



# Cigna Global Health Options

## Switching from another policy application form

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



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 fulfill the following criteria:

- You must currently hold an individual international medical insurance plan and not be 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, loadings, and/or endorsements 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)			
<b>Height:</b>	Feet	Inches	Centimetres
<b>Weight:</b>	Stones	Pounds	Kilogrammes
Have you smoked, vaped, used nicotine replacement products or any other tobacco products in the last 12 months?			
Yes			
No			
If <b>Yes</b> , how many per day? (If you use nicotine replacement products or vape, select "Less than 20 per day)			
Less than 20 per day			
20 or more per day			

### DEPENDENT 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)	
<b>Height:</b>	Feet
Inches	Centimetres
<b>Weight:</b>	Stones
Pounds	Kilogrammes
Have you smoked, vaped, used nicotine replacement products or any other tobacco products in the last 12 months?	
Yes	
No	
If <b>Yes</b> , how many per day? (If you use nicotine replacement products or vape, select "Less than 20 per day)	
Less than 20 per day	
20 or more per day	

### DEPENDENT 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)	
<b>Height:</b>	Feet
Inches	Centimetres
<b>Weight:</b>	Stones
Pounds	Kilogrammes
Have you smoked, vaped, used nicotine replacement products or any other tobacco products in the last 12 months?	
Yes	
No	
If <b>Yes</b> , how many per day? (If you use nicotine replacement products or vape, select "Less than 20 per day)	
Less than 20 per day	
20 or more per day	

### DEPENDENT 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)							
<b>Height:</b>	Feet	Inches	Centimetres	<b>Weight:</b>	Stones	Pounds	Kilogrammes
Have you smoked, vaped, used nicotine replacement products or any other tobacco products in the last 12 months?					Yes	No	
If <b>Yes</b> , how many per day? (If you use nicotine replacement products or vape, select "Less than 20 per day)				Less than 20 per day	20 or more per day		

### DEPENDENT 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)							
<b>Height:</b>	Feet	Inches	Centimetres	<b>Weight:</b>	Stones	Pounds	Kilogrammes
Have you smoked, vaped, used nicotine replacement products or any other tobacco products in the last 12 months?					Yes	No	
If <b>Yes</b> , how many per day? (If you use nicotine replacement products or vape, select "Less than 20 per day)				Less than 20 per day	20 or more per day		

### YOUR CURRENT PLAN

Name of your current insurance provider							
Name of your insurance plan							
Does anyone covered under this policy have any personal exclusions or loadings applied?						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
<i>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.</i>			
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)	

## SECTION B

### DECLARATION OF GOOD HEALTH

Please tell us about past and present medical history for yourself and ALL other persons to be covered under the policy. **Please note - We require you to disclose every aspect of the medical history requested 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 your application has been submitted, we may need to contact you for further information before we can finalise your cover. If you need help completing your application, please let us know. If you are answering on someone else's behalf, we expect you are able to do so accurately. If you are unsure about the answer to any question you should make the enquiries necessary to allow you to provide an accurate answer.

Careless misrepresentation could result in Cigna:

- applying exclusions, rejecting claims, and/or cancelling cover.

Deliberate misrepresentation could result in Cigna:

- cancelling cover, retaining premiums and recovering costs of paid claims.

Please note, even if you have disclosed any medical information up to this point, including on any call or correspondence, you are still required to disclose this information again when answering the following medical questionnaire.

### HEALTH INFORMATION

In the last 5 years, have you or anyone to be covered by this policy been diagnosed with, received treatment for, or been under review for:

- **Cancer or Tumor**
- **Heart or Circulatory disease or disorder**
- **Stroke or Neurological disease or disorder**
- **Spinal surgery or Joint replacement**
- **Mental Health or Neurodevelopmental disorders**

Yes

No

Do you or anyone to be covered under this policy have:

- **Any chronic or recurring conditions for which you have had symptoms or received treatment (including prescribed medication) in the last 12 months?**
- **Any treatment, tests or investigations planned or pending?**

Yes

No

For the avoidance of doubt, a chronic condition is a long-term or recurring disease. Or an illness, injury or condition needing ongoing monitoring, treatment (including medication) or rehabilitation, and lasts more than 3 months.

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	Date of onset	Tests/Investigations	Medication/ Treatment	Date of last symptoms/ treatment	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 adversely 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	<table><tr><td>Broker</td><td>Agent</td></tr><tr><td colspan="2">Other (please specify)</td></tr></table>	Broker	Agent	Other (please specify)	
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 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?	<table><tr><td>Email</td><td>Telephone</td></tr></table>	Email	Telephone
Email	Telephone		

**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](mailto:cgi.sales@cigna.com)**



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