SCAN ME FOR BROCHURE

Archipelago CHI Plan Application

Full Medical Underwriting (FMU)

Archipelago™ Insurance Limited

Need help completing this application?

Please contact either your advisor or us. You can find our contact details on our website at www.archipelagogrp.com

Please make sure that you have read the Benefits schedule before making your choice. You must make sure the plan meets your needs. Please contact us if you need a copy of this document.

Completing this Application

Please make sure you complete all sections. The questions should be considered carefully and answered as fully as possible. We will not be able to process your application if information is missing.

If we need more information from your doctor and they charge for this, you must pay the costs. Once we have all the information needed to consider your application we will either:

- agree to accept all of these declared medical conditions and may charge an increased premium,
- agree to accept some of these declared medical conditions and may charge an increased premium. The declared conditions we do not accept will be excluded and specified on your Certificate of Insurance,
- exclude all of the declared medical conditions. These will be specified on your Certificate of Insurance, or
- decline the application.

All other terms and conditions of the Policy Wordings still apply.

Your Duty of Disclosure

The questions in this application and any other information we ask for are essential for us to underwrite and administer your plan. You must tell us about all material facts before we can accept an application or renew a plan. If you do not tell us all material facts or misrepresent any material facts, it may affect your rights or your dependants' rights under the plan. A material fact is information likely to influence us in assessing or accepting the insurance. If there is any doubt about whether a fact is material, for your own protection, you must tell us. Failure to answer all questions fully and honestly may invalidate your insurance. A copy of the completed application can be supplied on request, but you should keep a record of all information you supply to us, including copies of all letters.

We must receive all outstanding information before we can process your application. If you do not complete this application in full, it will cause delays.

Cover Start Date

The plan is a yearly contract. Your cover will begin when we have received your signed acceptance of the special terms offered by our underwriters. We will not backdate cover under any circumstances.

Please fill in this application clearly in **BLOCK CAPITALS AND WRITE CLEARLY**.

SECTION A YOUR PERSONAL DETAILS (THE PLANHOLDER)

Title : ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Others, please specify :

Family name (surname) : First name(s) :

Current residential address :

Postcode : Country :

NRIC / Passport No : Date of Birth (dd/mm/yyyy) :

Nationality on passport : Home country :

Occupation : Gender : ☐ M ☐ F

Company name :

Job description :

Please also tick the relevant box below :

☐ Non-manual, administrative or clerical work
☐ Work of a supervisory nature or work which involves frequent travelling but not involve in manual work
☐ Involve occasional or regular manual work or use of manual tools
☐ Involves in the use of power tools
☐ Involves in operating heavy equipment
☐ Off-shore related work or air crew or ship crew
☐ Member of the armed forces or uniformed personnel

Height : (cm) or (inches) Weight : (kg) or (pounds)

Mobile : Phone :

Email address :

The amount of insurance premium tax and any other relevant taxes you will have to pay will depend on where you will be living. Please speak to your advisors 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 will be living.

Correspondence address

We will send all correspondence to this 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 :

SECTION B DEPENDANTS TO BE COVERED

You do not need to fill in the height and weight sections for dependants aged 17 years or younger.

Dependant 1

Title : ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Others, please specify :

Family name (surname) : First name(s) :

Current residential address :

Postcode : Country :

NRIC / Passport No : Date of Birth (dd/mm/yyyy) :

Nationality on passport : Home country :

Occupation : Gender : ☐ M ☐ F

Company name :

Job description :

Please also tick the relevant box below :

☐ Non-manual, administrative or clerical work
☐ Work of a supervisory nature or work which involves frequent travelling but not involve in manual work
☐ Involve occasional or regular manual work or use of manual tools
☐ Involves in the use of power tools
☐ Involves in operating heavy equipment
☐ Off-shore related work or air crew or ship crew
☐ Member of the armed forces or uniformed personnel

Height : (cm) or (inches) Weight : (kg) or (pounds)

Relationship to you :

Dependant 2

Title : ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Others, please specify :

Family name (surname) : First name(s) :

Current residential address :

Postcode : Country :

NRIC / Passport No : Date of Birth (dd/mm/yyyy) :

Nationality on passport : Home country :

Occupation : Gender : ☐ M ☐ F

Company name :

Job description :

Please also tick the relevant box below :

☐ Non-manual, administrative or clerical work
☐ Work of a supervisory nature or work which involves frequent travelling but not involve in manual work
☐ Involve occasional or regular manual work or use of manual tools
☐ Involves in the use of power tools
☐ Involves in operating heavy equipment
☐ Off-shore related work or air crew or ship crew
☐ Member of the armed forces or uniformed personnel

Height : (cm) or (inches) Weight : (kg) or (pounds)

Relationship to you :

Dependant 3

Title : ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Others, please specify :

Family name (surname) : First name(s) :

Current residential address :

Postcode : Country :

NRIC / Passport No : Date of Birth (dd/mm/yyyy) :

Nationality on passport : Home country :

Gender : ☐ M ☐ F

Height : (cm) or (inches) Weight : (kg) or (pounds)

Relationship to you :

IMPORTANT NOTE:
If you and your dependants reside outside of the United States (US), and wish or need to include cover in the US on your plan, you must choose Archipelago CHI ELITE.

SECTION C SELECT YOUR PLAN

To select your chosen plan level, please tick the appropriate box below.

☐ **Archipelago CHI ESSENTIAL** ☐ **Archipelago CHI PLUS** ☐ **Archipelago CHI ELITE**

SECTION D AREAS OF COVER

Choose your area of cover based on your country of residence, your home country if you need the option of returning to your home country for treatment, and any other country in which you may wish or need to receive treatment. See the 'Areas of cover guide' section of your Policy Wordings for more information.

You and your dependants must have the same area of cover.

Please tick the appropriate box below.

☐ **Area 1 :** Worldwide inclusive of USA (only available for Archipelago CHI ELITE)

☐ **Area 2 :** Worldwide excluding USA

☐ **Area 3 :** Asia including Singapore, Hong Kong, China, Japan, Australia, Kuwait, Qatar and United Arab Emirates (UAE)

☐ **Area 4 :** Asia excluding Singapore, Hong Kong, China, Japan, Australia, Kuwait, Qatar and United Arab Emirates (UAE)

SECTION E MEDICAL EVACUATION OPTIONS

You can add non-emergency medical evacuation to your plan, subject to a premium increase. See the 'Medical evacuation' section in your Benefits schedule for information on the cover this provides.

Do you wish to select this optional cover? ☐ Yes ☐ No

Archipelago CHI ESSENTIAL	adds USD 1,000 sub-limit
Archipelago CHI PLUS	adds USD 1,500 sub-limit
Archipelago CHI ELITE	adds USD 2,000 sub-limit

SECTION F DENTAL COVER OPTIONS

If you have chosen Archipelago CHI PLUS or CHI ELITE, you can choose to add routine and major restorative dental treatment to your plan, subject to a premium increase. See the 'Dental treatment' and 'Deductibles' sections in your Benefits schedule for information on the cover this provides and the coinsurance that applies.

Do you wish to select this optional cover? ☐ Yes ☐ No

Archipelago CHI PLUS	adds USD 150 sub-limit
Archipelago CHI ELITE	adds USD 750 sub-limit

SECTION G DEDUCTIBLES

Please tick the appropriate box below to select your annual excess or outpatient coinsurance amount.

Archipelago CHI plan	Annual Excess Amount	Outpatient Coinsurance Amount
CHI ESSENTIAL	☐ Nil ☐ USD 2,000 ☐ USD 5,000 ☐ USD 10,000	Not applicable
CHI PLUS	Not applicable	☐ 0% ☐ 10% ☐ 20% ☐ 30%
CHI ELITE	Not applicable	☐ 0% ☐ 10% ☐ 20% ☐ 30%

SECTION H ADD-ON PLANS AND BENEFITS

Do you want to add any of the following?

Maternity Plan	☐ Yes	☐ No	If yes, please proceed to Section H (i)
Travel Plan	☐ Yes	☐ No	If yes, please proceed to Section H (ii)
Personal Accident Plan	☐ Yes	☐ No	If yes, please proceed to Section H (iii)

Section H (i) Maternity Plan

The Maternity plan is available with Archipelago CHI PLUS and ELITE. The Maternity plan is only available with the same area of cover as your Archipelago CHI plan and for female members aged 18 to 44 at entry. Once you have reached the age of 46 during your plan year, your Maternity plan will not be renewed. Please see your Benefits schedule and Policy Wordings for full eligibility details.

Please select members to be covered under the Maternity plan.

☐ Planholder ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3

Please select the Maternity plan required.

Archipelago CHI PLUS	Area 1	Area 2 - 4
Maternity 75	N/A	☐
Maternity 150	N/A	☐

Archipelago CHI ELITE	Area 1	Area 2 - 4
Maternity 75	N/A	☐
Maternity 150	☐	☐

Please tick the appropriate box below to select your outpatient coinsurance amount.

☐ 0% ☐ 10% ☐ 20% ☐ 30%

Please answer the following question for all members to be covered under the Maternity plan:

M1. In the last five years, has anyone applying to be covered had any complications during pregnancy or childbirth? *Including, but not limited to, caesarean sections, ectopic pregnancies and pre-eclampsia.* ☐ Yes ☐ No

If the answer is 'Yes' to question M1, please also fill in the Additional medical information questionnaire under page 8 as applicable.

Section H (ii) Travel Plan

The Travel plan is available with all Archipelago CHI plans and provides worldwide cover. The maximum age at entry for the Travel plan is 79. Please see your Benefits schedule and your Policy Wordings for full eligibility details.

The Travel plan is only available with moratorium underwriting terms. Please read and sign the declaration below if you choose this add-on plan.

To select the Travel plan, please tick the appropriate box below:

Travel Plan ☐ Yes, planholder only ☐ Yes, planholder and all dependants

Travel add-on plan | Pre-existing medical conditions

You must read and sign this section if you have chosen the Travel plan.

Please read this declaration carefully before applying for any Travel plan. This plan is subject to moratorium underwriting terms as explained in the Policy Wordings. Please refer to benefit exclusion ET2 for the Travel 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 plan.

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

The Travel plan does not cover claims for, arising from or connected to a medical condition that, within the 24-month period before the date your trip is booked, or your date of joining as shown on your Certificate of Insurance, whichever is later, has one or more of the following characteristics:

- Clearly showed itself
- You had sign or symptoms of
- You asked for advice about
- You received treatment for
- To the best of your knowledge, you were aware that you had

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.

Planholder's Signature _____ Date (dd/mm/yyyy) _____

Section H (iii) Personal Accident Plan

The Personal Accident plan is available with all Archipelago CHI plans and provides worldwide cover. All members covered under the Personal Accident plan will have the same level of cover as the planholder. The maximum age at entry is 79. Please see your Benefits schedule and Policy Wordings for full eligibility details.

The Personal Accident plan provide cover for **managerial, clerical and administrative occupations only**. If your occupation puts you at greater risk of a bodily injury caused by an accident, the planholder must tell us. We will tell them if we agree to cover you and let them know any extra premium that will apply.

Please note that the Personal Accident plan benefits are only payable in relation to an accident that occurs during the plan year.

To select the Personal Accident plan, please tick the appropriate box below:

Personal Accident 85	☐ Yes, planholder only	☐ Yes, planholder and all dependants
Personal Accident 170	☐ Yes, planholder only	☐ Yes, planholder and all dependants
Personal Accident 255	☐ Yes, planholder only	☐ Yes, planholder and all dependants
Personal Accident 340	☐ Yes, planholder only	☐ Yes, planholder and all dependants
Personal Accident 425	☐ Yes, planholder only	☐ Yes, planholder and all dependants

SECTION I MEDICAL QUESTIONNAIRE

Please answer ALL questions in this section.

For the purpose of this application, diseases and disorders include any abnormality, injury, disability, illness or sickness, whatever the cause.

For the purpose of this application, medication includes the use of any substance:
- whatever the means of delivery, and
- whether or not a prescription is needed,

Including, but not limited to, vitamins, minerals and supplements, oral and injected medicines and drugs, suppositories, patches, creams, lotions, ointments, gels, drops, sprays and lozenges.

This does not include skin moisturisers, sun protection products, shampoo or mouthwash, unless used in relation to a symptom, disease or disorder.

If a medical professional has confirmed that you, or any of your dependants in this application, have a disease or disorder, we will treat this as a diagnosed medical condition, whether or not they have confirmed the diagnosis to you or your dependant in writing, and regardless of whether or not treatment, medication or a special diet was needed or received following the diagnosis. This includes diseases or disorders diagnosed as the result of routine health and wellness checks.

1. In the **last five years**, have you , or any of your dependants in this application:
   - needed or had any medical investigations, diagnostic tests or procedures for, or in relation,
   - been diagnosed with,
   - needed or received any treatment, medication or special diet for, or in relation to,
   - needed or had any follow-up consultations, tests or procedures for, or in relation to,

   any one or more of the following:

		Planholder		Dependant 1		Dependant 2		Dependant 3	
		Yes	No	Yes	No	Yes	No	Yes	No
1.1	Cancer?*	☐	☐	☐	☐	☐	☐	☐	☐
1.2	Cardiovascular diseases?**	☐	☐	☐	☐	☐	☐	☐	☐
1.3	Diabetes?	☐	☐	☐	☐	☐	☐	☐	☐

If the answer is 'Yes' for any part of question 1, please also fill in the additional Cancer, Cardiovascular diseases and disorders and Diabetes questionnaires as applicable.

2.	Were you, or any of your dependants in this application, diagnosed with any one or more of the following **more than five years ago**?								
2.1	Cancer?*	☐	☐	☐	☐	☐	☐	☐	☐
2.2	Cardiovascular diseases or disorders?**	☐	☐	☐	☐	☐	☐	☐	☐

If the answer is 'Yes' for any part of question 2, please also fill in the additional Cancer and Cardiovascular diseases and disorders questionnaires as applicable.

* *Including, but not limited to, bowel cancer, brain tumours, leukaemia, melanoma, myeloma and sarcoma.*

** *Including, but not limited to, hypertension or high blood pressure, hypertension or low blood pressure, hypercholesterolaemia or high cholesterol, abdominal aortic aneurysm (AAA), angina, atrial fibrillation (AF), stroke including transient ischaemic attack (TIA) and cerebrovascular accident (CVA), and supra ventricular tachycardia (SVT).*

3. In the **last five years**, have you, or any of your dependants in this application:
   - needed or had any medical investigations, diagnostics tests or procedures for, or in relation to,
   - been diagnosed with,
   - needed or received any treatment, medication or a special diet for, or in relation to,
   - needed or had any follow-up consultations, tests or procedures for, or in relation to any one or more of the following, that you have not already told us about in questions 1-2:

3.1	Diseases or disorders of the brain, nervous system or nerves? *Including, but not limited to, encephalitis, epilepsy, migranes, multiple sclerosis (MS), myalgic encephalomyelitis (ME), sciatica and trapped nerves.*	☐	☐	☐	☐	☐	☐	☐	☐

		Planholder		Dependant 1		Dependant 2		Dependant 3	
		Yes	No	Yes	No	Yes	No	Yes	No
3.2	Disease or disorders of the mouth, tongue, jaw, teeth or gums? *Including, but not limited to, abscesses, gingivitis, impacted teeth, temporomandibular joint (TLMJ) and tongue-tie.*	☐	☐	☐	☐	☐	☐	☐	☐
3.3	Diseases or disorders of one or both eyes or ears, the nose or throat? *Including, but not limited to, adenoids, blindness, cataracts, deafness, detached retina, deviated septum, glaucoma, glue ear, iritis, keratoconus, macular degeneration, otitis, sinusitis, tinnitus and tonsillitis.*	☐	☐	☐	☐	☐	☐	☐	☐
3.4	Diseases or disorders of one or both lungs, the trachea, bronchial tree or diaphragm? *Including, but not limited to, asthma, chest infections, chronic obstructive pulmonary disease (COPD), emphysema and tuberculosis (TB).*	☐	☐	☐	☐	☐	☐	☐	☐
3.5	Diseases or disorders of the oesophagus, stomach or duodenum? *Including, but not limited to, Barrett's oesophagus, duodenal ulcers, gastric ulcers, gastritis, gastro-oesophageal reflux disease (GORD) and oesophagitis.*	☐	☐	☐	☐	☐	☐	☐	☐
3.6	Diseases or disorders of the bowel, small intestine, appendix, large intestine, rectum or anus? *Including, but not limited to, anal fissures, colonic polyps, Crohn's disease, diverticulitis, haemorrhoids or piles, irritable bowel syndrome (IBS), pilonidal sinus and ulcerative colitis.*	☐	☐	☐	☐	☐	☐	☐	☐
3.7	Diseases or disorders of the liver, pancreas, spleen or gall bladder? *Including, but not limited to, enlarged spleen, gallstones, hepatitis and pancreatitis.*	☐	☐	☐	☐	☐	☐	☐	☐
3.8	Diseases or disorders of one or both kidneys, the bladder or urinary tract? *Including, but not limited to, cystitis, kidney stones, pyelonephritis, urinary tract incontinence, urinary retention and urinary tract infections (UTI).*	☐	☐	☐	☐	☐	☐	☐	☐
3.9	Diseases or disorders of the male reproductive system, genitals or prostate? *Including, but not limited to, balanitis, benign prostatic hyperplasia (BPH) or enlarged prostate, cryptorchidism or undescended testicles, erectile dysfunction, fertility and infertility, phimosis and prostatitis.*	☐	☐	☐	☐	☐	☐	☐	☐
3.10	Diseases or disorders of the female reproductive system, genitals or breasts? *Including, but not limited to, abnormal menstrual cycle or periods, abnormal PAP or smear test results, abnormal vaginal bleeding, endometrosis, fertility or infertility, fibroids, polycystic ovaries and uterine polyps.*	☐	☐	☐	☐	☐	☐	☐	☐
3.11	Diseases or disorders of the bones, body tissues, muscles, joints, cartilage, ligaments or tendons? *Including, but not limited to, back pain, cellulitis, fractured or broken bones, ganglions, gout, hallux valgus or bunions, joint pain, joint replacements, neck pain, osteoarthritis, plantar fasciitis, repetitive strain injuries (RSI), rheumatoid arthritis, slipped discs, sprains, tendonitis and tennis elbow.*	☐	☐	☐	☐	☐	☐	☐	☐
3.12	Diseases or disorders of the fingernails, toenails, hair or skin, including moles and birthmarks? *Including, but not limited to, alopecia, eczema, ingrowing toenails, moles that have changed in appearance, port-wine stains, psoriasis and venous ulcers.*	☐	☐	☐	☐	☐	☐	☐	☐

		Planholder		Dependant 1		Dependant 2		Dependant 3	
		Yes	No	Yes	No	Yes	No	Yes	No
3.13	Diseases or disorders of the blood or veins? *Including, but not limited to, anaemia, deep vein thrombosis (DVT), factor V Leiden, harmochromatosis, haemophilia and other blood clotting diseases or disorders, thalassaemia and varicose veins.*	☐	☐	☐	☐	☐	☐	☐	☐
3.14	Diseases or disorders of glands, including hormone imbalance? *Including, but not limited to, Addison's disease, hyperhidrosis or excessive sweating, hyperthyroidism, hypothyroidism and parathyroiditis.*	☐	☐	☐	☐	☐	☐	☐	☐
3.15	Hernias, lumps, cysts or benign tumours that you have not already told us about in question 3.1 – 3.14?	☐	☐	☐	☐	☐	☐	☐	☐
3.16	HIV or AIDS, auto-immune conditions of allergies that you have not already told us about in question 3.1 – 3.15? *Including, but not limited to, food allergies, insect allergies, lupus, myasthenia gravis and prescription drug allergies.*	☐	☐	☐	☐	☐	☐	☐	☐
3.17	Psychiatric, psychological or behavioural disorders? *Including, but not limited to, anxiety, attention deficit hyperactivity disorder (ADHD), depression, eating disorders and stress.*	☐	☐	☐	☐	☐	☐	☐	☐
4.	Do you, or any of your dependants in this application, have any one or more chronic, long-term or recurrent diseases or disorders that we have not asked you about in questions 1 – 3?	☐	☐	☐	☐	☐	☐	☐	☐
5.	In the **last two years**, have you, or any of your dependants in this application, had any abnormal test results that you have not already told us about in questions 1 – 4?	☐	☐	☐	☐	☐	☐	☐	☐
6.	Have you, or any of your dependants in this application, ever had any joint replacements that you have not already told us about in questions 1 – 4?	☐	☐	☐	☐	☐	☐	☐	☐
7.	Have you, or any of your dependants in this application, ever had any cosmetic treatment that you have not already told us about in questions 1 – 4?	☐	☐	☐	☐	☐	☐	☐	☐
8.	In the **last two years**, have you, or any of your dependants in this application, sought medical advice for any one or more symptoms***, but not had a disease or disorder diagnosed as a result of the advise?	☐	☐	☐	☐	☐	☐	☐	☐
9.	In the **last two years**, have you, or any of your dependants in this application, not sought medical advice for any one or more symptoms***?	☐	☐	☐	☐	☐	☐	☐	☐

*** *Including, but not limited to, abdominal pain, back pain, change in bowel habit, chest pain, dizziness, fainting, fatigue, joint pain, neck pain, persistent cough, rectal bleeding, recurrent headaches, shortness of breath and weight loss or gain.*

10.	In the **last two years**, have you, or any of your dependants in this application, regularly used any medication that you have not already told us about in questions 1 – 9?	☐	☐	☐	☐	☐	☐	☐	☐
11.	Are you or any of your dependants currently pregnant? If the answer is 'Yes' for any part of questions 3 – 10, please also fill in the Additional medical information questionnaire as applicable.	☐	☐	☐	☐	☐	☐	☐	☐

If the answer is 'Yes' for any part of questions 3 – 10, please also fill in the Additional medical information questionnaire as applicable.

Additional medical information

Name of applicant			
Question number			
What is the name of the disease or disorder (including joint replacements and cosmetic treatment), symptom(s) or complication(s) and when did it start? (dd/mm/yyyy)			
If you have ticked 'Yes' to question number 5, what abnormal test results have you had and when were they done? (dd/mm/yyyy)			
What treatment, medication or special diet have you been given? Please specify names of drugs and dosage required.			
What follow-up consultations, medical investigations, diagnostic tests or procedures are needed or have been recommended? Please give details including dates where necessary.			
Do you still have this disease or disorder (including joint replacements and cosmetic treatment), symptom(s), complications(s) or abnormal tests?			
What date did you last see any health care professional for this disease or disorder, (including joint replacements and cosmetic treatment), symptom(s), complication(s) or abnormal test? (dd/mm/yyyy)			
If you answered 'Yes' to question 10, what medication are you regularly using and why do you take it?			

SECTION J DOCTOR'S OR MEDICAL PRACTITIONER'S DETAILS

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

Applicant's name :		
Doctor's name :		
Hospital, Clinic of practice :		
Phone :	Fax :	
Email :		
Address :		
Country :		Postcode :

Please provide details in a separate page if your family are seen by more doctors than listed above, and confirm which members of your family each doctor has treated.

SECTION K PAYMENT OPTIONS

You can pay yearly, every three months or every month. We cannot accept payment by bank transfer 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 4% if you pay every three months).

To select how often you want to pay your premiums and your chosen payment method from the options available, please tick **ONE** of the appropriate boxes below.

	Credit / Debit Card	Bank Transfer
Yearly	☐	☐
Every three months	☐	N/A
Every month	☐	N/A

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 and late payments in your Policy Wordings.

Your premiums must be paid in USD.

SECTION L PAYMENT DETAILS

Credit / Debit Card

We can accept card payments by Visa, MasterCard or UnionPay. To make a payment please complete the Card Authorisation Form we give to you. Please make sure that your card is valid for at least six months from the start date of your plan. Please note that there will be Credit/Debit Card transaction fees and charges between 2%-4% which shall be borne by the Planholder/Cardholder.

Bank Transfers

Bank transfers must be in USD. 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 Insurance Limited' using the details below. To ensure that the full amount of the payment is received by us, please mark the bank transfer: BENEFICIARY TO RECEIVE IN FULL AND NETT AMOUNT.

Beneficiary :	Archipelago Insurance Limited (Non-Resident Account)
Beneficiary Address :	B-08-08, Gateway Corporate Suites, Gateway Kiaramas No.1, Jalan Desa Kiara, Mont' Kiara 50480 Kuala Lumpur
USD Account No :	1419 4101 0002 039
SWIFT Code :	MFBBMYKLXXX
Bank :	Alliance Bank Malaysia Berhad
Bank Address :	Unit A-OG-02, Block A, Plaza Mont' Kiara 2 Jalan Kiara Mont' Kiara 50480 Kuala Lumpur

SECTION M 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 Insurance Limited entities and its associates for the purposes of performance of the contract. Such personal data shall be governed by the personal data protection laws of that country. The planholder 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 organization 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 writing. 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 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. ☐

SECTION N DECLARATION

Full Medical Underwriting Declaration

You must ensure that all information provided is complete and accurate. If complete and accurate information is not provided we may not be able to cover a claim and we may cancel your plan. Please tell us about any change in the information given in this application which occurs between the date of signing and the date the cover commences. If you are unsure whether we need to know about a condition, you should tell us about it.

I declare that to the best of my knowledge and belief:
The information in this application and any additional information supplied is complete, true and correct. Where I have supplied medical information for any dependants to be included in this application, I confirm that I have checked with them that the information is correct and that I have their consent to provide this information on their behalf. I understand that no cover will apply for treatment of any medical condition or related medical condition which exists or has existed before the start date of the plan unless agreed and accepted by the insurer.

I also understand that Archipelago Insurance Limited will advise me of any medical conditions which they exclude from cover or for which a loading will be applied because of information I have provided to them. I consent to Archipelago Insurance Limited or its administrator contacting my doctor should further medical information be required to support my application, I also consent to Archipelago Insurance Limited or its administrator dealing with my broker, if one is appointed, and that they have authority to see medical information that I have declared in this application.

Additional Declaration

I am applying to be covered under the Archipelago CHI plan and any add-on 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 Policy Wordings, along with all eligible dependants included in this application or any dependants I enroll in the future after the start date of the plan. I confirm that I have authority to give Archipelago 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 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 Insurance Limited.

I authorise the doctor named in Section J 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 these plans.

I understand that if I do not provide the information asked for in Sections I and J, and I or any of my dependants included under these plans make a claim, which you view as being treatment for a pre-existing medical or related medical condition, the 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 Insurance Limited and any administrator acting on its behalf have 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 Insurance Limited. After reading all the terms and conditions and documents you have given me, I am satisfied that the products I have chosen meet my needs at this time.

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

Planholder Signature	Date (dd/mm/yyyy)	Dependant 1 Signature (if 18+)	Date (dd/mm/yyyy)
Dependant 2 Signature (if 18+)	Date (dd/mm/yyyy)	Dependant 3 Signature (if 18+)	Date (dd/mm/yyyy)

SECTION O CANCELLATION

If you feel a plan does not meet your needs, you may cancel it. You must tell us in writing within 15 days of receiving the Benefits schedule, Certificate of Insurance and Policy Wordings, or the date of joining, whichever is later. You must return the Certificate of Insurance when you cancel the plan. If the Archipelago CHI plan is cancelled, all Member ID Cards must also be returned. See the 'Cooling-off period' section in the Policy Wordings for full details.

SECTION P INTERMEDIARY DETAILS AND DECLARATION

Intermediary's details, if applicable

Intermediary Name :

Intermediary Company Name :

Email :

Office Tel. No. : Mobile No. :

I / We declare that:

- I / We are licensed Broker under Financial Services Act 2013 or Licensed Insurance Broker under Labuan Finance Services & Securities Act 2010 or any licensed intermediary under any applicable laws in foreign jurisdictions to render services in respect of this product.
- I / We have fully explained and disclosed the product details including features, benefits, risks relevant, terms and conditions to my/our Client.
- I / We have established and verified (Customer Due Diligence) the identity of my/ our client(s) in accordance with the Anti-Money Laundering, Anti-Terrorism Financing and Proceeds of Unlawful Activities Act 2001.

Signature of Authorised Intermediary : Date (dd/mm/yyyy) :

Archipelago Insurance Limited does not provide care or guarantee access to health services. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a health care professional. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change. For more information, refer to **www.archipelagogrp.com**.

If coverage provided by any insurance policy violates or will violate any UN or other applicable economic or trade sanctions, the coverage is immediately considered invalid. For example, Archipelago Insurance Limited cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the UN or other applicable economic or trade sanctions, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information on OFAC, visit **http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx**.

All plans are underwritten by Archipelago Insurance Limited.

Archipelago™
Insurance Limited

Archipelago Insurance Limited is licensed by Labuan FSA, Company No. LL09355, Licence No. IS2013163. Registered office address: Brumby Centre, Lot 42, Jalan Muhibbah, 87000 Labuan FT, Malaysia. Co-located office address: B-08-08 Gateway Corporate Suites, Gateway Kiaramas, No. 1 Jalan Desa Kiara, Mont Kiara, 50480 Kuala Lumpur, Malaysia. Phone : +603 6201 0491 Fax : +603 6201 0481
Email : customerservice@archipelagoltd.com Website : www.archipelagogrp.com