TRAVEL TOP UP APPLICATION FORM

Membership Number / Expiry Date

SECTION 1 - TYPE OF COVER (PLEASE TICK YOUR MEMBERSHIP PLAN)

Diamond Plan ☐ (USD250,000 emergency benefits per person)

Emerald Plan ☐ (USD100,000 emergency benefits per person)

Are you travelling to USA or Canada?† Yes ☐ No ☐

† Maximum 30 days, per annum.

SECTION 2 - PRINCIPAL APPLICANT'S DETAILS

Full Name: _____ Title: _____

Home Address: _____

Mobile No: _____ Business No: _____

Email: _____ Secondary Email: _____

SECTION 3 - DETAILS OF *ALL* MEMBERS TRAVELLING

Surname	First Name	Date of Birth

SECTION 4 - TRAVEL DATES (MINIMUM 10 TRAVEL DAYS)

From: DD / MM / YYYY To: DD / MM / YYYY (Both dates inclusive) Total Travel Days _____

Number of members travelling: _____ Premium Calculation* _____

* (1-2 Members - USD5 per person per day. 3+ Members - USD13 per day) x Total Travel Days

SECTION 5 - MEDICAL REQUIREMENTS

All members aged **70+** are required to provide a letter from their usual doctor stating that they are fit and well enough to undertake any planned travel period and itinerary. This requirement relates to travel benefits and travel worldwide as per Clause 6.6 of Terms and Conditions.

Any member who has undergone major surgery / treatment in the six months preceding date of travel is required to submit a medical report from his / her treating Specialist confirming that the Member is fit and well to travel and will not be susceptible to any extraordinary medical risk during the period of the intended travel.

SECTION 6 - DECLARATION

I hereby accept that, subject to my membership Terms and Conditions, the travel benefits requested and paid for are ***APPLICABLE IN EMERGENCIES ONLY*** as per Clause 5.8. I understand that in a non-excluded yet life threatening medical emergency, evacuation, accompaniment, medical treatment and repatriation will be provided at the behest of Health International's Medical Director. I understand that Health International will collect and process my personal data as per Clause 9.9 of the Terms and Conditions.

Member's Signature _____ Date (DD / MM / YY) _____

Official Use Only

Agent: _____ Processor Name: _____

Receipt No: _____ Rec. Date: _____ Card No: _____ Date Issued _____

Medical report received? Yes ☐ No ☐ Approved by Medical Director? Yes ☐ No ☐