy for the cost of any treatment or benefits received, Globalwide will only be liable for a proportional share of the total costs.
- I have read the important notes.
- I agree to the declaration above and understand that cover is provided in accordance with the terms and conditions of the Globalwide **Plan**.

Signature (Coverage Holder/main applicant): **Date** (mm/dd/yyyy):

/ /

Plans issued and arranged by GLOBALWIDE (USA).

Registered address: 102 S Tijon Street, STE 1100, Colorado Springs, CO 80903-2253, USA.