

# Application Form A

(Please use block letters)



Offshore Health & Travel Benefits  
serving the caribbean, latin america, and beyond

## For administration use

Ref. \_\_\_\_\_ Policy Number \_\_\_\_\_  
Date \_\_\_\_\_

**#Agent #6933**

## Commencement date

I / we request that the policy commences from 01 day \_\_\_\_\_ month \_\_\_\_\_ year

## Policyholder

First name(s) \_\_\_\_\_ Date of birth (day/month/year) \_\_\_\_\_  
Family name(s) \_\_\_\_\_ Sex (M/F) \_\_\_\_\_  
Address \_\_\_\_\_  
Address \_\_\_\_\_ Postal Code \_\_\_\_\_  
City \_\_\_\_\_ Telephone \_\_\_\_\_  
Country \_\_\_\_\_ Fax \_\_\_\_\_  
E-mail \_\_\_\_\_

## Online customer sign up

I hereby sign up as an online customer with International Health Insurance danmark a/s. As an online customer, I will receive all documents and correspondence from IHI via my personal site myPage on www.ihl.com.

## Intermediary's access to documents

In the event that I am represented by an intermediary, I hereby accept that my intermediary will get access to my documents online on his/her personal and secure IHI website.

## Reimbursement via bank transfer

If you would like us to transfer future reimbursements to your bank account, please state:

Account holder's name(s) \_\_\_\_\_  
Name of bank \_\_\_\_\_  
Bank address \_\_\_\_\_  
Postal Code \_\_\_\_\_ City \_\_\_\_\_ Country \_\_\_\_\_  
 Transfer to Danish account:       Transfer to foreign account:  
Reg. No. \_\_\_\_\_ Account No./IBAN No. \_\_\_\_\_  
Account No. \_\_\_\_\_ SWIFT No. \_\_\_\_\_

## Dependants

First name(s) \_\_\_\_\_ Date of birth (day/month/year) \_\_\_\_\_  
Family name(s) \_\_\_\_\_ Sex (M/F) \_\_\_\_\_  
First name(s) \_\_\_\_\_ Date of birth (day/month/year) \_\_\_\_\_  
Family name(s) \_\_\_\_\_ Sex (M/F) \_\_\_\_\_



\_\_\_\_\_

**Cover** - please choose modules, currency and deductible by ticking the relevant boxes

| Choice of modules   | Choice of deductible / currency                         |                                    |                                     |
|---|---|------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> Hospital Plan                     | <input type="checkbox"/> Nil                            | <input type="checkbox"/> Nil       | <input type="checkbox"/> Nil        |
| <input type="checkbox"/> Module 1 - Non-Hospitalisation Benefits      | <input type="checkbox"/> EUR 350                        | <input type="checkbox"/> GBP 250   | <input type="checkbox"/> USD 400    |
| <input type="checkbox"/> Module 2 - Medicine & Appliances             | <input type="checkbox"/> EUR 1,050                      | <input type="checkbox"/> GBP 750   | <input type="checkbox"/> USD 1,600  |
| <input type="checkbox"/> Module 3 - Medical Evacuation & Repatriation | <input type="checkbox"/> EUR 4,000                      | <input type="checkbox"/> GBP 2,750 | <input type="checkbox"/> USD 5,000  |
| <input type="checkbox"/> Module 4A - Dental & Optical                 | <input type="checkbox"/> EUR 8,000                      | <input type="checkbox"/> GBP 5,500 | <input type="checkbox"/> USD 10,000 |
| <input type="checkbox"/> Module 4B - Dental & Optical                 | <b>Please note that the chosen currency is binding.</b> |                                    |                                     |

**Premium payment**

Annual                       Semi-annual                       Quarterly

**Request for payment from a bank or another address** (if different from residential address)

|         |       |                       |       |
|---------|-------|-----------------------|-------|
| Name(s) | _____ |                       |       |
| Address | _____ | Account No. (if bank) | _____ |
| Address | _____ | Postal Code           | _____ |
| City    | _____ | Country               | _____ |

**Request for payment by international credit card**

I / we wish to pay the premium via credit card. International Health Insurance danmark a/s will charge the credit card company directly.

American Express                       VISA                       Eurocard / MasterCard  
 JCB                       Diners

Card no. \_\_\_\_\_                      Expiry date (m/y) \_\_\_\_\_                      CVC code\* (except American Express) \_\_\_\_\_

\* CVC code: The last three digits after the card number on the back of the card or the last three digits in the signature field.

**Cardholder's data if cardholder and policyholder are not the same person:**

Name(s) \_\_\_\_\_  
 Address \_\_\_\_\_  
 Address \_\_\_\_\_                      Postal Code \_\_\_\_\_  
 City \_\_\_\_\_                      Country \_\_\_\_\_

I also authorise International Health Insurance danmark a/s, until further notice in writing, to charge my credit card account with unspecified amounts in respect of my premium payments as and when these become due. The Company will inform me in advance of any premium adjustments.

**Please note that the Company will need the original, signed form to be able to charge the credit card.**

Cardholder's signature \_\_\_\_\_                      Date \_\_\_\_\_

