Cigna Global Health options application form

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

cigna healthcare

Please complete this application form and return it to us. See our contact information at the end of this form. Please complete this form in BLOCK CAPITALS.

To satisfy certain regulatory requirements, you must state in Section A below whether you or any other person receiving cover under the policy is a Politically Exposed Person. For clarity, you may be defined as a Politically Exposed Person if you, your family member, or a close associate holds a prominent public function including but not limited to a politician, senior government employee, judicial or military official, ambassador or senior executive of a state owned or international corporation.This requirement is only applicable if your policy is arranged through our Dubai International Finance Centre office.

SECTION A

APPLICATION DETAILS

Please complete this section for all persons to be covered under the policy, including the main policyholder and any dependents.

YOUR PLAN

Which plan are you applying for?	Silver		GoWld		Platinum	
When do you want your cover to begin? (DD/MM/YYYY)						

This policy is an annual renewable contract with a minimum period of cover of three (3) months.

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)		
Are you a Politically Exposed Person? (see explanatory notes above)	Yes		No		Occupation		
Are you currently in the US?	Yes				No		
	If yes, please identify state:				**If no, please proceed to Nationality question**		

Please provide your US address below if you are currently located in one of the following states: AZ, CA, CT, DC, FL, IL, IN, KS, LA, MI, NH, OH, SC, TN, TX, UT, VA.
If not located in one of the above states, please proceed to Nationality question

Address (Where you would like any mail correspondence to be delivered)							
Address							
City		State		Zip/Postal Code			
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)							
Address in location country (if known)							
Address line 1							
Address line 2							
Address line 3							
Country				Zip/Postal Code			
Correspondence address (If applicant is a US National, address must be outside the United States)							
Address line 1							
Address line 2							
Address line 3							
Country				Zip/Postal Code			
Daytime telephone number (Country code – Number)		Mobile telephone number (Country code – Number)		Fax (Country code – Number)			
Email address							
Height:	Feet	Inches	Centimetres	**Weight:**	Stones	Pounds	Kilogrammes
Have you smoked, 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		

DEPENDENT 1

Title		First Name		Other Initials		Surname	
Relationship to policyholder				Gender (please tick)	Male		Female
Are you a Politically Exposed Person? (see explanatory notes above)					Yes		No
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)							
Email Address							
Height:	Feet	Inches		Centimetres		**Weight:**	Stones	Pounds		Kilogrammes	
Have you smoked, 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		

DEPENDENT 2

Title		First Name		Other Initials		Surname	
Relationship to policyholder				Gender (please tick)	Male		Female
Are you a Politically Exposed Person? (see explanatory notes above)					Yes		No
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)							
Email Address							
Height:	Feet	Inches		Centimetres		**Weight:**	Stones	Pounds		Kilogrammes	
Have you smoked, 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		

DEPENDENT 3

Title		First Name		Other Initials		Surname	
Relationship to policyholder				Gender (please tick)	Male		Female
Are you a Politically Exposed Person? (see explanatory notes above)					Yes		No
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)							
Email Address							
Height:	Feet	Inches		Centimetres		**Weight:**	Stones	Pounds		Kilogrammes	
Have you smoked, 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		

DEPENDENT 4

Title		First Name		Other Initials		Surname	
Relationship to policyholder				Gender (please tick)	Male		Female
Are you a Politically Exposed Person? (see explanatory notes above)					Yes		No
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)							
Email Address							
Height:	Feet	Inches		Centimetres		**Weight:**	Stones	Pounds		Kilogrammes	
Have you smoked, 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		

SECTION B

APPLICANT DETAILS

Where do you want your cover?	Worldwide	Worldwide excluding USA

INPATIENT AND DAYPATIENT INTERNATIONAL MEDICAL INSURANCE

Choose your deductible	$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

Further information relating to how Deductibles and Cost-shares work can be found on page 43 of the customer guide.

OPTIONAL BENEFITS

Do you wish to upgrade your plan with any of the following options

International Outpatient

Yes ☐ **No** ☐

As per our definitions in your Policy Rules document, Inpatient means a patient who is admitted to hospital and who occupies a bed overnight or longer, for medical reasons.

Daypatient means a patient who is admitted to a hospital or daypatient unit or other medical facility for treatment or because they need a period of medically supervised recovery, but who does not occupy a bed overnight. This also includes surgical procedures carried out in a doctor's surgery.

Outpatient means a patient who attends a hospital, consulting room, or outpatient clinic for treatment but is not admitted as a daypatient or an inpatient and does not occupy a bed.

Deductible

$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%

International Evacuation and Crisis Assistance Plus™	**Yes** ☐	**No** ☐
International Health and Wellbeing	**Yes** ☐	**No** ☐
International Vision and Dental	**Yes** ☐	**No** ☐

Please note that International Outpatient, International Evacuation and Crisis Assistance Plus™, International Health and Wellbeing and International Vision and Dental plans can only be purchased in conjunction with the International Medical Insurance plan.

Please note that each plan chosen will apply to all dependents.

Your plan selection can only be amended at policy renewal. Should you wish to increase your level of cover at renewal, full medical underwriting and waiting periods may apply and an additional premium amount will be payable.

SECTION C

CONFIDENTIAL HEALTH QUESTIONNAIRE

Please tell us about past and present medical history for yourself and each person named in Section A. If you tick Yes to a question, please provide full details in Section D.

Once your application has been submitted we may need to contact you for further information before we can finalise your cover.

Careless or deliberate misrepresentation could result in Cigna 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.

Please note, if you have disclosed any medical information on a previous call or correspondence, you will be required to disclose this information again when answering the following medical questionnaire.

YOUR PLAN

	Has any applicant received treatment, tests or investigations for, or been diagnosed with, or had any symptoms of:	**POLICYHOLDER**		**DEPENDENT 1**		**DEPENDENT 2**		**DEPENDENT 3**		**DEPENDENT 4**	
1	**Diabetes and other endocrine (glandular) disorders** e.g. any thyroid disorder, weight problems, gout, pituitary or adrenal gland conditions.	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
2	**Heart or circulatory disorders** e.g. chest pain, heart attack, high blood pressure, vascular disease, coronary artery disease, angina, irregular heartbeat, aneurysm or heart murmur.	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
3	**Cancer, tumours or growths** including polyps, cysts or breast lumps.	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
4	**Muscle or skeletal problems** e.g. back pain, whiplash, arthritis, joint pain or problems, gout, fractures, cartilage, tendon or ligament problems.	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
5	**Asthma, allergies, breathing or respiratory disorders** e.g. chest infections, pneumonia, bronchitis, shortness of breath, rhinitis, TB, emphysema or chronic obstructive pulmonary disease.	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
6	**Gall bladder, stomach, intestinal, gastric or liver problems** e.g. irritable bowel disease, colitis, Crohn's disease, gastric or peptic ulcers, reflux, indigestion, heartburn, gall stones, hernia, haemorrhoids or hepatitis.	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
7	**Brain or neurological disorders** e.g. multiple sclerosis, epilepsy or seizures, stroke, migraines, recurring or severe headaches, meningitis, shingles or nerve pain.	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
8	**Skin problems** e.g. eczema, acne, moles, rashes, allergic reactions, cysts, dermatitis or psoriasis.	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
9	**Blood, infective or immune disorders** e.g. high cholesterol, anaemia, malaria, HIV or systemic lupus erythematosus.	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
10	**Urinary or reproductive disorders** e.g. urinary tract infections, kidney problems, fibroids, painful, irregular or heavy periods, fertility problems, polycystic ovarian syndrome, endometriosis, testicular or prostate problems.	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
11	**Anxiety, depression, psychiatric or mental health issues** including eating disorders, post-traumatic stress disorder, alcohol or drug issues.	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
12	**Ear, nose, throat, eye or dental problems** e.g. ear infections, sinus problems, tonsils and adenoids, cataracts, glaucoma, wisdom teeth problems.	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
	Please also answer the following questions:										
13	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.	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
14	Does anyone take any medication, receive any treatment of any kind or expect to have a review or follow up for any current or past medical problem not already mentioned?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

SECTION D

ADDITIONAL HEALTH INFORMATION

Please tell us more if you have answered 'Yes' to any questions in Section C. If you are unsure if any details are relevant, please include them anyway. If you run out of space, please use a separate sheet.

	Section C Question Number	**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.)
POLICYHOLDER					
DEPENDENT 1					
DEPENDENT 2					
DEPENDENT 3					
DEPENDENT 4					

SECTION E

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 Healthcare 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 Healthcare 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 (DD/MM/YYYY)				
Select the relationship to main policyholder	**Broker**		**Agent**	
	Other (please specify)			

ADDITIONAL DECLARATION APPLICABLE TO POLICIES UNDERWRITTEN BY CIGNA HONG KONG LICENSE, CIGNA WORLDWIDE GENERAL INSURANCE COMPANY LIMITED

Medical Protection Needs Assessment

The following questions are to evaluate the suitability of the insurance product under this application based on your needs and circumstances. Application can be suspended or rejected in case of suitability mismatch.

1. What is/are your objective(s) for purchasing the medical insurance policy? (Select all that apply)			
For the expenses of hospitalisation		**For the financial need when suffering from Critical Illness**	
For the long term care and financial needs in case of total permanent disability		**For the expenses of outpatient visits and other medical needs (such as Dental, Vision benefit, etc)**	
2. Which type(s) of medical insurance are you looking for? (Select all that apply)			
Indemnity (cover the eligible expenses by the policy)		**Non-indemnity (a payment based on a sum insured amount by the policy)**	

I understand that if relevant insurance application is affected or rejected due to suitability mismatch (i.e. the declared medical needs do not match with the insurance objective of the plan being applied), Cigna Healthcare shall not be liable for any loss incurred arising from the rejected application.

I confirm and agree with the above declaration	
Main policyholder's signature	
Date (DD/MM/YYYY)	

FRAUD NOTICE

Any person who, dishonestly and with intent to make a gain for themselves 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 they know 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 themselves 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 Healthcare companies, carefully selected third parties including any broker you appoint to act on your behalf, other providers of services under this plan 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 the collection, use and disclosure of my personal and special category data by Cigna Healthcare for the purposes required by the contract of insurance I have entered into.	

SPECIAL OFFERS, PROMOTIONS, PRODUCTS, SERVICES AND RESEARCH

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. We may also contact you for the purposes of conducting research.

If you would like to receive this information, please tick here				
If yes, how would you like us to contact you?	**Email**		**Telephone**	
I consent to being contacted by Cigna Healthcare and/or by a third party that has carefully been selected by Cigna Healthcare for the purposes of conducting research.	**Yes**		**No**	

SECTION F

PAYMENT DETAILS

This page, including your card details, will be securely disposed of once your application has been processed and the payment details have been securely stored.

PAYMENT DETAILS FOR YOUR PREMIUM

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**		**American Express**	
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**		Company name	
	Spouse/partner		**Other**		Relationship	
	Family member					
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 Healthcare 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 Healthcare according to my Policy Rules documentation.

Cardholder's signature		Date (DD/MM/YYYY)	

Upon completion of the application, please contact our Broker Sales Team for support.

Email: cgi.sales@cigna.com

Telephone: +44 (0) 1475 788 682
Toll free from US: 1-877-539-6296

200043 CGHO Application Form EN Broker 02/2025