

# COMPANY APPLICATION PART 1



To be completed by the employer (the policyholder)

(PLEASE USE BLOCK LETTERS)

## FOR ADMINISTRATION USE

Ref. <input style="width: 90%;" type="text"/>	Agreement Number <input style="width: 90%;" type="text"/>	<div style="border: 1px solid black; padding: 5px; min-height: 30px;">Producer ID</div>
Date <input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	

## COMMENCEMENT DATE

The company requests that this agreement commences from  day  month  year

## COMPANY INFORMATION

Company Name	<input style="width: 90%;" type="text"/>
Company Registration Number	<input style="width: 90%;" type="text"/>
Address	<input style="width: 90%;" type="text"/> <input style="width: 90%;" type="text"/> <input style="width: 90%;" type="text"/>
City	<input style="width: 90%;" type="text"/>
Country	<input style="width: 90%;" type="text"/>
Telephone	<input style="width: 90%;" type="text"/>
E-mail	<input style="width: 90%;" type="text"/>
Web Address	<input style="width: 90%;" type="text"/>

## DETAILS OF COMPANY CONTACT PERSON (DAILY ADMINISTRATOR)

Contact Person	<input style="width: 90%;" type="text"/>
Title	<input style="width: 90%;" type="text"/>
Preferred language of communication	<input style="width: 90%;" type="text"/>
Address (only if different from company address)	<input style="width: 90%;" type="text"/> <input style="width: 90%;" type="text"/> <input style="width: 90%;" type="text"/>
City	<input style="width: 90%;" type="text"/>
Country	<input style="width: 90%;" type="text"/>
Telephone	<input style="width: 90%;" type="text"/>
E-mail	<input style="width: 90%;" type="text"/>

# COMPANY APPLICATION PART 2



To be completed by the employer (the policyholder)

(PLEASE USE BLOCK LETTERS)

## FOR ADMINISTRATION USE

Ref. _____	Agreement Number _____	Producer ID _____
Date _____	_____	

## COMPANY INFORMATION (AS STATED IN PART 1)

Company Name _____
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## CHOICE OF COVER

**Please choose Modules**

<input checked="" type="radio"/> Module 1 - Hospitalisation & Inpatient Treatment *	<input type="radio"/> Module 2 - Outpatient Treatment
<input type="radio"/> Module 3 - Medicine & Appliances	<input type="radio"/> Module 4 - Medical Evacuation
<input type="radio"/> Module 5 - Rehabilitation & Nursing	<input type="radio"/> Module 6 - Dental & Optical

\* Module 1 is mandatory

## MEDICAL UNDERWRITING METHODS

**Please note that, if the employees are underwritten individually you cannot choose MHD for the dependant.**  
**Please have each of your employees and their dependants to be insured fill in the relevant forms.**

**Employees:**

<input type="radio"/> Individual (Form A & B)	<input type="radio"/> MHD (Form A)	<input type="radio"/> Other (to be agreed with ihi Bupa)
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**Dependant:**

<input type="radio"/> Individual (Form A & B)	<input type="radio"/> MHD (Form A)	<input type="radio"/> Other (to be agreed with ihi Bupa)
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## CHOICE OF CURRENCY AND DEDUCTIBLE

<b>USD</b>	<input type="radio"/> Nil	<input type="radio"/> 175	<input type="radio"/> 1,750
<b>EUR</b>	<input type="radio"/> Nil	<input type="radio"/> 150	<input type="radio"/> 1,500
<b>GBP</b>	<input type="radio"/> Nil	<input type="radio"/> 100	<input type="radio"/> 1,000

Please note that the chosen currency is binding

## EXTENSION OF COVER

Worldwide Add-On Option:	<input type="radio"/> Yes	<input type="radio"/> No
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# COMPANY APPLICATION PART 3



To be completed by the employer (the policyholder)

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## FOR ADMINISTRATION USE

Ref. <input type="text"/>	Agreement Number <input type="text"/>	Producer ID <input type="text"/>
Date <input type="text"/>	<input type="text"/>	

## PREMIUM PAYMENT

- Annual
- Semi-annual
- Quarterly
- Monthly \*

\* To be eligible for the monthly payment option, the company must be able to qualify for an automated payment procedure, e.g. a pre-arranged bank transfer. Must be pre-approved by ihi Bupa

## PAYMENT OPTIONS

- International bank transfer
- International credit card
- International cheque