Cigna Global Health options
Switching from another policy application form

Hello! We're glad you would like to join us

cigna healthcare

If you have an international medical insurance plan with another insurer, you may be able to switch to Cigna Global Health Options on the same underwriting terms. To be considered for this you need to answer the health questions below and fullfill the following criteria:

- You must currently hold an individual international medical insurance plan and not part of a group plan.
- You must have been fully medically underwritten.
- You must enclose a copy of your current certificate of insurance detailing any current medical exclusions you may have.

Please complete this application form and return it to us, either by email 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 dependants.

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 (Address where you would like any mail correspondence to be delivered)							
Daytime telephone number (Country code - Number)							
Mobile telephone number (Country code - Number)							
Fax (Country code - Number)							
Email address							
Nationality (What is the nationality on your passport that you will use to register this policy?)							
Location (The country in which you live/will live for the majority of your time for the period of cover)							

DEPENDANTS

1	First Name		Surname			
	Relationship to policyholder		Gender (please tick)	Male		Female
	Date of birth (DD/MM/YYYY)		Occupation			
	Nationality (What is the nationality on your passport that you will use to register this policy?)					
	Location (The country in which you live/will live for the majority of your time for the period of cover)					

2	First Name		Surname			
	Relationship to policyholder		Gender (please tick)	Male		Female
	Date of birth (DD/MM/YYYY)		Occupation			
	Nationality (What is the nationality on your passport that you will use to register this policy?)					
	Location (The country in which you live/will live for the majority of your time for the period of cover)					

3	First Name		Surname			
	Relationship to policyholder		Gender (please tick)	Male		Female
	Date of birth (DD/MM/YYYY)		Occupation			
	Nationality (What is the nationality on your passport that you will use to register this policy?)					
	Location (The country in which you live/will live for the majority of your time for the period of cover)					

4	First Name		Surname			
	Relationship to policyholder		Gender (please tick)	Male		Female
	Date of birth (DD/MM/YYYY)		Occupation			
	Nationality (What is the nationality on your passport that you will use to register this policy?)					
	Location (The country in which you live/will live for the majority of your time for the period of cover)					

YOUR CURRENT PLAN

Name of your current insurance provider					
Name of your insurance plan					
Have you or anyone covered under this policy had any exclusions?	Yes		No		
When did your cover start? (DD/ MM/YYYY)					
When is it due to end? (DD/MM/YYYY)					

YOUR NEXT PLAN

Which plan are you applying for?	Silver		Gold		Platinum		
Where do you want your cover?	Worldwide		Worldwide excluding USA				

COMMENCEMENT DATE

I/we request that the policy commences from	Day		Month		Year	

We will confirm to you the commencement date of your policy. Waiting periods may apply as set out in your policy conditions. This policy is an annual renewable contract with a minimum period of cover of three (3) months.

SECTION B

DECLARATION OF GOOD HEALTH

Please answer the following questions for everyone who has to be covered on the policy. **Please note - We require you to disclose every aspect of the medical history for all applicants. 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.**

Once this application has been submitted we may need to contact the applicant for further information before we can finalise the cover. If any applicant needs help completing this application, please contact us. If the applicant is unsure about the answer to any question the applicant should make the enquiries necessary to allow an accurate answer to be provided.

HEALTH INFORMATION

Have you or anyone to be covered under this policy been treated for a chronic condition or received repeat treatment/ medication for any condition since your policy was last underwritten?	**Yes**		**No**	
Do you or anyone to be covered under this policy have any appointments, treatment, tests or investigations planned or pending?	**Yes**		**No**	
Are you or anyone to be covered under this policy currently pregnant?	**Yes**		**No**	

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

ADDITIONAL HEALTH INFORMATION

If you have answered **Yes** to any of the questions above, please provide full details:

	Condition/Symptoms/ Diagnosis	Tests/Investigations	Medication/Treatment	Date of last symptoms	Current health status
Policyholder					
Dependant 1					
Dependant 2					
Dependant 3					
Dependant 4					

SECTION C

DECLARATION FOR ALL CUSTOMERS

I hereby declare that I have taken reasonable care to answer all questions accurately, honestly and completely. I acknowledge that if I do not answer all questions accurately and completely as a result of my carelessness or as a result of deliberate or reckless misrepresentation, Cigna Healthcare may reject claims, and/or cancel cover as per the terms and conditions of this policy.

The duty to answer our questions accurately, honestly and completely applies in respect of each person who is covered by this policy. If we determine on reasonable grounds that you, or any covered person, deliberately or recklessly provided us with false or misleading information, it could aversely affect this policy and we may treat this policy as if it had never existed, amend the terms of your insurance, or terminate your policy. I warrant and represent that I 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 you. 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. In the event that it is found that I, or any covered person, have deliberately or recklessly provided any information which is false or inaccurate, Cigna may void the contract of insurance as it relates to me or the covered person and refuse all claims and need not return any premiums paid in, except for where it would be unfair for the premiums to be retained. 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, or 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					
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: (I) 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 right to request a copy of personal information we hold about them. We may charge a fee to provide this information.

I acknowledge to the collection, use and disclosure of my personal and special category 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.

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

SECTION D

PAYMENT DETAILS

Your card details will be securely disposed of once your application has been processed.

Payment currency	**US Dollar**		**Euro**		**Sterling**				
Payment frequency	**Monthly**		**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)									
Please confirm that the payment card is that of the policyholder?	**Yes**		**No**						
If the cardholder is not the policyholder, please state the relationship to the policyholder	**Other beneficiary**		**Employer**						
	Spouse/partner		**Family member**		**Other**				
Date of birth of cardholder (DD/MM/YYYY)									
Nationality of cardholder									
Is the billing address the residence 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)									

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

Cigna Global Health Options
The Grosvenor Building
72 Gordon Street
Glasgow
G1 3RS
United Kingdom

Email: cgi.sales@cigna.com

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