



Cigna Global Health Options

Policy amendment form



Please complete this application and return the FULL form to your Cigna Healthcare representative.

APPLICANT DETAILS

Policy holders name	
Policy number	

HOW WE USE YOUR INFORMATION

We will collect, use, store, and disclose your personal information, including sensitive information (in particular, information relating to your medical history and any medical treatment you may have or have had), in accordance with relevant data protection legislation. We collect and will use your personal information, including sensitive information, for the purpose of carrying out our obligations under this plan. We may share your information, including sensitive information, with other Cigna companies and authorised healthcare providers, where necessary to carry out our obligations under this plan. This statement also applies to personal information of any beneficiaries detailed on this application form. You have the right to request a copy of your personal information held by us, and beneficiaries under your policy have the right to request a copy of personal information we hold about them. We may charge a fee to provide this information.

POLICY AMENDMENTS

	Change?			Select new plan design Please tick all selections you would like on your plan going forward.				
Product Close Care/Silver/Gold/Platinum Choice of product can only be changed at renewal.	Yes		No		Close Care	Silver	Gold	Platinum
Area of Cover Worldwide including USA / Worldwide excluding USA	Yes		No		Worldwide including USA		Worldwide excluding USA	
Module(s) for Silver, Gold, Platinum Policies	Yes		No		Outpatient Health & Wellbeing		Medical Evacuation Vision & Dental	
Module(s) for Cigna Close CareSM	Yes		No		Outpatient and Wellness		Dental Care and Treatment	

Please Note: If you are seeking to add only the Health and Wellbeing module for Silver, Gold or Platinum policies, there is no requirement to complete the health questionnaire. If you are seeking to add only the Vision & Dental module, please complete only Question 6 of the health questionnaire. For all other changes to your policy please complete the health questionnaire in full.

REASONS FOR CHANGING YOUR COVER?

Can you please tell us why you need to make these changes?	
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INTERNATIONAL MEDICAL INSURANCE PLAN

Deductible, cost share and out of pocket maximum amendments can only be made at renewal.

Do you wish to change your core deductible/cost share?	Yes	No					
Choose your deductible For further information relating to deductibles / cost-share please see Customer Guide	\$0	\$375	\$750	\$1,500	\$3,000	\$7,500	\$10,000
	€0	€275	€550	€1,100	€2,200	€5,500	€7,400
	£0	£250	£500	£1,000	£2,000	£5,000	£6,650
Then, select your cost share percentage	No cost share		10%	20%	30%		
Choose your out of pocket maximum (This is the maximum amount of cost share under International Medical Insurance plan you must pay in the event of a claim or claims per period of cover)						\$2,000	\$5,000
						€1,480	€3,700
						£1,330	£3,325

INTERNATIONAL OUTPATIENT - OPTIONAL MODULE

Deductible, cost share and out of pocket maximum amendments can only be made at renewal.

Do you wish to change your core deductible/cost share?	Yes	No				
Choose your deductible For further information relating to deductibles / cost-share please see Customer Guide	\$0	\$150	\$500	\$1,000	\$1,500	
	€0	€110	€370	€700	€1,100	
	£0	£100	£335	£600	£1,000	
Cost share after deductible (a \$3,000 / €2,200 / £2,000 out of pocket maximum is applied to cost shares on International Outpatient)						
		No cost share	10%	20%	30%	

POLICY HOLDER DETAILS									
Title		First Name		Other Initials		Surname			
Height: Feet		Inches		Centimeters		Weight: Stones		Pounds	Kilogrammes
Has the beneficiary smoked, vaped or used tobacco or nicotine replacement products in the last 12 months?								Yes	No
If Yes, how many per day?				Less than 20 per day	20 or more per day	Other			

BENEFICIARY 1 DETAILS									
Title		First Name		Other Initials		Surname			
Height: Feet		Inches		Centimeters		Weight: Stones		Pounds	Kilogrammes
Has the beneficiary smoked, vaped or used tobacco or nicotine replacement products in the last 12 months?								Yes	No
If Yes, how many per day?				Less than 20 per day	20 or more per day	Other			

BENEFICIARY 2 DETAILS									
Title		First Name		Other Initials		Surname			
Height: Feet		Inches		Centimeters		Weight: Stones		Pounds	Kilogrammes
Has the beneficiary smoked, vaped or used tobacco or nicotine replacement products in the last 12 months?								Yes	No
If Yes, how many per day?				Less than 20 per day	20 or more per day	Other			

BENEFICIARY 3 DETAILS									
Title		First Name		Other Initials		Surname			
Height: Feet		Inches		Centimeters		Weight: Stones		Pounds	Kilogrammes
Has the beneficiary smoked, vaped or used tobacco or nicotine replacement products in the last 12 months?								Yes	No
If Yes, how many per day?				Less than 20 per day	20 or more per day	Other			

DECLARATION FOR ALL CUSTOMERS									
Please note - We require you to disclose every aspect of the medical history for the beneficiary. This includes telling us about any changes to any medical conditions, treatment or medication and any outstanding, ongoing or repeat medical tests that have been suggested. If any applicant fails to inform us about a condition which we reasonably believe to have existed prior to the policy initial start date or the effective date of the change to the policy (whether the condition was already present, the applicant had symptoms, or taken advice from a medical practitioner); this could (subject to local law and regulation) result in us reducing the amount of any claims payment, which the applicant is due or in refusing to pay a claim or claims related to such condition altogether. You warrant and represent that you have each covered person's consent to disclose the personal information, including the sensitive personal information (e.g. medical information) contained in this form to us. You confirm that each covered person is aware of their duty to take reasonable care to answer questions accurately, honestly, completely and to the best of their knowledge. (Please note that if you are declaring the above on another person's behalf, it is your obligation to keep evidence of the consent you are providing hereto of your covered family members' actual declarations and consents.)									
Consent obtained (internal use only)					Date				
Policy Holder's Signature								Date	

Please tell us about past and present medical history for yourself and ALL other persons to be covered under the policy. We may need to contact you for further information before we can finalise your cover. If you need help completing this form, please let us know. If you are answering on someone else's behalf, we expect you are able to do so accurately. If you are unsure about the answer to any question you should make the enquiries necessary to allow you to provide an accurate answer.

Careless misrepresentation could result in Cigna;

- applying exclusions, rejecting claims, and/or cancelling cover.

Deliberate misrepresentation could result in Cigna;

- cancelling cover, retaining premiums and recovering costs of paid claims. Please note, even if you have disclosed any medical information up to this point, including on any call or correspondence, you are still required to disclose this information again when answering the following medical questionnaire.

		Yes	No
1	Has any applicant had symptoms of, been diagnosed with or had treatment for Cancer or Tumour, Heart Condition, Stroke, Brain, Neurodevelopmental or Neurological Disorders, Diabetes, Hepatitis or any Musculo-skeletal condition?		
2	Has any applicant had symptoms of, been diagnosed with or had treatment for any Liver, Kidney or Lung problem, Gastrointestinal problem, Urinary, Gynaecological or Prostate condition, Mental Health condition or any Drug or Alcohol misuse or dependence?		
3	Apart from what you have already told us, is any applicant taking any medication or receiving any treatment for a medical condition?		
4	Are any applicants awaiting any test results, treatment or investigations or expect to have a review or follow up for any current or past medical problem not already mentioned?		
5	Does anyone have any illness, condition or symptom not already mentioned? Please include details of any known or suspected issues whether or not medical advice has been sought or a diagnosis reached.		
6	Is any applicant experiencing any dental problems or symptoms, receiving or expecting to undergo any dental treatment?		
7	Is anyone on the plan currently pregnant?		

If you have answered "Yes" to any of the 7 Health Questions, please provide details below. If you are unsure that any details are relevant, please include them anyway. If you run out of space, please use the Additional Information section.

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