



Insurance Proposal Form

Form to be completed by Life Assured - Please print clearly

Section 1. Applicant Details

1. Title: (Mr/Mrs/Ms/Other)		2. Surname:		3. Forenames:	
4. Gender:		5. Date of Birth: (mm/dd/yy)		6. Height:	
<input type="checkbox"/> Male	<input type="checkbox"/> Female			m / feet	
8. Marital Status:		9. Home Country:		7. Weight:	
<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Single	<input type="checkbox"/> Other: _____		
10. Nationality:		11. Country of Residence:		12. Annual Salary: (US\$)	
13. Occupation: (Please provide full description)				14. Employer's Name and Address	
15. Social Security Number (If any):					
Country A: _____		Number: _____			
Country B: _____		Number: _____			
16. Are you entitled to any Social Security or Government plan in the Country of Residence? (If yes, please provide full details):					
<input type="checkbox"/> YES <input type="checkbox"/> NO					
17. Are you entitled to any reimbursement from another Insurer? (If yes, please provide full details):					
<input type="checkbox"/> YES <input type="checkbox"/> NO					
18. Details of Principal Residence:			19. Anticipated travel patterns for the next 12 months:		
Mailing Address: _____ _____			Destinations: _____ _____		
Country: _____			Frequency: _____		
Postal Code: _____			Duration: _____		
Contact Details:			Duties: _____		
<i>Home Tel. No.:</i> _____			_____		
<i>Mobile Tel No.:</i> _____			_____		
<i>Fax No.:</i> _____			_____		
<i>Email Address:</i> _____			_____		



Insurance Proposal Form

Section 2. Cover Required

Please tick (✓) cover required currency of benefits:	<input type="checkbox"/> US Dollar (\$)	<input type="checkbox"/> British Pound (£)	<input type="checkbox"/> Euro (€)
1. <input type="checkbox"/> LIFE INSURANCE	Sum Assured: _____		
2. <input type="checkbox"/> LONG TERM DISABILITY INSURANCE	Benefit (% Salary): _____ % per month with escalation of <input type="checkbox"/> 0 % <input type="checkbox"/> 3 % per annum. Deferred Period (weeks) <input type="checkbox"/> 13 <input type="checkbox"/> 26		
3. <input type="checkbox"/> SHORT TERM DISABILITY INSURANCE	Benefit (% Salary): _____ per month with escalation of (Nil or 3%) __ % per annum. Deferred Period (weeks) <input type="checkbox"/> 13 <input type="checkbox"/> 26 Benefits under Short Term Disability are Payable for maximum 5 years. Cannot be covered in conjunction with Long Term Disability Insurance.		
4. <input type="checkbox"/> ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE	Sum Assured: _____		
5. <input type="checkbox"/> WAR & TERRORISM EXTENSION	An extension for War & Terrorism Coverage (excluding NCB Perils) can be added to the above benefits, but is subject to Underwriters' approval and additional premium loading.		
6. <input type="checkbox"/> NCB PERILS EXTENSION	An extension for Nuclear, Chemical and Biological Perils can be added to the above benefits, but is subject to Underwriters' approval and additional premium loading.		
Requested Effective Date: (dd/mm/yy)			

TRAVEL PATTERN
Please advise below your anticipated travel pattern for the next 12 months including destinations, frequency of travel, duration of travel, and duties whilst travelling.
If you are applying for the War & Terrorism / NCB extension(s), please provide details of the security arrangements in place.



Insurance Proposal Form

STATEMENT OF HEALTH BY APPLICANT

All questions must be completed. Failure to include all material medical information or providing false information may result in cancellation of cover or denial of claim payment at time of claim.

Section 3. Medical Questionnaire (Part A)

If your answer is "Yes" to any of the following six questions please answer additional questions, otherwise please move on to next question.		
1) Does your state of health prevent you from performing your activity at full time?	Yes	No
If yes, please answer following additional questions: a) Partial or total sick leave: b) Reasons of sick leave:		
2) Have you suffered in the last 10 years from a disease or an accident entailing 30 days or more sick leave and/or medical treatment?	Yes	No
If yes, please answer following additional questions: a) Cause and length of sick leave: b) Date of sick leave:		
3) Did you or are you planning to undergo a surgical operation?	Yes	No
If yes, please answer following additional questions: a) Which one? b) When?		
4) Do you suffer from any disabling illness, physical defect, infirmity or congenital illness or from the consequences of an illness or accident?	Yes	No
If yes, please answer following additional questions: a) Which disablement? b) Which ones? c) Date of accident? d) Wounds?		
5) Are you currently pregnant?	Yes	No
If yes, please answer the following question: What is your expected due date?		
6) Do you receive any disability pension or work accident pension?	Yes	No
If yes, please answer the following question: Why?		



Section 3. Medical Questionnaire (Part B)

Have you been advised, counselled, tested, diagnosed, treated, hospitalized, or recommended for treatment within the last 10 years for the following: (If you answer "Yes" to any question, please circle the condition to which you are referring and give complete details in Part C).		
1) Seizures or seizure disorder; paralysis; multiple sclerosis; or any disorder of the central nervous system?	Yes	No
2) Mental retardation; any mental, behavioural, emotional, or eating disorder; anxiety, depression, neurosis or psychosis; psycho-therapy; psychological, marital or any form of counselling or therapy?	Yes	No
3) High blood pressure; heart attack; stroke; chest pain or palpitations; murmur; varicose veins, blood clot, anaemia, or any other blood, heart, or circulatory disorder or condition?	Yes	No
4) Asthma; emphysema; bronchitis; sinusitis; pneumonia; allergies; apnea; or any breathing difficulty, lung or respiratory disease, disorder or condition?	Yes	No
5) Colitis; chronic diarrhoea or intestinal problems; hernia; ulcer of the stomach or duodenum; haemorrhoids or rectal disorder; hepatitis or liver disorder; gallbladder, pancreas, oesophagus, or any other digestive disorder or condition?	Yes	No
6) Cancer, tumour, growth, cyst, enlarged lymph nodes; psoriasis, keratosis, lesions of the skin or mouth, or any other skin disorder?	Yes	No
7) Disease or disorder of the breast; kidney; kidney stones; bladder; prostate; abnormal PSA, or any other urinary disorder or infection?	Yes	No
8) Disease or disorder of the genital or reproductive system; herpes, any sexually disease; endometriosis, or abnormal pap smear?	Yes	No
9) Been treated for infertility; taken any medication, or advised to seek treatment, medication, diagnostic tests or surgery for infertility?	Yes	No
10) Arthritis; rheumatism; gout; TMJ (temporomandibular joint syndrome); any injury to or disease or disorder of the spine, back, jaw, bones, muscles, or joints; joint replacement; or chiropractic treatment?	Yes	No
11) Pituitary, adrenal, or thyroid disorder; lupus; diabetes?	Yes	No
12) Cataracts; glaucoma; or any eye disorder; hearing loss; or any ear nose, or throat disorder?	Yes	No
13) Alcoholism; alcohol, drug or substance abuse or dependency?	Yes	No
14) Acquired immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), HIV Positive, or other immune disorders?	Yes	No
15) Have any parents, children, or siblings suffered from cancer, diabetes, hyperlipedemia, chronic mental diseases before 50 years of age?	Yes	No
16) Have you gained or lost more than 12 kilos or 25 pounds during the last 12 months?	Yes	No
17) Have you smoked cigarettes or used tobacco in any form in the past 12 months?	Yes	No
18) Have you ever been declined, postponed, rated, or limited for Life, Health, or Accident Insurance?	Yes	No
19) Have you been hospitalized in the last 10 years for any reason?	Yes	No
20) Do you engage in any profession, sport, or hobby that could be considered hazardous?	Yes	No
21) During the past 3 years, has any illness or injury prevented you from work?	Yes	No
22) During the past 5 years, have you consulted or been advised to consult a medical practitioner for any significant physical impairment, deformity sickness, operation, injury, or hospitalization other than revealed in questions above?	Yes	No



Insurance Proposal Form

Section 3. Medical Questionnaire (Part C)

Give details of each item answered "Yes" in Part B.

(If more space is needed, attach separate page, which must be signed and dated)

Question No.	Condition/ Diagnosis	Treatment (Surgeries/ Medications)	Treatment Dates from/to	Ongoing or Date of Recovery	Name, Location or Telephone Number of Physician, Hospital/Institution

Section 4. MEDICAL PRACTITIONER

Please provide details of your family Doctor(s), if you have one:

Details of Current Family Doctor:	Details of Previous Family Doctor, if changed within past 5 years:
Name: _____ Mailing Address: _____ _____ _____ Email: _____ Telephone No.: _____	Name: _____ Mailing Address: _____ _____ _____ Email: _____ Telephone No.: _____

Section 5. BENEFICIARY INFORMATION (APPLICABLE FOR LIFE COVER ONLY)

Please provide details of the beneficiary for any Life Insurance Benefit:

Is Beneficiary an Individual(s) or an Entity:	<input type="checkbox"/> Individual(s) <input type="checkbox"/> Entity (Trust, Estate, Corporation or Partnership)
Name: _____ Telephone No.: _____	
Mailing Address: _____ _____ _____	



Insurance Proposal Form

Section 6. METHOD OF PAYMENT

Please tick (✓) Method of Payment

<input type="checkbox"/> Check (Drawn on US Bank in US dollars) Payable to: GBG Holdings, Inc. Send Payment to: GBG Holdings, Inc. 26000 Towne Centre Drive, Suite 100 Foothill Ranch, CA 92610	<input type="checkbox"/> Wire Transfer (Sent in US dollars) Send Payment to: Bank of America 4980 Irvine Blvd. Irvine, CA 92620 Routing #: 026009593 For further credit to: GBG Holdings, Inc. Account # : 27866-70521 Swift Code: BOFAUS3N
<input type="checkbox"/> Electronic Payment (For US Banks and in US dollars) Send Payment to: Bank of America Routing No.: 026009593 Account No.: 27866-70521	<input type="checkbox"/> Credit Card Please visit www.tiecare.com and click on payment. For Personal Assistance please call 888-824-6627

Section 7. REPRESENTATIONS, ACKNOWLEDGMENTS, AND AUTHORIZATIONS

I apply for coverage as indicated here above, for which I am or may become eligible under the agreement with Colonial Medical Insurance Company Limited; and/or Colonial Life Assurance Company Limited; and/or Sagikor Capital Life Insurance Co.; and/or Gulf Insurance PCC LTD-Gulf Cell; and/or Lloyd's Underwriters, all as underwritten and managed by Global Benefits Europe B.V., and which is hereinafter called the Insurer.

The insurance plan shall be governed exclusively by the laws of Bermuda/Bahamas/Guernsey/U.K, as applicable.

I have been informed of the terms and conditions of the insurance plan. I accept these terms and conditions and declare that to the best of my knowledge and belief the statements made in this Application form are true and complete. I understand that failure to disclose information in this application may be the basis for cancellation of policy or claims denial.

I hereby declare that I am currently actively at work and mentally and physically capable of conducting the regular duties of my employment and have not been absent from work for more than 10 consecutive days in the preceding twelve months.

I agree that there shall be no insurance until this application has been accepted by the Insurer, and the first full premium has been paid, and that payment has been effectively received by the Insurer.

I authorize any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, or other person or firm to provide the Insurer or their authorized representative information, including copies of records, concerning advice, care, or treatment provided to me, including without limitation, information relating to mental illness or use of drugs or alcohol.

I understand that such information will be used by the Insurer for the purpose of evaluating my application for insurance, or by Insurer representatives involved in evaluating, determining, or administering claims for insurance benefits for. I understand that I or any authorized representative will receive a copy of this authorization upon request.

Signature of Life to be Assured: Date Signed:	
--	--

TieCare/GBG Representative: (or broker name and contact information, if applicable)	
---	--

EXPEDITING YOUR APPLICATION

We cannot accept your application if this Health Declaration is incomplete. Should we need to contact you rapidly regarding the Health Declaration, please circle your preferred method and provide details:

Telephone / Private E-Mail / Other: _____



Insurance Proposal Form

Please use additional space below for any long answers you may have or additional information you may think is necessary:

Large empty rectangular area for providing long answers or additional information.

26000 Towne Centre Drive
Suite 100, Foothill Ranch
CA 92610 USA
Fax: 949-470-2110



Global Benefits Group, Inc.



TieCare International, Inc.