Archipelago
Life Insurance Limited

UltraCare plan

Individual application
Continuation of Personal Medical Exclusions (CPME) transfer

Need help completing this application?
Please contact either your advisor or us. You can find our contact details on our website at www.archipelagolife.com

You must tell us about all material facts before we accept an application or renew the plan. A material fact is information likely to influence us in assessing and accepting the insurance. If you do not tell us all material facts or if you misrepresent any material facts, this may render the insurance voidable from inception (the start of the contract) and enable us to repudiate liability (entitle us not to pay your claims). If there is any doubt about whether a fact is material, for your own protection, you must tell us.

If any of the details that you give on this application are different from the details that you gave when you received your quotation, your premium may be different.

Please complete this application clearly in BLOCK CAPITALS.

If you have received a quotation from us, please write the quotation number and option number if you have one:

Quotation number:	Option number:

A Your personal details (the planholder)

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Country where you live[1]:	How long have you lived there?
Home country:	Nationality on passport:
Occupation[2]:	Date of birth (dd/mm/yyyy): Sex: ☐ M ☐ F

[1] The amount of insurance premium tax and any other relevant taxes you will have to pay will depend on the country where you live. Please speak to your advisor or contact us if you are unsure whether your premium will be affected. Please make sure that your plan meets the requirements of the country where you live.
[2] Some occupations may have an increased premium. Please contact us for more information.

Your address[3]

[3] We will send all correspondence to this address unless you have completed the details below for a correspondence address.
You must tell us immediately about any changes to your contact or personal details. A change in circumstances may affect your cover.

Address:	
Town:	City:
Postcode:	Country:
Phone:	Mobile:
Email:	

Correspondence address – if different from your address above

Address:	
Town:	City:
Postcode:	Country:
Phone:	Mobile:
Email:	

B Dependants to be covered

Dependant 1

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: ☐ M ☐ F
Country where they live[1]:	Nationality on passport:
Occupation[2]:	Relationship to you:

Dependant 2

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: ☐ M ☐ F
Country where they live[1]:	Nationality on passport:
Occupation[2]:	Relationship to you:

Dependant 3

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: ☐ M ☐ F
Country where they live[1]:	Nationality on passport:
Occupation[2]:	Relationship to you:

Dependant 4

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: ☐ M ☐ F
Country where they live[1]:	Nationality on passport:
Occupation[2]:	Relationship to you:

If you have any more dependants to be covered, please give us details on a separate sheet of paper and send it to us with this application.

C Cover start date

The plan is a yearly contract. Your cover will start on the expiry date of your existing plan. We cannot backdate cover under any circumstances.

Date existing cover ends (dd/mm/yyyy):
Date existing medical insurance was first taken out with the current insurer (dd/mm/yyyy):

A copy of the current certificate of insurance must be provided for each member applying for CPME terms.

D Your cover options

Level of cover and type of plan

Please tell us the type of UltraCare plan that you need. Please make sure that you have read the Table of benefits before making your choice. You must make sure the plan meets your needs. Please contact us if you need a copy of this document.

☐ UltraCare Standard	☐ UltraCare Select	☐ UltraCare Comprehensive
☐ UltraCare Elite with free worldwide Travel add-on plan	☐ UltraCare Elite without free worldwide Travel add-on plan	

Area of cover

Choose the area of cover from the descriptions below based on the country where you live and your home country if you need the option of returning to your home country for treatment. Please see the 'Individual eligibility' section in the Plan guide for restrictions on US citizens. You and your dependants must have the same area of cover.

☐ **Area 2** Worldwide, not including the USA

☐ **Area 3** Worldwide

Excess options (deductibles)

If you want to change the excess from the standard excess shown, please tick the appropriate box below.

Excess options	UltraCare Standard	UltraCare Select	UltraCare Comprehensive	UltraCare Elite
No excess	N/A	☐ 10% premium increase	☐ 10% premium increase	Standard
$45	Standard	Standard	Standard	☐ 4.5% premium discount
$85	N/A	☐ 5% premium discount	☐ 5% premium discount	☐ 9.5% premium discount
$170	N/A	☐ 10% premium discount	☐ 10% premium discount	☐ 14% premium discount
$425	N/A	☐ 15% premium discount	☐ 15% premium discount	☐ 19% premium discount
$850	☐ 10% premium discount	☐ 20% premium discount	☐ 20% premium discount	☐ 23.5% premium discount
$1,700	☐ 20% premium discount	☐ 25% premium discount	☐ 25% premium discount	☐ 28.5% premium discount
$4,250	☐ 30% premium discount	☐ 30% premium discount	☐ 30% premium discount	☐ 33% premium discount
$8,500	☐ 40% premium discount	☐ 40% premium discount	☐ 40% premium discount	☐ 43% premium discount

UltraCare Standard plan

You must pay a standard excess amount of $45 for each medical condition in each plan year for all out-patient medical treatment claims.

If you choose a voluntary excess, this will apply for each medical condition in each plan year for all in-patient, daycare and out-patient medical treatment, including organ transplants.

UltraCare Select plan

You must pay a standard excess amount of $45 for each medical condition in each plan year for all out-patient medical treatment claims, including HIV or AIDS and maintenance of chronic medical conditions.

If you choose a voluntary excess, this will apply for each medical condition in each plan year for all in-patient, daycare and out-patient medical treatment, including organ transplants, HIV or AIDS, emergency medical treatment outside your area of cover and maintenance of chronic medical conditions.

UltraCare Comprehensive plan

You must pay a standard excess amount of $45 for each medical condition in each plan year for all out-patient medical treatment claims, including congenital abnormalities, HIV or AIDS and maintenance of chronic medical conditions.

If you choose a voluntary excess, this will apply for each medical condition in each plan year for all in-patient, daycare and out-patient medical treatment, including congenital abnormalities, organ transplants, HIV or AIDS, emergency medical treatment outside your area of cover and maintenance of chronic medical conditions.

UltraCare Elite plan

You do not have to pay a standard excess on this plan. If you choose a voluntary excess, this will apply for each medical condition in each plan year for all in-patient, daycare and out-patient medical treatment, including congenital abnormalities, organ transplants, HIV or AIDS, emergency medical treatment outside your area of cover and maintenance of chronic medical conditions.

Co-insurance (deductibles)

UltraCare Comprehensive plan

You must pay 25% of all out-patient dental treatment claims. The maximum amount we will pay to you for out-patient dental treatment will be 75% of each eligible claim. The total amount we will pay to you for an eligible claim for out-patient dental treatment will be 75% of the limit shown on your Table of benefits. You cannot remove this co-insurance.

E Add-on plans and benefits

The Travel and Maternity add-on plans are only available with moratorium underwriting terms. Please read and sign the declaration in section F of this application if you choose one of these add-on plans.

Do you want to add any of the following?

Travel add-on plan (do not complete if you have chosen UltraCare Elite)	☐ Yes ☐ No
If yes, please tell us which type:	☐ Planholder only ☐ Planholder and all dependants
Maternity add-on plan	☐ Yes ☐ No
If yes, please tell us which level of co-insurance you have chosen for each person:	☐ No co-insurance ☐ 10% ☐ 20%

The Maternity add-on plan is only available for female members. The minimum age at entry for this plan is 18. The maximum age at entry is 44. Cover only becomes available for treatment received 12 months after the start date of this add-on plan.

Personal accident add-on plan	☐ Yes ☐ No

If yes, please circle the number of Personal accident units you need for each person as set out in the Personal accident add-on plan Table of benefits. You must be aged 18 to 74 when joining this plan.

Planholder: 1 2 3 4 5	Dependant 1: 1 2 3 4 5	Dependant 2: 1 2 3 4 5
	Dependant 3: 1 2 3 4 5	Dependant 4: 1 2 3 4 5

If you have any more dependants to be covered, please give us details on a separate sheet of paper and send it to us with this application.

The Personal accident add-on plan provides cover for managerial, clerical and administrative occupations only. The plan does not cover claims arising from engaging in manual or dangerous occupations or hazardous pursuits. If you or any dependants on this application engage in any hazardous pursuit or occupation which puts you at greater risk of a bodily injury caused by an accident, please give full details on a separate sheet and include it with this application. If you are in any doubt as to whether an occupation is manual or dangerous or a pursuit is a hazardous one, please tell us. If we agree to provide cover, extra premiums may apply.

F Pre-existing medical conditions for add-on plans

You must read and sign this section if you have chosen Travel or Maternity add-on plans in section E.

Please read this declaration carefully before applying for any Travel or Maternity add-on plans. These plans are subject to moratorium underwriting terms as explained in the Plan guide. Please refer to benefit exclusion BE1 for the Maternity add-on plan and BET2 for the Travel add-on plan.

You must sign this section to show that you understand and accept our 24-month moratorium. We will not process your application unless you have signed this section as well as the declaration section on this application.

It is important that you read, understand and accept all of the paragraphs in the following declaration for your UltraCare plan.

This declaration applies to you and to any eligible dependants you have included in the application.

The 24-month moratorium is a waiting period of 24 months from your date of joining, or the date shown on the special terms section of your Certificate of insurance, that must have passed before claims for pre-existing medical conditions may be eligible under the plan.

A pre-existing medical condition or related medical condition is one that, within a 24-month period before the date of joining, or the date shown on the special terms section of your Certificate of insurance, has one or more of the following characteristics:

- was foreseeable;
- clearly showed itself;
- you had signs or symptoms of;
- you asked for advice about;
- you received treatment for;
- to the best of your knowledge, you were aware you had.

Pre-existing medical conditions or related medical conditions may be covered after you have had 24 months' continuous cover under the plan and within that time you have not:

- experienced symptoms;
- asked for advice; or
- needed or received treatment, medication or a special diet.

If you have:

- experienced symptoms;
- asked for advice; or
- needed or received treatment, medication or a special diet;

then you will have to wait until you have completed a continuous 24-month period when none of these apply to you. Pre-existing medical conditions or related medical conditions may then be covered. This is the rolling part of the moratorium.

I confirm that I have read, understood and accept this moratorium underwriting clause about pre-existing medical conditions and that it applies to any eligible dependants included in the application.

Signature:	Date (dd/mm/yyyy):

G Paying your premiums

To enjoy the full benefit of the plan, you must make sure the premiums are paid on or before the premium due date. You must tell us about any changes to your payment details to make sure that we can continue to collect any premiums due.

You can find full payment details and information on unpaid or late payments in the Plan guide. If you have not paid the premiums, we will suspend all claims until the premiums are up to date

Currency

Your premiums must be paid in US dollars ($).

Payment options

You can pay yearly, every three months or every month. Please choose how often you want to pay your premiums and tick the relevant method applicable to it. We cannot accept payment by bank transfer, cheque or banker's draft if you are paying by instalments. Due to administration costs, the total premiums you pay every month or every three months will be higher than if you pay the premiums every year (about 12% more if you pay every month and 7.5% if you pay every three months).

	Card	Bank transfer	Cheque or banker's draft
Yearly	☐	☐	☐
Every three months	☐	N/A	N/A
Every month	☐	N/A	N/A

Add-on plans and benefits

Travel and Personal accident add-on plan premiums can only be paid yearly.

If you have chosen the Maternity add-on plan, please tell us how often you want to pay your Maternity add-on plan premiums. Due to administration costs, the total premiums you pay every month or every three months will be higher than if you pay the premiums every year (about 12% if you pay every month and 7.5% if you pay every three months).

☐ Yearly	☐ Same as UltraCare plan (if every month or every three months)

Payment details

Card

We can accept card payments by Visa or MasterCard. Please complete the Credit card authority attached to this application. Please make sure that your card is valid for at least three months from the start date of your plan.

Bank transfers

Bank transfers must be in the currency of your plan. Please make sure that you give your full name and quotation or plan number as the reference for your bank transfer. Please send your payment to 'Archipelago Life Insurance Limited' and to the corresponding details below.

US dollar ($) Account	
Bank:	Alliance Bank Malaysia Berhad
Address:	Unit A-0G-02, Block A Plaza Mont' Kiara 2, Jalan Kiara, Mont' Kiara 50480 Kuala Lumpur, Malaysia
Account No:	1419 4101 0002 039
Swift Code:	MFBBMYKLXXX

To ensure that the full amount of your payment is received by us, please mark your bank transfer: 'PAY FULL AMOUNT' or 'Bank Charges Debit Account'.

Cheque or banker's draft

Cheques and banker's drafts must be in the currency of your plan and payable to 'Archipelago Life Insurance Limited'. Please make sure that your full name and quotation or plan number are clearly shown on the back of the cheque or banker's draft in case your payment becomes separated from this application.

H Doctor's or medical practitioner's details

Please give the contact details of any family doctor or medical practitioner who has treated you or your dependants in the last two years. If you do not provide this information, it may result in a delay in processing any claims and/or your claim may be rejected.

Name:	Name:
Hospital, clinic or practice:	Hospital, clinic or practice:
Phone:	Phone:
Fax:	Fax:
Email:	Email:
Address:	Address:
Postcode:	Postcode:

I Medical questionnaire

We assess your CPME application based on your answers to the following questions and the information on your current certificate of insurance. Your current certificate of insurance must show your current insurance arrangements. A copy of the current certificate of insurance must be provided for each member applying for CPME terms.

1. Have you or any of your dependants ever had a past history of cancer (including benign brain tumours), a heart condition or stroke, joint disorder, psychiatric or mental illness?	☐ Yes	☐ No
2. In the last 12 months have you or any of your dependants had any signs or symptoms that may require a visit to a medical professional or are you or any of your dependants awaiting any reviews, treatment or investigation for any current or past medical problems?	☐ Yes	☐ No
3. Do you or any of your dependants have any long-term, ongoing or chronic condition for which you have regular appointments or need a review or treatment for?	☐ Yes	☐ No
4. If you are applying for the Maternity add-on plan, is anyone to be covered on this plan currently pregnant?	☐ Yes	☐ No
5. In the last 2 years, have you or any of your dependants on this application had any other problems or concerns about their health which are not dealt with in questions 1-4 above?	☐ Yes	☐ No

If you answer yes to any of the above questions, please provide details in section M Medical details.

J Data Protection

We are committed to protecting your personal data and privacy. Any personal information that we collect from you will be kept confidential and will be processed in accordance with the Personal Data Protection Act 2010.

We will use any personal data to process your claims, administer your plan, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

We may also, in carrying out your instructions, processing and administering claims, transfer your personal data to other Archipelago Life Insurance Limited entities for the purposes of performance of the contract. Such personal data shall be governed by the personal data protection laws of that country. The policyholder is responsible for ensuring that all data provided to the Insurer is accurate at all times and is obliged to inform the Insurer of any changes.

Your information may also be used for fraud prevention and audit purposes. If you give us false or inaccurate information and we suspect fraud, we will record this. We may pass such information to law enforcement or other legal agencies, governmental or judicial bodies, or to regulators.

Your medical information will only be disclosed to those involved with your treatment or care, including your medical practitioner, or their agents. If you ask us to, we will also send your medical information to any person or organisation that may be responsible for meeting your treatment expenses, or their agents. Your information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information.

If you want us to disclose your medical information to another individual or next of kin, you must tell us. In exceptional emergency situations, and in accordance with medical confidentiality guidelines and relevant law, we may be required to disclose such information to relatives, family members or other third parties.

To help us ensure that your personal information remains accurate and up to date, please inform us of any changes.

All membership documents will be sent to the planholder.

We may, from time to time, provide you with marketing information about Archipelago Life Insurance Limited, our products and services and those of any associated companies which may be of interest to you. If you do not want us to use your details in this way, please tick the box. ☐

K Declaration

I am applying to be covered under the UltraCare plan or plans I have chosen together with the dependants listed in this application. Any reference to the insurer includes, where applicable, any third party administrators acting on the insurer's behalf.

I have read, understood and agree to keep to the terms and conditions shown in the Plan guide, along with all eligible dependants included in this application or any dependants I enrol in the future after the start date of the plan. I confirm that I have authority to give Archipelago Life Insurance Limited and any administrator acting on its behalf information about my family members referred to in this application and where necessary that I have checked with them that the information I have provided is correct. I confirm that to the best of my knowledge, the information I have provided in this application is complete and accurate and that it contains all the information required for the underwriting option I have selected.

By agreeing to the UltraCare terms and conditions I consent to any personal data, including medical information, that you may collect about myself and my family members and dependants, being processed by or on behalf of Archipelago Life Insurance Limited.

I authorise the doctor named in section H or any other medical establishment, including any other health professional who has treated me and any of my dependants included under this plan, to give you any information you may need in connection with any claim made under this plan.

I understand that you are not obliged to conduct any searches or to make any enquiries of any medical practitioners (or any other persons) to check the accuracy of the statements of fact set out in this application, and that it remains my responsibility to take reasonable care to ensure that the statements, material facts and other information I provide to you are true, accurate and complete.

I understand that if I do not provide the information asked for in sections F, H, I and M (if applicable), and I or any of my dependants included under this plan make a claim, which you view as being treatment for a pre-existing medical or related medical condition, my claim may be rejected.

I understand that should I or one of my dependants attend a hospital, clinic or medical facility where direct billing or cashless arrangements are in place and the claim is subsequently found to be ineligible, Archipelago Life Insurance Limited and any administrator acting on its behalf has the right to recover the full amount of the ineligible claim from me or one of my dependants.

I understand and agree that this declaration and the information in this application will form the basis of the contract between me, my dependants and Archipelago Life Insurance Limited. After reading all the terms and conditions and documents you have given me, I am satisfied that the product I have chosen meets my needs at this time.

For your own benefit and protection, you should read the terms and conditions shown in the Plan guide carefully before signing this declaration. If you do not understand any point, please ask for more information.

Signature:	Date (dd/mm/yyyy):

K Declaration (continued)

Cancellation

If you feel this plan does not meet your needs, you may cancel it. You must tell us in writing by letter, fax or email and return all membership cards and Certificates of insurance within 30 days of the date of joining or receiving the plan documents, whichever is later.

L Broker details

Broker's or advisor's details if applicable:

M Medical details

Name	Question number	Symptom and/or medical condition	When did the symptoms start?	What treatment did you receive and when? (Please include dates and any medication prescribed)	What was the outcome of the treatment? (e.g. ongoing, still under review, complete recovery, recurrent or likely to recur?)

If you require more space, please give us details on a separate sheet of paper and send it to us with this application.

N Contact details

Please return your completed application to your advisor or send it to us using the contact details below:

Archipelago Life Insurance Limited. Registered in Labuan. Licence No. IS2013141. Company No. LL09829. B-08-07 Gateway Corporate Suites, Gateway Kiaramas, No. 1 Jalan Desa Kiara, Mont Kiara, 50480 Kuala Lumpur, Malaysia. Tel. +603 6201 0899 F. +603 62010481 Email customerservice@archipelagolife.com

InterGlobal
An Aetna Company

Credit card authority

We are committed to safeguarding your personal data. Your payment details will be processed securely in accordance with our strict safety procedures and relevant legislation. We can accept card payments by Visa or MasterCard. There are two ways to pay by card:

1. Complete the Credit card authority below in full and fax the application to: +603 6201 0481.
2. Complete the Credit card authority below in full and post.

Please do not send your card details to us by email. Email and internet messages cannot be guaranteed to be completely secure and can be intercepted, lost or stolen. We will not process card payments sent by email.

To Archipelago Life Insurance Limited

Please complete in BLOCK CAPITALS.

Quotation number and option number if you have one:	and/or	Plan number:

Name(s) *(as shown on your card)*:

If you are not the planholder, describe your relationship to the planholder:

My card billing address is:

Postcode:

Please tick the appropriate box:

☐ Visa ☐ MasterCard | My card number is: | | | | | | | | | | | | | | | | |

Issue date: | Expiry date: | Card security code:

For your safety and security and to facilitate the processing of your payment, we require that you enter your card's verification number (card security code). The verification number is the last three digits of the number printed on the signature strip on the back of your card.

Your card details will be held and processed in accordance with strict data security regulations and guidelines which we adhere to. Once your payments have been initiated this number will be destroyed by us.

Please charge the above card in US dollars ($) and *(please tick)*:

☐ Yearly ☐ Every three months ☐ Every month

I hereby authorise the Card Account specified above to be debited with the current premium due, and all subsequent renewal premiums and other charges due as notified by Archipelago Life Insurance Limited until I give notice in writing that I wish to withdraw my authorisation. I understand that Archipelago Life Insurance Limited will give at least 4 weeks' notice of renewal, and that the premiums may vary each year. I understand that Archipelago Life Insurance Limited cannot be held liable if my plan lapses as a result of the card being declined and I have not provided or responded to requests for alternative methods of payment.

Cardholder's signature(s): Date (dd/mm/yyyy):