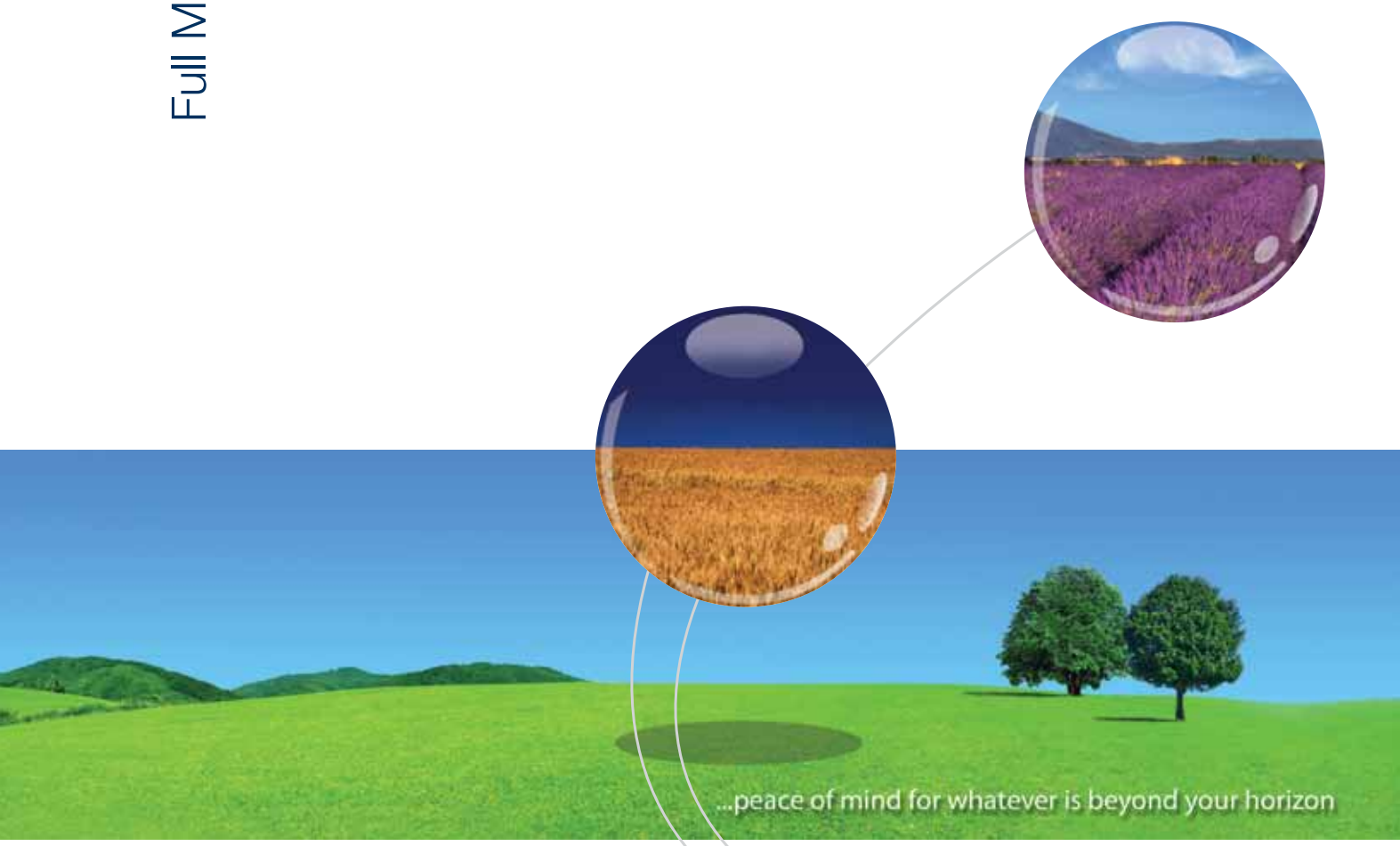
Private Client

Full Medical Underwriting Application

Prima Premier

Prima Classic

your health **your** choice **your** plan



aLC
GLOBAL HEALTH INSURANCE

Details of Policyholder

Please print clearly in capital letters

Title (Mr/Mrs/Ms/Miss/Other)		First Name	
Other Initials		Surname	
Residential Address			
		Postcode	
Country			
Correspondence/Postal Address (if different from above)			
		Postcode	
Email address			
Telephone Number Home		Office	
Mobile		Fax	

Details of all persons to be covered

Please enter the details of all persons to be covered under this policy, including the policyholder if applicable. (This can include your spouse/partner and any children under the age of 25 years of age who are permanently living with you or in full time education.)

	1st Person	2nd Person
Title (Mr/Mrs/Ms/Miss/Other)		
First Name		
Other Initials		
Surname		
Gender		
Date of Birth dd/mm/yy		
Relationship to Policyholder		
Occupation		
Nationality		
Country of Residence		

	3rd Person	4th Person
Title (Mr/Mrs/Ms/Miss/Other)		
First Name		
Other Initials		
Surname		
Gender		
Date of Birth dd/mm/yy		
Relationship to Policyholder		
Occupation		
Nationality		
Country of Residence		

If there is insufficient space on this form, please supply details on a separate sheet and attach it to this Application.

Cover required

Please tick to indicate your preferred plan:

Prima Premier ☐ Prima Classic ☐

Please tick to indicate the level of cover you require:

Prima Premier		Prima Classic	
In-patient/day-patient Treatment	✓	In-patient/day-patient/ out-patient Treatment	✓
Out-patient Treatment	☐		
Routine Pregnancy & Childbirth		**Routine Pregnancy & Childbirth**	
Limited to £3,000: €3,600: US$4,500	☐	Limited to £3,000: €3,600: US$4,500	☐
Limited to £5,000: €6,000: US$7,500	☐	Limited to £5,000: €6,000: US$7,500	☐
Limited to £7,500: €9,000: US$11,250	☐		
Limited to £10,000: €12,000: US$15,000	☐		
Dental Treatment	☐	Dental Treatment	☐
Evacuation or Repatriation	☐	Evacuation or Repatriation	☐

The level of cover selected can be amended at any renewal date.

Area of Cover

Area 1 ☐ Europe **Area 2** ☐ Worldwide excluding USA **Area 3** ☐ Worldwide

Currency

Please tick one currency in which you wish to pay your premium. You will also receive your benefits in this currency.

Sterling (£) ☐ Euro (€) ☐ Dollars (US$) ☐

Policy excess

Our Prima Premier and Prima Classic have a standard policy excess of £150: €180: US$225 which applies per person per policy year to both in-patient and out-patient expenses. You can amend this by ticking an alternative excess as detailed below. If no box is ticked then the policy will be issued with the standard excess. The policy excess currency must be the same as detailed above.

(standard policy excess £150: €180: US$225)

☐ Nil	☐ £50	☐ £300	☐ £500	☐ £1,000	☐ £2,500	☐ £5,000	☐ £7,500
☐ Nil	☐ €60	☐ €360	☐ €600	☐ €1,200	☐ €3,000	☐ €6,000	☐ €9,000
☐ Nil	☐ US$75	☐ US$450	☐ US$750	☐ US$1,500	☐ US$3,750	☐ US$7,500	☐ US$11,250

Method of payment

Premiums are payable Annually, Quarterly or Monthly. Please tick which method you wish to use.

☐ Annually By Credit / Debit Card, Cheque or Bank Transfer (Details to be provided upon acceptance)

☐ Quarterly By Credit / Debit Card (or Direct Debit sterling bank accounts only with a valid UK sort code)

☐ Monthly By Credit / Debit Card (or Direct Debit sterling bank accounts only with a valid UK sort code)

All cheque payments must be in favour of **AXA PPP-ALC Health**. ALC Health do not accept liability for any payments made by other methods or for any payment which does not clearly identify the policyholder.

If you wish to pay your premiums by credit card, debit card or DDM, annually, quarterly or monthly, at your policy renewal date we will automatically collect your premium from the card details already notified to us or by DDM, unless you instruct us to the contrary. If you have chosen to pay by credit /debit card please supply the following information:

Card Type AMEX ☐ MasterCard ☐ Delta ☐ Switch ☐ VISA ☐

Card Number _____ Name on Card _____

Address# _____

_____ Postcode _____

Issue Date (mm/yy) _____ Expiry Date (mm/yy) _____

Switch Issue Number* _____

Address to which card registered (if different from Residential Address)

* This is the number on the front of SWITCH cards.

Confidential Medical History

Please answer all the questions in full and to the best of your knowledge and belief.

If you have any doubts whether something may affect how we deal with your application (we call these material facts), you should include it as your policy may be invalid if you fail to disclose any material facts.

If for any reason you do not answer a question, we shall take that as meaning you have nothing to disclose. You do not need to tell us about any genetic test results.

Please note, once you have joined ALC Health, we do not pay for treatment of any medical condition (or treatment of any medical condition arising from or associated with such a medical condition) which you already had when you joined and which you should have told us about.

This applies if you did not tell us at all or did not tell us everything. On the information provided we may, or may not exclude the medical condition.

This includes any such medical condition(s) or symptoms, whether or not being treated and any previous medical condition(s) which recurs or which you should reasonably have known about even if you had not consulted a doctor.

Please give details of all those individuals who answer 'Yes' to any questions.

Please note: You are advised to keep a record of all information supplied in connection with this application, including any letters you send to us. If you would like a copy of this application form please let us know within three months.

Section A. You must declare your medical history even if you have been insured with us or anyone else before.

A 1. Have you or any members of your family (if included in this application) consulted with a medical practitioner, been admitted to hospital or nursing home, or suffered from an intermittent or recurring illness during the last five years?

Applicant member	1st family member	2nd family member	3rd family member	4th family member
Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

A 2. Have you or any members of your family (if included in this application) consulted with a medical practitioner in the past year?

Applicant member	1st family member	2nd family member	3rd family member	4th family member
Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

A 3. Have you or any members of your family (if included in this application) had any medical condition, disability or health problem, not mentioned above, whether or not a doctor has been consulted, for example, gynaecological or menstrual problems, complications of pregnancy, signs or symptoms of varicose veins, back trouble, joint disorders, joint replacements, foot problems (eg bunions), indigestion or bowel problems, abdominal pain, skin problems, allergies, anxiety, depression or other psychiatric problems, trouble with heart, limbs, ears, eyes, urination etc, and is there any other information which you should, in good faith, disclose?

Applicant member	1st family member	2nd family member	3rd family member	4th family member
Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Section B. Additional information (Please continue on a separate sheet if necessary. Tick this box if attached ☐)

B.1 If you have answered yes to any of the questions in part A please give full details here or anything else you should disclose to us in good faith.

Section no. | Name of patient | Nature of illness

Period of illness

Month Year | Duration | Present state of health in this respect

Section no. | Name of patient | Nature of illness

Period of illness

Month Year | Duration | Present state of health in this respect

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Period of illness

Month Year | Duration | Present state of health in this respect

You must declare any condition you or any applicant has had during your/their lifetime which may have an impact on your/their future health. If you are in any doubt as to whether a condition may be relevant to this application, you must declare it in good faith.

Commencement date

Date on which you wish this policy to commence.

Day | Month | Year

Cover under this policy cannot commence until such time as we receive and accept this Application Form.

If you wish your cover to commence at a future date, you must notify us of any material change to the information provided in this Application Form. You cannot apply for cover to commence more than 60 days in advance of completion of this Application Form.

Data Protection Act 1998

We and the underwriters, AXA PPP International, will collect certain information about you in the course of considering your application and, if a policy is issued to you, conducting our relationship with you. This information will be processed for the purposes of underwriting your insurance coverage, managing any policy issued and administering claims. Your information may be passed to Underwriters, Medical Practitioners, Medical Assistance Companies and Claims Administrators for these purposes. This may involve the transfer of your information to countries that do not have data protection laws. The same duty of confidentiality is required of any third parties to whom the administration of your policy may be subcontracted. Your name and contact details will not be disclosed to other organisations (except as stated above).

You may have a right of access to, and correction of, information that we hold about you. Please contact us if you would like to exercise either of these rights. Some of the information we collect about you may be classified as 'sensitive' – that is information about racial or ethnic origin and physical or mental health. Data protection laws impose specific conditions in relation to sensitive information, including in some circumstances the need to obtain your explicit consent before we process the information. By signing this proposal form you consent to the processing and transfer of information (including sensitive information) described in this notice. Without this consent we will not be able to consider your application.

Declaration by Policyholder

1 I have received and read the full Definitions, Benefits, Exclusions and Conditions of this Policy including General Condition 7 relating to Governing Law. I understand that the Application Form, Certificate of Insurance and the Policy Wording make up the contract between us and all form part of the policy. I am aware that cover shall be provided in accordance with the policy. (General Exclusion 1 relating to Pre-existing Conditions is not applicable to full medical underwriting terms. Any personal exclusions will be stated on your Certificate of Insurance).

2 I declare that the information given in this Application is true and complete in respect of all persons to be covered under the policy, including all answers given which are not in my own handwriting. I understand that it is unlawful for me or my dependants to knowingly provide false, incomplete or misleading facts or information for the purposes of defrauding or attempting to defraud AXA PPP International.

3 I understand that if I am not satisfied with the content of this policy, I may cancel the insurance within 14 days of the completion of this contract as set out in the Policy Wording.

4 If I have indicated that I wish to pay by credit/debit card or DDM, I authorise à la carte healthcare limited to debit my account up to 4 days in advance of the collection/renewal date with the appropriate premium, and all subsequent renewal premiums due as notified until I give written notice that I wish to terminate this Agreement. I understand that à la carte healthcare limited cannot be liable if my policy is lapsed should the credit/debit card or DDM be declined and I do not respond to requests for alternative methods of payment within 7 days.

5 I have read the Data Protection Act 1998 notice as contained in this Application Form.

Signature | Date

I wish to receive all policy documentation and future correspondence electronically from ALC Health ☐

Agency Name

Agency Number

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