# Evolution Health Plan (EU) Estonia

FMU

morganprice europe

## Application form

**Part A**

**Please complete all parts of this form and return it to your agent/ insurance broker.** It is important that you complete this Application Form fully. Failure to do so may result in the form being returned to you for completion.

This Application Form asks questions that are material to both the risk underwritten and the calculation of the premium by SI Insurance (Europe), SA (the "Insurer"). You must take care when answering any questions the Insurer asks by ensuring that all the information provided is accurate and complete (the 'Duty'), and the Duty applies when the policy is varied or renewed.

The Insurer may withdraw from the insurance contract and decline all claims, should it determine that you provided false or misleading information to the Insurer and were negligent or grossly negligent when doing so or did so intentionally.

All Application Forms are reviewed prior to acceptance and therefore no cover shall be granted until confirmation is provided.

Please indicate that you agree to communicate with Insurers in respect of this Application Form and all subsequent communications in the English language: I consent ◯ I do not consent ◯

## 1 Your personal details

Title | Forename(s) | Surname/Family Name

Date of birth | Gender | Height | Weight

Overseas address | Post/Zip code

Phone | Mob | Email

Home address | Post/Zip code

Occupation | Nationality

Home country *(for which you have a passport)*

Country for which this cover is required *(where you will be spending most of you time)*?

How long have you been resident in your country of residence *(years/months)*?

## 2 Cover required

Date upon which annual cover to commence, or the date on which your proposal is accepted by insurers, whichever is the later

| Choose your geographical area of cover | Europe ◯ | Worldwide excluding USA, China, Singapore & Hong Kong ◯ | Worldwide excluding USA ◯ | Worldwide ◯ |
|---|---|---|---|---|

Choose your level of cover: Standard ◯ Standard Plus ◯ Comprehensive ◯ Premium ◯ Elite ◯

## 2 Cover required — continued

Please select the annual excess you wish to apply to your policy

Nil ◯ 100 ◯ 250 ◯ 500 ◯ 1000 ◯
2500 ◯ 5000 ◯ 7500 ◯ 10000 ◯

In addition you may select a co-insurance applicable to out-patient claims only. In effect this is a percentage of each out-patient claim for which you are responsible.

Nil co-insurance ◯ 10% co-insurance ◯ 20% co-insurance ◯

**N.B. This option is not applicable to the Standard level of cover as there are no out-patient benefits on Standard.**

Home country evacuation module (120 adult/75 child) ☐

Please specify the currency in which you wish to pay premiums and receive benefits

US Dollar $ ◯ Sterling £ ◯ Euro € ◯

Do you or any of the persons to be included in this proposal, have existing health insurance? Yes ◯ No ◯

If yes, which provider?

To avoid any delays and ensure that we can process your application swiftly and efficiently - Please ensure that you include the following items with your application:

- Copy of passport

Have you or any of the people to be included in the proposal, ever been refused cover by an insurance company or been accepted on special terms? *(If yes provide details on a separate sheet)* Yes ◯ No ◯

## 3 Dependants to be included

| | Full name of dependants | Relationship to proposer | D.O.B | Nationality | Gender | Height | Weight | Occupation |
|---|---|---|---|---|---|---|---|---|
| Spouse | | | | | | | | |
| Dep. 1 | | | | | | | | |
| Dep. 2 | | | | | | | | |

**Please provide us with the name and address of your regular personal or family doctor/physician. If you do not have a regular doctor, please give the last doctor you visited and approximate date. - If there is a different doctor for each applicant, please provide all details and indicate which physician applies to each applicant.**

**NB. This must be supplied for us to be able to process your application**

## 4 Payment method

Please specify how you would like to pay

- Annually by credit/debit card ◯
- Semi annual by credit/debit card ◯
- Quarterly by credit/debit card ◯
- Monthly by credit/debit card ◯
- Annually by bank transfer *- details supplied on request* ◯
- Monthly by direct debit *- only available in the EU on Euro policies only* ◯

**Service fees - credit/debit card & SEPA Direct Debits**

| | |
|---|---|
| Annual payment | 0% |
| Semi annual payments | +4% |
| Quarterly payments | +5% |
| Monthly payments | +8% |

- If paying by credit/debit card please complete attached payment form

**Service fees - bank transfer**

| | |
|---|---|
| Annual bank transfer | £10/€15/$30 |

The bank transfer fee does not need to be included as long as the payee selects to pay all charges.

## 5 Declaration

For the purpose of this declaration, ("I/We") means any insured person intended to benefit from insurance cover as per the policy wording.

a. I/We have been provided with a copy and read the policy wording and I/we understand it to be part of the contract of insurance. In particular I/We have read, understand and accept the definitions, benefits and exclusions of the policy.
b. I/We have read, understand and accept Section 6 of this application form on data protection.
c. I/We am consenting for my/our insurance broker to act on my behalf for the purposes of transferring sensitive data.
d. To the best of my/our knowledge and belief the information given in connection with this application form, whether in my hand or not, is true and I/we have answered all questions asked in this application form honestly and fully. I/We also understand that I/we must tell the insurer straight away if anything that I/we have already told the insurer changes. I/we understand that non-disclosure or misrepresentation of any facts may entitle the insurer to void the insurance. This application form and the information provided contains statements upon which the Insurer will rely in deciding whether to accept this insurance and in determining the terms and conditions of such acceptance.
e. I/We understand that the signing of this application form does not bind me/us to complete, or the insurer to accept this insurance.
f. If I/we have elected to pay our premium by instalments using credit or debit cards and Morgan Price have agreed to this, I/we authorise Morgan Price to continue to deduct such instalments as and when they become due unless I/we cancel this credit/debit card authorisation by giving at least 14 days notice in writing. I/we understand that if I/we have made a claim, no refund will be due and I/we will have to pay any outstanding instalments due in the current period of cover.
g. I/We am authorised to sign this application form on behalf of all my/our dependents declared at Section 3 of this Application Form.
h. I/We consent to communicate with Insurers in respect of this Application Form including all subsequent communications in the English language.

Signature of primary applicant ✗ _____ Date _____

## 6 Data Protection & General Data Protection Regulations

**Data Protection**

SI Insurance (Europe), SA ("we/us/our") is the data controller of your personal data and is part of the Sompo International[1] group which records and holds data in accordance with data protection legislation. For more detail about how Sompo International uses your personal information can be found within the policy wording and on its website at https://www.sompo-intl.com/privacy-policies/.
This notice aims to give you information on how we collect and process your personal data when using our insurance services, including any data you may provide when you purchase our insurance products or services. Personal data, or personal information, means any information about an individual from which that person can be identified. It does not include data where the identity has been removed (anonymous data). Where we need to collect personal data by law, or under the terms of an (insurance) contract we have with you and you fail to provide that data when requested, we may not be able to perform the contract we have or are trying to enter into with you or provide the insurance services to you (for example, to provide you with medical claims insurance services). In this case, we may have to cancel the insurance product or insurance service you have with us but we will notify you if this is the case at the time. We will only use your personal data when the law allows us to. Most commonly, we will use your personal data in the following circumstances:

- Where we need to perform the insurance contract we are about to enter into or have entered into with you
- Where we need to assess any medical conditions, claims and Health data to perform our obligations under the insurance contract;
- Where it is necessary for our legitimate interests (or those of a third party) and your interests and fundamental rights do not override those interests;
- Where we need to comply with a legal or regulatory obligation.

We will only use your personal data for the purposes of providing insurance products and services unless otherwise indicated to you. We may have to share your personal data with our insurance partners, which may include reinsurers, insurance intermediaries, third party medical claims administrators and other related parties to satisfy our contractual and legal obligations under the insurance contract (policy terms). For example, Morgan Price International Healthcare Ltd together with its insurance partners is the data processor of your personal data (the insurance partner of your policy will be advised to you when you purchase the cover).

We will collect your personal data including but not limited to special categories of Personal Data about you (this includes details about your sex, ethnicity, age, and information about your health and medical conditions). We respect your privacy and we are committed to protecting your personal data.

Many of our external third parties are based outside the European Economic Area (EEA) so their processing of your personal data will involve a transfer of data outside the EEA. Whenever we transfer your personal data out of the EEA, we ensure a similar degree of protection is afforded to it by ensuring that we use specific contracts approved by the European Commission. We have put in place appropriate security measures to prevent your personal data from being accidentally lost, used or accessed in an unauthorised way, altered or disclosed. In addition, we limit access to your personal data to those employees, agents, contractors and other third parties who have a business need to know. They will only process your personal data on our instructions and they are subject to a duty of confidentiality.

We will only retain your personal data for as long as necessary to fulfil the purposes we collected it for, including for the purposes of satisfying any legal, accounting, or reporting requirements.

Under certain circumstances, you have rights under data protection laws in relation to your personal data. More details of these rights can be found within our privacy policy and at https://www.sompo-intl.com/privacy-policies. These rights include: Request access to your personal data; Request correction of your personal data; Request erasure of your personal data; Object to processing of your personal data; Request restriction of processing your personal data; Request transfer of your personal data and Right to withdraw consent.

[1] The term "Sompo International" refers to and includes each and every subsidiary of Sompo International Holdings Ltd., a Bermuda exempted company ("SIHL"). To the extent, however, that an affiliate of SIHL that is not a subsidiary of SIHL receives or uses personal information that is covered by this Policy and requires protection under the Data Protection Legislation, then such affiliate is included within "Sompo International" for purposes of protecting the data that such affiliate receives or uses. For a list of Sompo International offices, please see https://www.sompo-intl.com/location/corporate. For a list of affiliates that are included in the Sompo Group, please see https://www.sompo-hd.com/en/group/group_list/.

**Luxembourg Professional Secrecy**

Sompo International has chosen SI Insurance (Europe), SA, a Luxembourg based and wholly owned subsidiary of Sompo International Holdings Ltd., to insure the risks located in the EEA. As such, this proposal/insurance policy will be subject to the Luxembourg professional secrecy rules. All insurance industry professionals in Luxembourg are required to maintain the confidentiality of the information entrusted to them during the exercise of their mandate or as part of their professional duties. By way of derogation, SI Insurance (Europe), SA may transfer this information to the entities in charge of the provision of outsourced services on behalf of the insurer. The service providers are subject to an obligation of professional secrecy or bound by a confidentiality agreement.

By signing the application form for (re)insurance or the (re)insurance contract, or the payment of the policy premium, the policyholder accepts the sharing of the information covered by Luxembourg professional secrecy with SI Insurance (Europe), SA's service providers to the extent it is needed for the service outsourcing. More details can be found on www.sompo-intl.com/locations/luxembourg.

**FOR OFFICE USE ONLY!**

Policy No. _____

Surname: _____

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# 7. Confidential medical declaration

**Part B**

**Important:** You and the persons applying for cover under this policy must declare to us any and all known pre-existing medical conditions. If you do not tell us, your policy may be cancelled and any claim you make may not be paid.

| | | Policyholder | Spouse | Dep. 1 | Dep. 2 |
|---|---|---|---|---|---|
| 1. | Are any medical/surgical/dental consultations and/or procedures (including x-ray, lab or other testing) recommended, scheduled or contemplated for any applicant? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| | **Additional information MUST be provided here if "Yes" is answered.** | | | | |
| 2. | Has any applicant ever been refused medical or dental insurance, or ever had a policy postponed, rated or accepted on special terms? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| | **Additional information MUST be provided here if "Yes" is answered.** | | | | |
| 3. | Has any applicant been examined by, consulted with, or received medical treatment from a medical professional in the last 12 months? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| | **Additional information MUST be provided here if "Yes" is answered.** | | | | |
| 4. | Has any applicant been examined by, consulted with, or received medical treatment from a medical specialist or consultant in the last 5 years? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| | **Additional information MUST be provided here if "Yes" is answered.** | | | | |
| 5. | Has any applicant been confined (stayed overnight) in a hospital, clinic, sanatorium, or other treatment facility in the last 5 years? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| | **Additional information MUST be provided here if "Yes" is answered.** | | | | |

6. Has any applicant had any disease or impairment of or suffered any symptoms or required any medication, treatment or hospital consultation(s) for the following? - *Please answer all questions.*
**Please note that if you answer yes to any of these questions, you MUST provide further details in the additional information section.**

| | | | | | |
|---|---|---|---|---|---|
| 6.1. | AIDS/ARC/HIV | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.2. | Alcohol dependency or drug/substance abuse | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |

| | | Policyholder | Spouse | Dep. 1 | Dep. 2 |
|---|---|---|---|---|---|
| 6.3. | Anaemia or any blood disorder | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.4. | Arthritis, or any disorder of any muscles or joints | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.5. | Asthma, bronchitis or any other respiratory disorder | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.6. | Back/spine/neck | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.7. | Blood pressure/hypertension<br>*If yes, please complete our hypertension questionnaire* | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.8. | Blood vessels/clots/circulatory system | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.9. | Bones (including fractures) | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.10. | Brain/head | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.11. | Cancer, tumour, growth or cyst<br>*If yes, please complete our cancer questionnaire* | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.12. | Carpal tunnel syndrome | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.13. | Cerebrovascular disease/disorder or stroke | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.14. | Chest pains, palpitations, heart murmur, angina, heart attack or any other heart disorder | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.15. | Cholesterol/Hypercholesterolemia<br>*If yes, please complete our cholesterol questionnaire* | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.16. | Cystic fibrosis | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.17. | Dental/gum disease | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.18. | Diabetes (including where under control by medication)<br>*If yes, please complete our diabetes questionnaire* | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.19. | Ears, eyes, nose or throat | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.20. | Epilepsy, convulsions, seizures, fits | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.21. | Gastrointestinal disorder (stomach/intestines) | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.22. | Gout | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.23. | Hernia | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| | *If yes, please state the type of hernia i.e inguinal* | | | | |
| 6.24. | Immune system disorder | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.25. | Injury, operation, physical defect or deformity | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |

| | | Policyholder | Spouse | Dep. 1 | Dep. 2 |
|---|---|---|---|---|---|
| 6.26. | Kidney/bladder/urinary tract | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.27. | Liver, gall-bladder, pancreas or spleen | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.28. | Lungs/breathing | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.29. | Mental/nervous disorder | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.30. | Neurological/nervous system | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.31. | Paralysis | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.32. | Prostate | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.33. | Rheumatic fever | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.34. | Reproductive disorder or infertility | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.35. | Skin | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.36. | Sleep disorder | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.37. | Stroke | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.38. | Surgical operation | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.39. | Ulcer | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.40. | Thyroid (including where under control by medication)<br>*If yes, please complete our thyroid questionnaire* | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.41. | Urinary abnormality | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.42. | Other medical condition not listed | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.43. | Are you currently undergoing or been advised to undergo any dental treatment? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.44. | Have you smoked, used tobacco or nicotine replacements in the last 12 months?<br>If so, how many per day? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.45. | Do you have any known allergies, including food allergies? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.46. | Have you suffered any symptoms for which you have not sought medical advice? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.47. | Do you have any known check-ups or doctor appointments pending now or in the future? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.48. | Are you currently under the care of any specialist? (e.g. a cardiologist or oncologist) | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 6.49. | Are you currently pregnant? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |

## Additional information

If you answered "Yes" to any of the questions in Section 7, you MUST complete the additional information below. If you require additional space, please continue on a separate sheet.

| | Question no. | Name of illness/medical condition* | Dates (to and from) | What medical treatment was provided? | Current medication name and daily dose | Have you had any hospital stay in relation to this condition? | What is the current status of the condition?** |
|---|---|---|---|---|---|---|---|
| Policyholder | | | | | | | |
| Spouse | | | | | | | |
| Dep. 1 | | | | | | | |
| Dep. 2 | | | | | | | |

*Where applicable, please state the area of the body affected (e.g. left or right arm)
**Please enter either Complete Recovery, Ongoing or Recurrent (or likely to recur)