Cigna Global Health Options

Policy amendment form

cigna healthcare

Please complete this application and return the FULL form to your Cigna Healthcare representative.

APPLICANT DETAILS

Policy holders name	
Policy number	

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 right to request a copy of personal information we hold about them. We may charge a fee to provide this information.

POLICY AMENDMENTS

	Change?		Select new plan design Please tick all selections you would like on your plan going forward.
Product Close Care/Silver/Gold/Platinum **Choice of product can only be changed at renewal.**	Yes ☐	No ☐	Close Care ◯ Silver ◯ Gold ◯ Platinum ◯
Area of Cover Worldwide including USA / Worldwide excluding USA	Yes ☐	No ☐	Worldwide including USA ☐ Worldwide excluding USA ◯
Module(s) for Silver, Gold, Platinum Policies	Yes ◯	No ☐	Outpatient ☐ Medical Evacuation ☐ Health & Wellbeing ☐ Vision & Dental ☐
Module(s) for Cigna Close Care℠	Yes ☐	No ◯	Outpatient and Wellness ☐ Dental Care and Treatment ☐

Please Note: If you are seeking to add only the Health and Wellbeing module for Silver, Gold or Platinum policies, there is no requirement to complete the health questionnaire. If you are seeking to add only the Vision & Dental module, please complete only Question 6 of the health questionnaire. For all other changes to your policy please complete the health questionnaire in full.

REASONS FOR CHANGING YOUR COVER?

Can you please tell us why you need to make these changes?	

INTERNATIONAL MEDICAL INSURANCE PLAN

Deductible, cost share and out of pocket maximum amendments can only be made at renewal.

Do you wish to change your core deductible/cost share?	Yes ☐ No ☐
Choose your deductible For further information relating to deductibles / cost-share please see Customer Guide	$0 ☐ $375 ☐ $750 ☐ $1,500 ☐ $3,000 ☐ $7,500 ☐ $10,000 ☐ €0 ☐ €275 ☐ €550 ☐ €1,100 ☐ €2,200 ☐ €5,500 ☐ €7,400 ☐ £0 ☐ £250 ☐ £500 ☐ £1,000 ☐ £2,000 ☐ £5,000 ☐ £6.650 ☐
Then, select your cost share percentage	No cost share ◯ 10% ◯ 20% ◯ 30% ◯
Choose your out of pocket maximum (This is the maximum amount of cost share under International Medical Insurance plan you must pay in the event of a claim or claims per period of cover)	$2,000 ☐ $5,000 ☐ €1,480 ☐ €3,700 ☐ £1,330 ☐ £3,325 ☐

INTERNATIONAL OUTPATIENT - OPTIONAL MODULE

Deductible, cost share and out of pocket maximum amendments can only be made at renewal.

Do you wish to change your core deductible/cost share?	Yes ☐ No ☐
Choose your deductible For further information relating to deductibles / cost-share please see Customer Guide	$0 ☐ $150 ☐ $500 ☐ $1,000 ☐ $1,500 ☐ €0 ☐ €110 ☐ €370 ☐ €700 ☐ €1,100 ☐ £0 ☐ £100 ☐ £335 ☐ £600 ☐ £1,000 ☐
Cost share after deductible (a $3,000 / €2,200 / £2,000 out of pocket maximum is applied to cost shares on International Outpatient)	
	No cost share ☐ 10% ☐ 20% ☐ 30% ☐

POLICY HOLDER DETAILS

Title		First Name		Other Initials		Surname	
Height: Feet		Inches		Centimeters		**Weight**: Stones		Pounds		Kilograms	
Has the beneficiary smoked, vaped or used tobacco or nicotine replacement products in the last 12 months?							Yes ☐ No ☐
If **Yes**, how many per day?	Less than 20 per day ☐	20 or more per day ☐	Other				

BENEFICIARY 1 DETAILS

Title		First Name		Other Initials		Surname	
Height: Feet		Inches		Centimeters		**Weight**: Stones		Pounds		Kilograms	
Has the beneficiary smoked, vaped or used tobacco or nicotine replacement products in the last 12 months?							Yes ☐ No ☐
If **Yes**, how many per day?	Less than 20 per day ☐	20 or more per day ☐	Other				

BENEFICIARY 2 DETAILS

Title		First Name		Other Initials		Surname	
Height: Feet		Inches		Centimeters		**Weight**: Stones		Pounds		Kilograms	
Has the beneficiary smoked, vaped or used tobacco or nicotine replacement products in the last 12 months?							Yes ☐ No ☐
If **Yes**, how many per day?	Less than 20 per day ☐	20 or more per day ☐	Other				

BENEFICIARY 3 DETAILS

Title		First Name		Other Initials		Surname	
Height: Feet		Inches		Centimeters		**Weight**: Stones		Pounds		Kilograms	
Has the beneficiary smoked, vaped or used tobacco or nicotine replacement products in the last 12 months?							Yes ☐ No ☐
If **Yes**, how many per day?	Less than 20 per day ☐	20 or more per day ☐	Other				

DECLARATION FOR ALL CUSTOMERS

Please note - We require you to disclose every aspect of the medical history for the beneficiary. This includes telling us about any changes to any medical conditions, treatment or medication and any outstanding, ongoing or repeat medical tests that have been suggested.

If any applicant fails to inform us about a condition which we reasonably believe to have existed prior to the policy initial start date or the effective date of the change to the policy (whether the condition was already present, the applicant had symptoms, or taken advice from a medical practitioner); this could (subject to local law and regulation) result in us reducing the amount of any claims payment, which the applicant is due or in refusing to pay a claim or claims related to such condition altogether.

You warrant and represent that you have each covered person's consent to disclose the personal information, including the sensitive personal information (e.g. medical information) contained in this form to us. You confirm that each covered person is aware of their duty to take reasonable care to answer 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.)

Consent obtained (internal use only)	☐	**Date**	
Policy Holder's Signature		**Date**	

CONFIDENTIAL HEALTH QUESTIONNAIRE

Please read the following questions very carefully. Please take reasonable care to answer all questions honestly and fully. Careless misrepresentation could result in Cigna Healthcare reducing the amount of any claims proportionately; whereas deliberate or reckless misrepresentation could result in Cigna Healthcare rejecting claims, and/or cancelling cover. If you need help completing your application, please contact us.

If you are unsure about the answer to any question you should make the enquiries necessary to allow you to provide an accurate answer.

You now need to provide information about the medical history of all beneficiaries. This includes any ongoing symptoms or conditions, any information disclosed during your initial application and any claims which you have incurred while on cover. Depending on the medical history, we might need some further information before we can finalise cover.

		Yes	No
1	Has any applicant had symptoms of, been diagnosed with or had treatment for Cancer or Tumour, Heart Condition, Stroke, Brain or Neurological Disorders, Diabetes, Hepatitis or any Musculo-skeletal condition?	☐	☐
2	Has any applicant had symptoms of, been diagnosed with or had treatment for any Liver, Kidney or Lung problem, Gastrointestinal problem, Urinary, Gynaecological or Prostate condition, Mental Health condition or any Drug or Alcohol misuse or dependence?	☐	☐
3	Apart from what you have already told us, is any applicant taking any medication or receiving any treatment for a medical condition?	☐	☐
4	Are any applicants awaiting any test results, treatment or investigations or expect to have a review or follow up for any current or past medical problem not already mentioned?	☐	☐
5	Does anyone have any illness, condition or symptom not already mentioned? Please include details of any known or suspected issues whether or not medical advice has been sought or a diagnosis reached.	☐	☐
6	Is any applicant experiencing any dental problems or symptoms, receiving or expecting to undergo any dental treatment?	☐	☐
7	Is anyone on the plan currently pregnant?	☐	☐

ADDITIONAL HEALTH INFORMATION

If you have answered "Yes" to any of the 7 Health Questions, please provide details below. If you are unsure that any details are relevant, please include them anyway. If you run out of space, please use the Additional Information section.

Question Number	Who has suffered from this condition?	What is the name of the illness or medical problem. Where applicable state the area of the body affected? (e.g. left arm, right foot).	When did the symptoms occur and when did you last have symptoms?	What treatment was provided? (Include details of medication and dates of when treatment started and ended).	What is the current status of the illness or medical problem? (E.g. ongoing, complete recovery, recurrent or likely to recur.)

SPACE FOR ADDITIONAL INFORMATION

Please return ALL pages of the form to your Cigna Healthcare representative.

591798 CGHO POLICY AMENDMENT FORM 10/2023