Application Form for Journey individual health insurance Plan Basic

⚠ **Please note: We will not be able to process the application if any fields are left incomplete.**
For more information, please refer to the Terms and Conditions of Insurance.

Please read these instructions carefully before filling in the Application Form:

1. This document is governed by the Terms and Conditions of Insurance. Capitalised terms in this document shall have the same meaning as provided in the Glossaries, unless otherwise explicitly stated to the contrary.
2. For inbound Germany (policy purchased for expatriates moving to Germany), there is a maximum insurance period of 5 years, including all policy extensions and/or previous health insurance cover taken out with other insurance companies. Therefore, any applicant who has been residing in Germany for more than 5 years, is not eligible for the product.
3. Insurance cover applies to insured events occurring in the following areas, as selected by the applicant in the Application Form:

   Geographical Area I: Worldwide including United States of America
   Geographical Area II: Worldwide excluding United States of America

   Treatment abroad is excluded from Benefits if such Treatment was the sole reason or one of the reasons for traveling abroad.

   If any applicant relocates to a Geographical Area different from the one agreed to be covered under the Insurance Policy for any duration, such relocation must be immediately notified to the Insurer, and this change will affect the premium and any Benefits to be granted under the Insurance Policy.
4. This insurance product is designed for individuals living outside their home country for a temporary period. When staying in the United States of America, please note that it is not classified as Affordable Care Act (ACA) product. This product is intended as supplemental international cover for individuals who already have primary ACA-compliant health insurance. Please ensure the cover is suitable for your circumstances before purchasing.

I hereby apply for a health Insurance Policy for Global Health Journey for the persons to be insured as listed below.

A. Main applicant's personal details (applicant 1)

☐ I act as Policyholder only and not as Insured Person ☐ I act as both Policyholder and Insured Person

Start date of insurance (dd/mm/yyyy)

☐ Date of Signature ☐ Or specify future start date:

Gender ☐ M ☐ F	**Title**
First name	**Surname**
Date of birth (dd/mm/yyyy)	**Occupation and industry**

Correspondence address

Building name/number	**Street**
Postal/zip/area code AND town/city	**Country AND region**
Contact details: mobile number (+ country code / area code)	**Contact details: e-mail address**

Previous or existing customer of Globality S.A. and/or Foyer Global Health S.A.? If yes, please provide insurance number(s)

☐ **Yes**
☐ **No**

Nationality or nationalities

Country where the application is signed	**Country of future location (where applicant 1 will reside)**

Contractual language (all correspondence/documents will be provided in this language)

☐ English ☐ German ☐ French ☐ Spanish

B. Applicants

Applicant 2

Start date of insurance (dd/mm/yyyy)

☐ Date of signature ☐ Or specify future start date:

Gender ☐ M ☐ F	**Title**
First name	**Surname**

Relationship to the main applicant

☐ Partner ☐ Child

Date of birth (dd/mm/yyyy)	**Occupation and industry**

Correspondence address ☐ Same address as the main applicant ☐ Different address

Building name/number	**Street**
Postal/zip/area code AND town/city	**Country AND region**
Contact details: mobile number (+ country code / area code)	**Contact details: e-mail address**

Previous or existing customer of Globality S.A. and/or Foyer Global Health S.A.? If yes, please provide insurance number(s)

☐ **Yes**
☐ **No**

Nationality or nationalities

Country where the application is signed	**Country of future location (where applicant 2 will reside)**

Applicant 3	
Start date of insurance (dd/mm/yyyy) ☐ Date of signature ☐ Or specify future start date:	
Gender ☐ M ☐ F	**Title**
First name	**Surname**
Relationship to the main applicant ☐ Partner ☐ Child	
Date of birth (dd/mm/yyyy)	**Occupation and industry**
Correspondence address ☐ Same address as the main applicant ☐ Different address	
Building name/number	**Street**
Postal/zip/area code AND town/city	**Country AND region**
Contact details: mobile number (+ country code / area code)	**Contact details: e-mail address**
Previous or existing customer of Globality S.A. and/or Foyer Global Health S.A.? ☐ **Yes** ☐ **No**	**If yes, please provide insurance number(s)**
Nationality or nationalities	
Country where the application is signed	**Country of future location (where applicant 3 will reside)**

Applicant 4	
Start date of insurance (dd/mm/yyyy) ☐ Date of signature ☐ Or specify future start date:	
Gender ☐ M ☐ F	**Title**
First name	**Surname**
Relationship to the main applicant ☐ Partner ☐ Child	
Date of birth (dd/mm/yyyy)	**Occupation and industry**
Correspondence address ☐ Same address as the main applicant ☐ Different address	
Building name/number	**Street**
Postal/zip/area code AND town/city	**Country AND region**
Contact details: mobile number (+ country code / area code)	**Contact details: e-mail address**
Previous or existing customer of Globality S.A. and/or Foyer Global Health S.A.? ☐ **Yes** ☐ **No**	**If yes, please provide insurance number(s)**
Nationality or nationalities	
Country where the application is signed	**Country of future location (where applicant 4 will reside)**

C. Plan level and Geographical Area

Contractual currency:

- ☐ EUR
- ☐ USD
- ☐ GBP
- ☐ CHF

Applicant	Plan level			Geographical Area
1	**Basic**	No Deductible	Fixed Co-Payment of 20%	☐ **Geographical Area I: Worldwide including United States of America** ☐ **Geographical Area II: Worldwide excluding United States of America**
2	**Basic**	No Deductible	Fixed Co-Payment of 20%	☐ **Geographical Area I: Worldwide including United States of America** ☐ **Geographical Area II: Worldwide excluding United States of America**
3	**Basic**	No Deductible	Fixed Co-Payment of 20%	☐ **Geographical Area I: Worldwide including United States of America** ☐ **Geographical Area II: Worldwide excluding United States of America**
4	**Basic**	No Deductible	Fixed Co-Payment of 20%	☐ **Geographical Area I: Worldwide including United States of America** ☐ **Geographical Area II: Worldwide excluding United States of America**

⚠ **Please note:**

- Co-Payments apply to Outpatient Treatments only.
- This insurance product is designed for individuals living outside their home country for a temporary period. When staying in the United States of America, please note that it is not classified as Affordable Care Act (ACA) product. This product is intended as supplemental international cover for individuals who already have primary ACA-compliant health insurance. Please ensure the cover is suitable for your circumstances before purchasing.

D. Previous cover and Doctor details

⚠ **Mandatory: The following details (point 1. OR point 2.) are required.**

1. Do the applicants have or ever had health insurance cover within the last 3 years (including compulsory statutory/private health insurance)?

Applicant	Answer	Previous insurer	Insurance no.	Level of cover	Start date (dd/mm/yyyy)	End date (dd/mm/yyyy)
1	☐ Yes ☐ No			☐ Inpatient ☐ Outpatient ☐ Dental		
2	☐ Yes ☐ No			☐ Inpatient ☐ Outpatient ☐ Dental		
3	☐ Yes ☐ No			☐ Inpatient ☐ Outpatient ☐ Dental		
4	☐ Yes ☐ No			☐ Inpatient ☐ Outpatient ☐ Dental		

2. Please specify the name and address of the Doctor best able to provide further information regarding the applicants' health (last 3 years). If there is more than one Doctor/clinic associated with the persons in this application please provide any additional information in the information box at the end of Section E or include a separate page.

Applicant	Doctor's name	Address of the Hospital/clinic/Doctor	Phone no. and e-mail address
1			
2			
3			
4			

E. Medical history (Health questionnaire)

⚠ **Please tick only one. In the event neither is ticked (☐) the application will go for FMU (Full Medical Underwriting).**

☐ **Moratorium Cover**
Moratorium cover is only available if all applicants are aged 55 or younger at the time of application (as indicated by the signature date in Section G). If this option is selected, the health questions in Section E should not be completed, as all Pre-Existing Medical Conditions and any related conditions are excluded from cover for a minimum waiting period of 24 months from the policy start date. For further details, please refer to the Terms and Conditions of Insurance. If Moratorium cover is chosen, please directly proceed to complete Section F.

☐ **Full Medical Underwriting**
To assess whether the Pre-Existing Medical Conditions can be covered from the start date of the Insurance Policy, all the health questions listed below must be answered correctly and to the best of the applicant's knowledge. The medical risk assessment may result in Foyer Global Health S.A. adding conditions to the Insurance Policy, charging an extra premium, adding an exclusion or rejecting the Application Form/an applicant.

Important: All health questions listed below must be answered in detail. Symptoms, illnesses and the consequences of an Accident should be mentioned even if the applicant considers them to be unimportant. Dashes do not qualify as an answer. If more space is needed: continue on a separate sheet, specifying the number of the concerned applicant, and refer to that sheet in the Application Form. If the applicant does not wish to reveal certain information to the intermediary, this information must be provided directly to Foyer Global Health S.A. in writing within three days of the reception of the Application Form by Foyer Global Health S.A.. In this case, the applicant must indicate in the Application Form that the information is to be provided separately.

The Insurer draws the applicants' attention to the fact that, if the health questions in this Application Form, where of relevance for acceptance of the risk, are answered incorrectly or incompletely, the Insurer may – if the duty to provide information has not been willfully violated – terminate the Insurance Policy within one month of being informed of the violation, insofar as the Insurer can prove that the Insurer would not have insured the risk in any case. The Insurance Policy shall be null and void if the Insurer's assessment of the risk is affected by willful violation of the applicants' duty to provide information. In this case, the applicant is obliged to repay the insurance Benefits already received. The Insurer will not refund the paid premiums.

Conditions arising between signing the Application Form and the date of signing the Particular Conditions will equally be deemed to be Pre-Existing. Therefore it is necessary that the applicant advises the Insurer immediately of any material changes to the information provided, which would occur between submission of this Application Form and its acceptance by the Insurer (Please refer to "Responsibility for the information provided in the Application Form", page 11).

Pre-Existing Conditions
Pre-Existing Conditions refer to any Medical Conditions, Diseases, Bodily Injuries, or their consequences that the applicant was aware of, or received medical advice, diagnosis, or Treatment for, prior to signing the Application Form.

This includes:

i. Any condition for which the applicant underwent diagnostic testing (including preventive screenings or routine health check-ups) that resulted in abnormal findings, regardless of whether a formal diagnosis was made.
ii. Any signs or symptoms, whether diagnosed or not, as well as any physical or organic abnormalities, congenital anomalies, disabilities, or deformities.
iii. The presence of any medical devices such as Implants (excluding dental implants), stents, prostheses, or any other devices permanently or temporarily attached to the body.

Additionally, any illness, injury, or Medical Condition that arises between the date of signing the Application Form and the date of signing the Particular Conditions will also be considered a Pre-Existing Condition.

Pre-Existing Conditions may be covered under the Insurance Policy following a full medical underwriting.

If insurance cover already exists or existed with Globality S.A. or Foyer Global Health S.A., it is not necessary to specify any disorders or courses of Treatment during the last five years which are already fully known to Globality S.A. or Foyer Global Health S.A. on account of the invoices or medical certificates presented to Globality S.A. or Foyer Global Health S.A. in conjunction with the previously existing insurance contract.

⚠ **If the applicant has selected "Moratorium" in Section E above, please skip the below questionnaire and continue in Section F.**

General Questions (Level 1)					
No.	**Question**	**Applicant 1**	**Applicant 2**	**Applicant 3**	**Applicant 4**
1	What is your height in cm and weight in kg?	☐ cm ☐ kg	☐ cm ☐ kg	☐ cm ☐ kg	☐ cm ☐ kg
2a	Do you smoke more than 20 cigarettes or use more than 1 vape (10 mg/ml) per day?	☐ Yes ☐ No If yes, how many?	☐ Yes ☐ No If yes, how many?	☐ Yes ☐ No If yes, how many?	☐ Yes ☐ No If yes, how many?
2b	Have you ever been treated for, diagnosed with, or currently have a drug or substance addiction?	☐ Yes ☐ No If yes, please provide further details such as Treatments or rehabilitation dates, current status, etc.	☐ Yes ☐ No If yes, please provide further details such as Treatments or rehabilitation dates, current status, etc.	☐ Yes ☐ No If yes, please provide further details such as Treatments or rehabilitation dates, current status, etc.	☐ Yes ☐ No If yes, please provide further details such as Treatments or rehabilitation dates, current status, etc.
3	Do you drink more than 14 units of alcohol per week? Alcohol: units (1 unit = 250 ml beer / 100 ml wine/ 25 ml spirit)	☐ Yes ☐ No If yes, how many?	☐ Yes ☐ No If yes, how many?	☐ Yes ☐ No If yes, how many?	☐ Yes ☐ No If yes, how many?

General Health Questions (Level 1)					
No.	**In the last 5 years, ...**	**Applicant 1**	**Applicant 2**	**Applicant 3**	**Applicant 4**
1	Have you received, currently receiving, or is any inpatient, day care or Outpatient Treatment recommended or planned?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2	Have you taken, are currently taking or planning to take any prescription Medication, over the counter Medication (without prescription), or alternative/herbal/ traditional medicine?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3	Have you undergone or been recommended any diagnostic tests with or without a diagnosis, or have you received abnormal results from any preventative or health check-up tests?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4	Do you currently have any form of sickness or injury, undiagnosed signs or symptoms, physical/organic defects, congenital anomalies, any form of disabilty or deformity?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5	Do you have any implants (excluding dental implants), stents, prosthesis or any other devices internally fixed to your body?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If all general health questions 1–5 are answered with "No" please proceed to Section F.

Specific Health Questions (Level 2)

⚠ **Please give as many details as you can, including dates (start and end or indicate if it is an ongoing condition), quantities, frequencies, diagnosis, any related tests and results, scans, related Treatments received or recommended Treatment and give details of the treating Doctor where applicable. Please provide supporting documents such as medical reports or test results where available.**

Question No. ☐ Applicant No. ☐

Diagnosis	Past history (i.e. since when or period)	Treatment (taken or recommended)	Start and end date
Name of medicine, period of medicine usage, dosage or quantity, frequency	Hospital and Doctor details	Additional details if any	Mention the attached supporting medical reports

Question No. ☐ Applicant No. ☐

Diagnosis	Past history (i.e. since when or period)	Treatment (taken or recommended)	Start and end date
Name of medicine, period of medicine usage, dosage or quantity, frequency	Hospital and Doctor details	Additional details if any	Mention the attached supporting medical reports

Question No. ☐ Applicant No. ☐

Diagnosis	Past history (i.e. since when or period)	Treatment (taken or recommended)	Start and end date
Name of medicine, period of medicine usage, dosage or quantity, frequency	Hospital and Doctor details	Additional details if any	Mention the attached supporting medical reports

Question No. ☐ Applicant No. ☐

Diagnosis	Past history (i.e. since when or period)	Treatment (taken or recommended)	Start and end date
Name of medicine, period of medicine usage, dosage or quantity, frequency	Hospital and Doctor details	Additional details if any	Mention the attached supporting medical reports

Question No. ☐ Applicant No. ☐

Diagnosis	Past history (i.e. since when or period)	Treatment (taken or recommended)	Start and end date
Name of medicine, period of medicine usage, dosage or quantity, frequency	Hospital and Doctor details	Additional details if any	Mention the attached supporting medical reports

Question No. ☐ Applicant No. ☐

Diagnosis	Past history (i.e. since when or period)	Treatment (taken or recommended)	Start and end date
Name of medicine, period of medicine usage, dosage or quantity, frequency	Hospital and Doctor details	Additional details if any	Mention the attached supporting medical reports

Question No. ☐ Applicant No. ☐

Diagnosis	Past history (i.e. since when or period)	Treatment (taken or recommended)	Start and end date
Name of medicine, period of medicine usage, dosage or quantity, frequency	Hospital and Doctor details	Additional details if any	Mention the attached supporting medical reports

Question No. ☐ Applicant No. ☐

Diagnosis	Past history (i.e. since when or period)	Treatment (taken or recommended)	Start and end date
Name of medicine, period of medicine usage, dosage or quantity, frequency	Hospital and Doctor details	Additional details if any	Mention the attached supporting medical reports

In case you don't currently recollect your medical history or don't have required documents to provide, you can approach the treating Doctor and request for the following:

Please provide a medical report outlining the exact diagnosis, diagnostic findings including investigation reports, medical history, current status, current and past Treatments/therapies and planned Treatment or the applicant could also download our medical examination report and get it filled up by the Doctor.

Additional information and remarks:

F. Payment of premiums

Payment frequency

☐ monthly ☐ quarterly ☐ semi-annually ☐ annually

Payment method

☐ **Direct debit** (applies only for Euro premiums within the Eurozone*, UK and Denmark or where specifically supported by the applicant's bank).

*Eurozone includes: Austria, Belgium, Bulgaria, Croatia, Cyprus, Estonia, Finland, France, Germany, Greece, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Portugal, Republic of Ireland, Slovakia, Slovenia, Spain.

☐ **Premium payment by bank transfer**

☐ **Credit card**
Together with the welcome package, access will be provided to a secure webpage through which credit card details must be entered to activate insurance cover.

G. Declarations from all the persons to be insured including the main applicant

The following points are known to me:

Responsibility for the information provided in the Application Form

Before declaring the intention to conclude the Insurance Policy, the applicants must inform the Insurer of all circumstances known and requested by the Insurer, which are of importance for the Insurer's decision to provide the agreed insurance cover.

Conditions that arise between signing the Application Form and the date of signing the Particular Conditions are deemed to be Pre-Existing.

Attention is drawn to the above given information with regard to the legal consequences of incorrectly answering the questions concerning the state of health.

Professional secrecy, outsourcing, and outsourcing to cloud computing service providers

Foyer Global Health S.A. attaches great importance to respecting the professional secrecy and the confidentiality of its customer's data and undertakes at all times to implement all necessary and required measures to ensure the confidentiality of data according with the highest quality standards and in compliance with the regulations in force.

To guarantee a high level of quality of services and to provide the most advanced technologies to its customers, the Insurer may use service providers, subcontractors and technologies using cloud computing.

In any case, the data communicated will be protected according to high quality standards and in compliance with the regulations including those provided by the GDPR.

Within the framework of the execution of the Insurance Policy and in order to allow for the optimal provision of the related insurance services according to high quality standards, the Insurer relies on outsourcing service providers and the use of cloud arrangements. In this context, information and data pertaining to all the persons to be insured including the main applicant, notably personal identification data (such as gender, title, surname, first name, physical address, e-mail address, telephone number and date of birth) and communication data (such as reports of exchanges by call or e-mail or social networks or via a portal) are made available and disclosed to the relevant service providers.

By signing this Application Form, all the persons to be insured including the main applicant expressly acknowledge, accept, agree and consent to the aforementioned outsourcing and use of the cloud as well as the related necessary transfer and disclosure of information and data, which are further detailed in the Insurance Policy and on the website of the Insurer under the link https://www.foyer.lu/en/transparency.

All the persons to be insured including the main applicant also expressly acknowledge, accept, agree and consent to the fact that the information published on the Insurer's website may be changed and/or completed from time to time and expressly undertake to regularly consult such website.

The outsourcing table published on the Insurer's website specifies the currently existing outsourcing contracts, the exact nature of the outsourced services, the type of information that is transmitted and the country of establishment of the service provider(s). Should a service provider not be subject to an obligation of professional secrecy similar to that of the Insurer, the Insurer shall enter into a confidentiality agreement with the service provider in order to require it to comply with such a confidentiality obligation as part of the outsourcing concerned.

In the event of a change in the outsourcing table (examples: addition of a service provider, use of cloud computing), the main applicant shall be informed of the change by e-mail and/or any other relevant communication channel provided for under the Insurance Policy or agreed with the main applicant. The main applicant undertakes to inform all the persons to be insured of such change.

If, within 2 months of a change in the subcontracting table, the main applicant has not objected in writing to such change, all the persons to be insured including the main applicant shall be deemed to have irrevocably accepted the relevant change. In case of an objection by the main applicant, such objection must be notified to the Insurer by registered letter and such notification shall qualify as a termination event at the next expiry of the Insurance Policy.

If the main applicant holds several Insurance Policies with the Insurer, the main applicant shall notify one objection per Insurance Policy.

Previous insurance

Please append, for each applicant referred to herein, all data about previous health insurance or applicable state healthcare systems of the past 3 years (including any data pertaining to compulsory statutory/private/public health insurance) for inpatient, outpatient and dental cover.

Application and acceptance of the health insurance application

This Application Form does not bind either the applicant nor the Insurer to conclude the Insurance Policy. However, the Insurer shall notify the applicant, within 30 days of the receipt of the Application Form, of an insurance offer, the subjection of the insurance to an inquiry or survey, or the refusal to insure. The Insurer will provide insurance cover in good faith, assuming that the applicant has correctly and completely answered all the relevant questions raised before the start of the Insurance Policy (this is known as the 'precontractual duty to disclose information').

The conclusion of Insurance Policy is subject to the acceptance of the Application Form by the Insurer in writing. The payment of the first premium to the intermediary or the Insurer does not constitute an acceptance of the Application Form by the Insurer.

By signing this Application Form, the applicants confirm that they have read, understood, and expressly acknowledge, accept, agree to, and consent to the Terms and Conditions outlined in this Application Form, the General Conditions of Insurance, and the Special Conditions.

Furthermore, the applicants undertake to signing the Particular Conditions should the Insurer accept the Application Form.

The applicants agree, accept, and consent that any notices issued by the Insurer concerning the Insurance Policy may be addressed to the applicants. The main applicant undertakes to inform all the persons to be insured of such notices, where applicable, and the Insurer shall not be held responsible for any failure by the main applicant to fulfil this obligation.

Medical secrecy waiver

By signing this Form, the applicants give consent to professionals to provide Foyer Global Health S.A. with information on their health and Treatment as detailed in Section E.

If the applicants do not give this consent, they understand the following:

1. The applicants will have to decide, in each instance, whether or not they will give consent to the specified persons or institutions to forward information to Foyer Global Health S.A..
2. It may take longer to investigate their Claims, Benefits may be reduced, or the Insurer may be relieved from its obligation to pay Benefits if the obligation to pay Benefits cannot be fully established on the basis of the remaining sources of information.

All information and documents regarding the policy will be sent:

☐ to the correspondence address of the main applicant

☐ to the following insurance intermediary to whom the applicants give consent to receive them on their behalf:

To be completed by the insurance intermediary:	
The intermediary is authorised to act as the agent (mandataire) of the applicants, with the mandate to collect and receive, on their behalf and in their name, any information and documentation related to the Insurance Policy from the Insurer.	**When answering the questions in this form, did the applicants provide information which has not been recorded in this Application Form?** ☐ **No** ☐ **Yes** **If yes, please give details below:**

Direct marketing

☐ By signing this form, the applicants herewith agree that information on special offers by Foyer Global Health S.A. may be sent to them in writing, electronically, and by telephone. This consent may be revoked at any time.

All persons aged 18 years and older have to sign. For minors and incapable adults, the authorized legal representative(s) have to sign. In case main applicant and applicant 1 are same, please sign once.

Place and date	Signature of the main applicant	Applicant 1 (if different to main applicant)
Applicant 2	Applicant 3	Applicant 4

Insurance intermediary name and number	Sub-intermediary 1 name and number
Signature of insurance intermediary	Sub-intermediary 2 name and number

Please return the fully completed Application Form by e-mail to sales@globalhealth.insurance