

# GlobalLife & GlobalIncomeProtection

## APPLICATION FORM

Private Health Associates US  
PO Box 100116, Fort Worth,  
Texas 76185, USA  
Tel: 1-866-360-3543  
Fax: 1-817-738-4090  
Email: info@einsuresource.com

### YOUR PERSONAL DETAILS

First Names: \_\_\_\_\_ Surname: Mr / Dr / Mrs / Ms / Miss \_\_\_\_\_

Postal address: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Tel No: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Sex:  Male  Female Fax No: \_\_\_\_\_

Occupation: \_\_\_\_\_

Nationality: (Please enclose a copy of your passport) \_\_\_\_\_

Your country of overseas residence: \_\_\_\_\_

Please state your current salary: (Proof of your salary will be required in the event of a claim) \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Is your occupation 100% office based?  YES  NO

If your occupation is not 100% office based, please provide a full job description: \_\_\_\_\_

Do you participate in any hazardous activities?  YES  NO

If yes, please give full details of any hazardous activities you participate in including how often you participate: \_\_\_\_\_

### GLOBAL LIFE PLAN APPLICATION

Please state the amount of life cover you require: \_\_\_\_\_

Your life cover must not exceed 20 times your current salary. (The maximum benefit available is £600,000 or \$1,000,000 or €1,000,000)

Do you have any other life insurance cover in force?  YES  NO

If you do have other life insurance, please state the amount(s) and the insurer(s): \_\_\_\_\_

### ACCIDENT PROTECTION BENEFIT APPLICATION Available only when you take the Global Life plan

Please state the amount of Accident Protection benefit you require: \_\_\_\_\_

Your Accident Protection benefit must not exceed your Global Life plan benefit.

The maximum benefit available is £300,000 or \$500,000 or €500,000. If you are also applying for a Global Income plan the maximum benefit available is £200,000 or \$335,000 or €335,000. The total combined benefit of your Global Life and Accident Benefit cannot exceed £600,000 or US\$1,000,000 or €1,000,000

### GLOBAL INCOME PROTECTION PLAN APPLICATION

Please state the amount of annual Income benefit you require: \_\_\_\_\_

The benefit we pay will be restricted to 75% of your pre-disability salary, less any other income you are entitled to receive whilst you are disabled. The maximum benefit available is £90,000 or \$144,000 or €144,000.

Please state the deferment period you require:  3 months  6 months

Do you have other disability insurance?  YES  NO

If you do have other disability insurance, please give full details: \_\_\_\_\_

### PAYMENT DETAILS

METHOD & FREQUENCY OF PAYMENT CREDIT/DEBIT CARD DETAILS

Annually by cheque/transfer  Credit/debit card:  VISA  MASTERCARD  AMEX  SWITCH  DOMESTIC MAESTRO  DELTA  SOLO

Annually by credit card/direct debit\*  Full card number: \_\_\_\_\_

Monthly by credit card/direct debit\*  Expiry date: \_\_\_\_\_ Issue No: (if applicable) \_\_\_\_\_ Issue Date: (if applicable) \_\_\_\_\_

Quarterly by credit card/direct debit\*  Address to which card is registered: (if different from the postal address given above) \_\_\_\_\_

Semi-annually by credit card/direct debit\*  \_\_\_\_\_

\*If you pay by direct debit you must pay in sterling from a UK bank account

Name as on card: \_\_\_\_\_

Signature (of card holder): \_\_\_\_\_

**HEALTH DECLARATION**

Your height (cms)  Your weight (kgs)  Your height (feet and inches)  Your weight (lbs)

Please answer each of the following questions by ticking the appropriate box.

- 1. Have you been absent from work for more than five consecutive days in the last five years?  YES  NO
  - 2. Have you any physical defect or infirmity?  YES  NO
  - 3. Have you consulted a doctor within the last three years?  YES  NO
  - 4. Have you ever undergone a surgical operation?  YES  NO
  - 5. Have you any reason to believe that a surgical operation will be required in the near future?  YES  NO
  - 6. Have you ever been hospitalised?  YES  NO
  - 7. Have you ever suffered from:
    - (a) Any nervous or mental disorders, fainting, blackouts or fits?  YES  NO
    - (b) High blood pressure, heart or circulatory disorder?  YES  NO
    - (c) Any rheumatic or arthritic condition or diabetes?  YES  NO
    - (d) Slipped disc or other spinal disorder?  YES  NO
    - (e) Any respiratory, urinary or allergic condition?  YES  NO
    - (f) Any stomach, liver or bowel disorder?  YES  NO
    - (g) Any disease of the immune system (e.g. AIDS)?  YES  NO
    - (h) Any other medical condition requiring investigation?  YES  NO
  - 8. Have you ever been tested for the HIV virus?  YES  NO
- If the answer to this question (# 8) is YES, was the result positive?  YES  NO

If the answer to any of the above questions is yes, please give full details below. If necessary, please continue on to another sheet of paper.

Question No.	Diagnosis of illness and the name and address of the treating physician	Date on which first diagnosed	Full details of treatment and tests received, and test results (attach medical reports where possible)	Dates of treatment and/or tests	Your present state of health with regard to this ailment. If treatment is still being received, please give full details

**DECLARATION**

I hereby apply for cover under the Global Protection plan. I declare that the information I have given in this application form is true and complete. I understand that upon receipt of my Global Protection plan documents, if I am not entirely satisfied, I can cancel my application and receive a full refund of the premium I have paid, provided I return the documents to William Russell Limited within 30 days of the start of the policy. I authorise any doctor named above and any other doctor or medical practitioner who has attended me to provide William Russell Limited with any information they may require in connection with this application and/or in connection with any claim on my Global Protection plan. If I have indicated that I wish to pay by credit/debit card, or by direct debit, I authorise William Russell Limited to debit my account with the appropriate premiums due, and all subsequent renewal premiums due as notified by William Russell Limited until I give notice in writing that I wish to terminate my plan. I understand that William Russell Limited cannot be liable if my plan is lapsed because my account could not be debited. I understand that William Russell Limited will give me 4 weeks notice of renewal and that premiums will vary each year. I declare that I am actively at work and in the event of a claim I authorise my employer or accountant to release information to William Russell Limited and Hauteville Insurance Company Limited regarding my salary. I agree that William Russell Limited and Hauteville Insurance Company Limited may rescind this plan and release themselves from any liability whatsoever if it is proved that I have omitted to declare any relevant information, or have given any incorrect, incomplete or misleading information.

Signature of applicant:

Date:

**PLEASE ENSURE YOU HAVE GIVEN AN ANSWER TO EVERY QUESTION. AN INCOMPLETE FORM WILL DELAY YOUR APPLICATION.**

**William Russell Limited**

William Russell House  
The Square, Lightwater, Surrey, GU18 5SS, UK.

Tel: + 44 1276 486455  
Fax: + 44 1276 486466

sales@william-russell.com

**William Russell (Far East) Limited**

402, 4th Floor, Chinachem Tower,  
34-37 Connaught Road, Central, Hong Kong.

Tel: + 852 3690 2145  
Fax: + 852 3690 2142

hkoffice@william-russell.com