



Individual Application Form

Please complete the sections relevant to your application. Please note it is vital all relevant questions on this form are answered accurately and that all relevant information is disclosed.

SECTION A - Lead Applicants Details

Title	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Other: <input type="text"/>			
Forename(s)	<input type="text"/>			
Surname	<input type="text"/>			
Address	<input type="text"/>			
	<input type="text"/>			
Country of Residence	<input type="text"/>			
Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth	<input type="text"/> d <input type="text"/> d / <input type="text"/> m <input type="text"/> m / <input type="text"/> y <input type="text"/> y
Height (m)	<input type="text"/>		Weight (kg)	<input type="text"/>
Home Telephone	<input type="text"/>		Mobile	<input type="text"/>
E-mail	<input type="text"/>			
Home Country	<input type="text"/>			
Nationality	<input type="text"/>		Passport No.	<input type="text"/>
Elected Country (for elective medical transfer. Must be in same geographical area)	<input type="text"/>			

SECTION B - Plan Selection

UNDERWRITING METHOD

FMU (Full Medical Underwriting) – All the details of your medical history are required in the application form with this option. By choosing this option you will know exactly what you are covered for. If you or any of your dependents have a medical condition that is likely to recur or is ongoing, that condition (and anything related to it) may not be covered. You must complete underwriting 'Section F and G' of this Application Form. Pre-existing medical conditions will not be covered unless they are declared to and accepted by us in writing.

Date of Commencement	<input type="text"/> d <input type="text"/> d / <input type="text"/> m <input type="text"/> m / <input type="text"/> y <input type="text"/> y			
Core Programme Selected	Light <input type="checkbox"/>		Bright <input type="checkbox"/>	
Optional Extensions	Dental Care <input type="checkbox"/>		Outpatient Care <input type="checkbox"/>	
Geographical Cover*	Area 1 <input type="checkbox"/>	Area 2 <input type="checkbox"/>	Area 3 <input type="checkbox"/>	Area 4 <input type="checkbox"/>
Outpatient Care Deductible	Nil <input type="checkbox"/>	\$100 <input type="checkbox"/>	\$300 <input type="checkbox"/>	

***AREA 1** comprises the following countries: Albania, Andorra, Austria, Belarus, Belgium, Bosnia Herzegovina, Bulgaria, Channel Islands, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, Great Britain, Greece, Greenland, Hungary, Iceland, Ireland, all islands of the Mediterranean, Isle of Man, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Macedonia, Madeira, Malta, Moldova, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Romania, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, Ukraine, Vatican State.

AREA 2 comprises Area 1 countries plus the People's Republic of China (mainland China only, excluding Hong Kong, Macau, and Taiwan).

AREA 3 comprises all countries worldwide with the exception of the following: United States of America, Canada, Anguilla, Antigua & Barbuda, Aruba, Bahamas, Barbados, Bermuda, Cayman Islands, Cuba, Curaçao, Dominica, Dominican Republic, Dutch Antilles (including St. Maarten), Grenada, Guadeloupe, Haiti, Jamaica, Martinique, Puerto Rico, St. Kitts-Nevis, St. Lucia, St. Vincent, Trinidad & Tobago, Virgin Islands.

AREA 4 comprises all countries worldwide.

SECTION C - Other Applicant Details

Insert the names of your dependents that require cover at this time. If you have more than three dependents please use an additional Application Form.

Dependent 1

Forename(s)			
Surname			
Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth <input type="text" value="d"/> <input type="text" value="d"/> / <input type="text" value="m"/> <input type="text" value="m"/> / <input type="text" value="y"/> <input type="text" value="y"/>
Place of Birth	Country:	Town/City:	
Height (m)	<input type="text"/>	Weight (kg)	<input type="text"/>
Relationship to Lead Applicant			

Dependent 2

Forename(s)			
Surname			
Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth <input type="text" value="d"/> <input type="text" value="d"/> / <input type="text" value="m"/> <input type="text" value="m"/> / <input type="text" value="y"/> <input type="text" value="y"/>
Place of Birth	Country:	Town/City:	
Height (m)	<input type="text"/>	Weight (kg)	<input type="text"/>
Relationship to Lead Applicant			

Dependent 3

Forename(s)			
Surname			
Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth <input type="text" value="d"/> <input type="text" value="d"/> / <input type="text" value="m"/> <input type="text" value="m"/> / <input type="text" value="y"/> <input type="text" value="y"/>
Place of Birth	Country:	Town/City:	
Height (m)	<input type="text"/>	Weight (kg)	<input type="text"/>
Relationship to Lead Applicant			

I confirm that all dependent children live in my household, are dependent solely upon me for support, and, if aged 19 to 25, are in full-time education.

Signature of Lead Applicant	<input type="text"/>	Date	<input type="text" value="d"/> <input type="text" value="d"/> / <input type="text" value="m"/> <input type="text" value="m"/> / <input type="text" value="y"/> <input type="text" value="y"/>
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Name	<input type="text"/>
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SECTION D - Payment Details

Premium Payment Annual

We can accept payment in US Dollars, Pounds Sterling or Euros or in any other major local currency as agreed with us. Where the currency is other than US Dollars, the exchange rate must be provided by us. Your application will be processed on receipt of payment.

Premium payment must be received by the due date for cover to be effective.

Payment by Cheque

Please make your cheque payable to LAMP Insurance Company Limited

Payment by Bank Transfer

Please make your bank transfer payable to:

Beneficiary	LAMP Insurance Company Limited		
Account Number	60329686	Sort/Branch Code	40-05-15
Swift Code	MIDLGB22		
IBAN No.	GB77 MIDL 4005 1560 3296 86		
Name of the Bank	HSBC		
Address of the Bank	45 Milsom Street, Bath, BA1 1DU, United Kingdom		

Please ensure that your name is clearly stated on the bank transfer as the originator

Payment by Credit Card

Card Type	<input checked="" type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD <input type="checkbox"/>
Card Number	<input type="text"/>
Issue Date (if applicable)	<input type="text"/> m <input type="text"/> m / <input type="text"/> y <input type="text"/> y
Expiry Date	<input type="text"/> m <input type="text"/> m / <input type="text"/> y <input type="text"/> y
Security (CVC) Code*	<input type="text"/>

* Last 3 digits in the signature field on the back of the card

Name (as appears on the card)	<input type="text"/>
Billing Address	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
	Postcode <input type="text"/>

- I authorise LAMP Insurance Company Limited to debit my card account with unspecified amounts in respect of my current and renewal premium payments as and when these become due, until further notice. I understand that LAMP Insurance Company Limited will give me due notice of renewal and that the premiums may vary each year.

Cardholders Signature	<input type="text"/>	Date	<input type="text"/> d <input type="text"/> d / <input type="text"/> m <input type="text"/> m / <input type="text"/> y <input type="text"/> y
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SECTION E - Banking Details (For reimbursement of any claims)

Currency of Account	<input checked="" type="checkbox"/> Pound Sterling £ <input type="checkbox"/> USD \$ <input type="checkbox"/> Euro € <input type="checkbox"/> Other:		
Name of Bank	<input type="text"/>		
Address	<input type="text"/>		
	<input type="text"/>		
Postcode	<input type="text"/>	Country	<input type="text"/>
Account Number	<input type="text"/>	Sort Code	<input type="text"/>
Swift Code	<input type="text"/>		

SECTION F - Statement of Health for Individual Application

Please answer YES or NO. If Yes, please specify details in the space provided on the following page. All information supplied will be treated in strict confidence. All material facts including those relating to these questions must be disclosed. Failure to do so may invalidate the policy. A material fact is information that would be likely to influence the insurer's assessment and acceptance of this Application Form. If you are in any doubt whether a fact is material then it should be disclosed.

	Lead Applicant	Dependent 1	Dependent 2	Dependent 3
Is any individual pregnant?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Are any inpatient or outpatient medical/surgical or dental procedures or oral surgery (including diagnostic testing) recommended/contemplated?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Is any individual currently taking medication?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Does any individual use tobacco products?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Has any individual been examined by or consulted with a physician or doctor or received any medical treatment in the last 5 years? (routine check ups, minor ailments (coughs and colds) of a non-chronic and non-recurring nature can be ignored)	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Has any individual ever been denied medical, dental, optical or disability coverage or been quoted anything other than standard terms for them?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

Within the last ten years has there been any disease/impairment of or any treatment for any of the following (ignore diagnostics with a negative outcome)? If Yes, please give the disease/impairment, year of onset, duration and treatment details in the space provided on the following page.

	Lead Applicant	Dependent 1	Dependent 2	Dependent 3
AIDS/HIV	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Alcoholism/Substance Abuse	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Arthritis	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Asthma	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Back/Neck/Spine	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Blood Vessels/Heart	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Bones	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Brain/Head	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Cancer	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Carpal Tunnel Syndrome	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Diabetes	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Ears/Eyes	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Epilepsy	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Gastrointestinal Disorder/Intestines	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Hereditary Disorders	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Hernia	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Immune System Disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Kidney/Bladder	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Liver	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Lungs	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Mental/Nervous Disorder/Nervous System	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Paralysis	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Reproductive System Disorder	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Rheumatic Fever	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Seizures	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Sexually Transmitted Infections	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Skin	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Stroke/Blood Pressure/Hypertension	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Surgical Operation	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Thyroid	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Tumor/Growth	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Ulcer	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

SECTION G - Statement of Oral Health (Only complete this section if you have selected the Dental Care Optional Extension)

Please indicate if there is an oral/dental condition needing treatment by any individual requesting coverage.

	Lead Applicant	Dependent 1	Dependent 2	Dependent 3
Routine dental examination in the last year?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Any fillings needed?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Any crowns needed?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Any denture/bridgework/implant needed?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Missing teeth needing replacement?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Damaged teeth needing repair?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Gum problem needing treatment?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Root canal treatment needed?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Any teeth needing extraction?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Periodontal disease needing treatment?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Orthodontic treatment needed?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

Use this space to complete extra information required for Section F or G. Continue on a separate sheet of paper if there is insufficient space.

SECTION H - Data Protection

LAMP Insurance Company Limited assures you that all your personal and medical information will be held in strictest confidence and in accordance with applicable legislation. Personal data may be passed to other companies with the LAMP Group or given to third party providers in relation to services which we provide to you, and may be transferred by electronic or other means. You have a right to know what information is held about you, and to amend or delete any data we hold which is inaccurate or out-of-date.

SECTION I - Declaration

- I hereby apply for membership to the LAMP International Healthcare Plan.
- I accept the benefits terms conditions and limits provided for in the terms of the insurance policy and I agree to be bound by such terms.
- I understand that this Application is subject to written acceptance by LAMP Insurance Company Limited.
- I confirm the correctness of the statements and information contained in this application and confirm the correctness of all other documents submitted now or in the future concerning this application. This clause will constitute a condition precedent to the payment of the benefits provided for in the terms of the Plan. We accept that LAMP Insurance Company Limited will be relying on such statements and information when agreeing to accept this application. LAMP Insurance Company Limited reserves the right to investigate where uncertainty exists about the validity of information provided.
- I, the applicant and the listed dependents, agree to being called upon to submit such medical examinations and tests as LAMP Insurance Company Limited deems necessary.
- I acknowledge that LAMP Insurance Company Limited reserves the right to cancel the membership of this Plan if any amount due is not paid by or on the due date concerned.
- I agree to give LAMP Insurance Company Limited immediate written notice should any changes material to the assessment of this application occur before the date upon which LAMP Insurance Company Limited grants written acceptance. This will give LAMP Insurance Company Limited the opportunity to reconsider the terms of acceptance.
- **AUTHORISATION:** To all physicians/hospitals/healthcare institutions/insurers/medical or hospital service providers/employers: You are authorised to provide LAMP Insurance Company Limited information concerning healthcare, advice, treatment, supplies, absence (including those related to mental illness and/or AIDS/ARC/HIV) relating to me or any members of my family for whom coverage has been requested. This information will be used to determine eligibility for coverage. This authorisation will be valid for twenty four months from the date of signature of this form.

Signed

Date

 / /

Name

Please return this questionnaire to your broker/intermediary, or to:

Healthcare Underwriting Department
LAMP Insurance Company Limited
260/262 Main Street
Gibraltar

Email: healthcare@lampinsurance.com

LAMP Insurance Company Limited, 260/262 Main Street, Gibraltar
Tel: +350 200 51904

LAMP Insurance Company Limited is licensed by the Chief Executive of the
Financial Service Commission of Gibraltar under the Insurance Companies Ordinance
Registered Address: 260/262 Main Street, Gibraltar
Company Number: 93562
Email: info@lampinsurance.com
Web: www.lampinsurance.com