GLOBAL HEALTHCARE AND ASSISTANCE
expacare

Medical Questionnaire

Please use BLOCK CAPITALS and Black Ink when completing the form.
Please contact us on +44 (0) 1344 381650 if you have any queries. Please send your completed form to us by:

- Post to Expacare, The Columbia Centre, Station Road, Bracknell, Berkshire, RG12 1LP, United Kingdom
- Fax to +44 (0) 1344 381690
- Email to info@expacare.com
- Alternatively, please send the form to your insurance broker

1. GROUP NAME (IF APPLICABLE)

2. MAIN APPLICANT / POLICYHOLDER

First name: Last name:

Nationality: Country of overseas residence:

Residential address:

Telephone: Email:

Occupation:

Male ☐ Female ☐ Date of birth: DD / MM / YY

3. FAMILY MEMBERS TO BE INCLUDED ON COVER

You may include your partner/spouse and children. Child dependants aged 19-23 can join as long as we receive written confirmation from their place of study that they are in full time education.

PARTNER / SPOUSE

First Name	Last Name	Nationality	Country of Residence	Occupation	Male / Female	Date of Birth DD / MM / YY

CHILD DEPENDANTS

	First Name	Last Name	Nationality	Country of Residence	Occupation	Male / Female	Date of Birth DD / MM / YY
Child Dependant 1							
Child Dependant 2							
Child Dependant 3							
Child Dependant 4							

4. MEDICAL QUESTIONNAIRE

Do you or anyone to be covered currently have a health insurance policy with another insurance company? Yes ☐ No ☐

If yes, please specify which company: .....

Have you or anyone to be covered ever had a health insurance policy? Yes ☐ No ☐

If yes, please specify which company and confirm how long you were on cover: .....

Have you or anyone to be covered ever been declined or had exclusions applied on another health care policy? Yes ☐ No ☐

If yes, please provide details for each applicant in the Medical History Section, Part 3 on page 3.

5. MEDICAL HISTORY - PART 1

Have you or any named dependant in the last 5 years:

- seen a doctor, specialist or healthcare professional;
- experienced any signs or symptoms;
- been admitted to hospital, had any operations or investigations; including x-rays, biopsies and blood tests;

For any of the following? (If 'Yes' for any question please provide full details in Medical History - Part 3)

	Main Applicant / Policyholder	Spouse or Partner	Child Dependant 1	Child Dependant 2	Child Dependant 3	Child Dependant 4
	NAME	NAME	NAME	NAME	NAME	NAME
1. Heart and Circulatory Disorders. e.g. chest pain (angina), abnormal heart beat, varicose veins, high blood pressure, circulation problems, blood lipid or cholesterol problems.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2. Respiratory Disorders. e.g. asthma, bronchitis, COPD, pneumonia, tuberculosis, chest infections, cystic fibrosis.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
3. Skeletal & Muscular Disorders. e.g. back, shoulder or neck problems, disc disorders, osteoporosis, cartilage, tendon, or ligament disorders, joint replacements, fractures, bunions.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
4. Digestive Disorders. e.g. Crohn's disease, colitis, irritable bowel syndrome, changes in bowel habit, rectal bleeding, indigestion/reflux, hernia, cirrhosis, jaundice, liver/pancreas or gall bladder problems, haemorrhoids.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
5. Blood Disorders. e.g. anaemia, leukaemia, hepatitis, HIV, deep vein thrombosis (DVT), abnormal blood tests.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6. Neurological Disorders. e.g. epilepsy, seizures, multiple sclerosis, meningitis, migraines, headaches, dementia.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
7. Psychiatric Disorders. e.g. depression, stress, anxiety, eating disorders, schizophrenia, addictions (including drug or alcohol dependency).	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
8. Ear, Nose, Throat or Eye Problems. e.g. cataracts, glaucoma, blepharitis, ear infections, hearing problems, vertigo, tinnitus, tonsillitis, gum infections, wisdom teeth or sinus problems.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
9. Dental or Maxillofacial Problems. e.g. wisdom teeth problems, gingivitis, dental/gum infections, abscesses.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10. Urinary Problems. e.g. urinary tract infections, urinary/ kidney stones, incontinence or urgency, renal failure, bladder or kidney problems.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

5. MEDICAL HISTORY - PART 1 (CONTINUED)

	Main Applicant / Policyholder	Spouse or Partner	Child Dependant 1	Child Dependant 2	Child Dependant 3	Child Dependant 4
11. Endocrine (glandular) Disorders. e.g. diabetes, thyroid problems, pituitary, adrenal or hormonal problems.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
12. Allergies or Skin Problems. e.g. psoriasis, eczema, acne, moles, warts, lipomas.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
13. Male Disorders. e.g. abnormal PSA result, infertility, sexually transmitted infections, prostate or testicular disorders.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
14. Female Disorders. e.g. menstrual problems, fibroids, endometriosis, polycystic ovaries, abnormal smear test, menopausal symptoms, sexually transmitted infections, infertility, breast lumps, child birth or pregnancy problems.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
15. Autoimmune & Infective Disorders. e.g. myasthenia gravis, malaria, Lupus, Sjogrens syndrome.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
16. For any medical condition not listed in questions 1-15 above. Please provide full details in Medical History - Part 3.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

5. MEDICAL HISTORY - PART 2

Please answer the following question for you or any named dependant.
(If 'Yes' for any question please provide full details in Medical History - Part 3)

	Main Applicant / Policyholder	Spouse or Partner	Child Dependant 1	Child Dependant 2	Child Dependant 3	Child Dependant 4
17. Do you take any medication on a regular basis, prescribed or otherwise? Please list in Medical History - Part 3.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
18. Have you ever had any past history of any joint replacements, heart conditions or strokes?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
19. Have you ever been diagnosed with any conditions, or suffered symptoms for any undiagnosed condition, not mentioned in Medical History - Part 1?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
20. Have you ever been diagnosed with any cancerous or pre-cancerous condition? If any please advise in Part 3.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
21. Do you currently have any planned or pending check-ups, investigations or treatment?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

5. MEDICAL HISTORY - PART 3

If you have answered 'Yes' to any of the questions 1-21 please provide full details below.

Name	Question number	Symptom or medical condition and area of body affected. e.g. skin rash on back	Date when symptoms started.	Date when symptoms finished.	What treatment did you receive and when? Please confirm dates and detail any medications provided.	What was the outcome? e.g. ongoing, still under review, complete recovery, recurrent or likely to recur?

If you need further space please include details on a separate sheet.

6. DATA PROTECTION NOTICE

We take our responsibility for confidentiality very seriously. Any information you give us will be held securely and fairly in accordance with the Data Protection Act 1998.

How we may use members' personal data or disclose it to third parties:

- To administer the plan and process claims.
- To liaise with treatment providers about treatment and costs.
- To process claims that are also covered by another insurer or third party.
- To help us develop services we think will be in the members' best interest.
- For statistical analysis to help us assess how the scheme is being used.
- To detect fraud and improper claims.

Giving you information:

- We may contact members by letter, telephone or electronic mail about services or products that we believe you may be interested in. If you do not wish to receive such information, please tick here ☐

Communication:

- We may monitor any communication we have with members, including telephone conversations to ensure we have an accurate record, and have followed your instructions.

At times, the provision of our services may necessitate the transfer of your personal data outside the European Economic Area and/or the disclosure of the same to insurers, partners, agents and professional advisers. Such employees, contractors and agents who have access to your personal data are required to keep that information confidential and are not permitted to use it for any other purposes. By signing this Application Form you consent to such transfer of data.

We will abide by the stated principles of the Data Protection Act at all times. These can be viewed on the Information Commissioner's website – www.dataprotection.gov.uk. Members have the right to know what information we hold about them and can request this by writing to the:

Data Protection Officer, Expacare Limited, The Columbia Centre, Station Road, Bracknell, Berkshire, RG12 1LP

We may request an administration fee for supplying a copy of any personal or medical information.

7. CONSENT FOR RELEASE OF MEDICAL INFORMATION

Expacare Limited requires your authority for release of medical information about you as we may require further information to support your application, or for future claims.

I hereby authorise any organisation or person who has or may have information concerning my health to furnish Expacare or their respective representatives with:

1. All records of any treatment or discussion of my health
2. All information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment) and employment history
3. A medical certificate in the form attached completed by any health provider who Expacare may require.

You do not have to give your consent but we would not be able to process your application without it.

8. AUTHORISATION AND DECLARATION

I am applying to be covered under an Expacare plan together with the dependants listed on this form.

I declare that to the best of my knowledge and belief, the information given on this form and any additional information supplied is true and complete and that the information completed is full and accurate. I understand and accept that in the event of this form being fraudulent in whole as or in part, the policy will be invalidated and I will be liable for prosecution.

I understand that if I provide inaccurate or incomplete information, or do not provide the information asked for in this form and make a claim, which Expacare view as being treatment for a pre-existing medical or related medical condition, my claim may be rejected.

If you are in any doubt as to whether information is relevant or not, or do not know the answer, or how to answer, any specific question, then please contact us for guidance.

I understand that Expacare will advise me of any medical conditions which they will exclude from cover based on the information I have provided to them.

You must tell Expacare about any change in the information given in this application which occurs between the date of signing and the date that cover starts.

I understand that the answers provided are necessary in order for Expacare to process my application and I consent to the processing of the personal data, including medical information.

I authorise and herewith agree that Expacare Limited may forward data obtained from the form to the Insurer or its authorised Claims Administrator or any Reinsurer for the purpose of assessing the risk and handling the reinsurance.

I authorise any doctor, physician or practitioner who has examined or observed me or any of the applicants for diagnosis, treatment, disease or ailment, to give to the Insurance Company full particulars of these, including any prior medical history and medical records.

I have read and understood the Rules attached to my application and I understand them to form part of any contract of Insurance issued as a result of my application.

I agree that this declaration and the information provided in this form together with that set out in the membership guide and insurance certificate shall form the basis of the contract(s) between the insured Person(s) and the Insurer.

By signing this form, I consent to Expacare dealing with my broker, if one is appointed. I also consent that they have authority to see medical information that I have disclosed in this application and in addition any subsequent medical information that Expacare obtain in the course of dealing with my application and policy.

Signature of main applicant/policyholder: .....

DATE: (DD/MM/YY): .....

Signature of Spouse/Partner: .....

DATE: (DD/MM/YY): .....

Signature of Child Dependant 1: .....

DATE: (DD/MM/YY): .....

Signature of Child Dependant 2: .....

DATE: (DD/MM/YY): .....

Signature of Child Dependant 3: .....

DATE: (DD/MM/YY): .....

Signature of Child Dependant 4: .....

DATE: (DD/MM/YY): .....

Parents/guardians may sign the form on behalf of any dependants aged 0-17