Global health plan

Underwritten by AXA PPP healthcare Limited

Individual application form

Plan Transfer

If you are completing this form by hand, please use BLACK INK and write in BLOCK CAPITALS throughout

To help speed up your application, please give us your quotation number if relevant
This can be found on your quote letter

Q

If you have ever held an AXA PPP International or AXA PPP healthcare policy, please also give us your membership (or customer) number
This can be found on your membership card

1 About the policy

For full details on the different types of cover available, optional upgrades you may include and excess levels, please refer to axaglobalhealthcare.com or ask your Intermediary.

1.1 On what date would you like cover to start?
If you want the policy to start immediately, it can be back-dated to the day that you apply, provided it is within 3 weeks of us receiving your application.

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1.2 What type of cover do you require?

i Choose one type of cover only and tick any optional upgrades you wish to include.

Different optional upgrades are available depending on the type of cover and will apply to all members covered by this policy.

- ☐ **Prestige Plus**
- ☐ **Prestige** ☐ Dental cover
- ☐ **Comprehensive** ☐ Dental cover ☐ Travel insurance
- ☐ **Standard** ☐ Out-patient treatment ☐ Travel insurance

1.3 Do you need the policy to cover treatment in the USA?

☐ No ☐ Yes

1.4 In what currency would you like to pay your premium?

i Choose one currency only

☐ £ Sterling ☐ $ US Dollar ☐ € Euro

1.5 What excess level do you require?

i Choose one level of excess only

Excess will be applied in the same currency that you have selected to pay your premiums in question 1.4

☐ **No excess**			
☐ **Level 1**	£100	$160	€125
☐ **Level 2**	£250	$400	€320
☐ **Level 3**	£500	$800	€640
☐ **Level 4**	£1,000	$1,600	€1,275
☐ **Level 5**	£2,000	$3,200	€2,550

The following levels of excess are available on Standard plans without the out-patient optional benefit only:

☐ **Level 6**	£5,000	$8,000	€6,375
☐ **Level 7**	£10,000	$16,000	€12,750

Notes to help you with your application

We aim to make it as easy as possible for you to apply for your health insurance, so please read the following notes before you start. If you have any questions, please contact your Intermediary or call our helpline on **+44 (0) 1892 508 800** and we'll be pleased to help you. Lines are open Monday to Friday, 8am to 5pm (UK time).

Please be aware of the following points before you start to complete this form

Your policy will be underwritten by AXA PPP healthcare Limited ("AXA PPP"). AXA Global Healthcare (UK) Limited is acting on behalf of AXA PPP for the purpose of accepting and administering this policy.

- ✕ **Please do not use this form** if you are switching from another insurer, or if you have chosen to be Fully Medically Underwritten or Moratorium underwriting on your policy.
- Please take care to provide accurate and complete answers to all questions for all members who are to be insured under this plan. This will help avoid any delay in processing your application.
- If you don't answer truthfully and accurately, it will very likely mean that a claim will be declined and your policy may be cancelled.
- The person named in 2 **About the Policyholder** will be the Policyholder and legal owner of this policy. If this policy is for a child or children only, the person named in 2 **About the Policyholder** will not be entitled to cover under this policy.
  Please make sure you have permission to advise us of all the medical details for all family members you wish to add to this policy.

Please be aware of the following points before you start to complete this form

- If you are completing this form by hand, please use **BLACK INK** and write in **BLOCK CAPITALS** throughout
- If you are completing this form digitally, please print it out once completed and sign the 7 **Declaration** before returning it to us
- If you have an Intermediary who is going to complete this form on your behalf using the information you have provided, you must read all of the questions and answers carefully before signing 7 **Declaration** at the end. Your Intermediary is acting on your behalf in this respect.
- If you need extra space, please use 6 **Additional Information**

To complete this application form you will need

- Details of medication or treatment that you or anyone else to be insured on this policy are currently and have received within the last five years.
- Your payment details.

Once you've completed your application

- Please check your details carefully and make sure you have signed and dated the 7 **Declaration**.
- Completed applications can be emailed to us at intsales@axa.com, however we can't accept digital signatures so you must print, sign and scan 7 **Declaration**.
- Return the completed form to us at
  AXA Global Healthcare (UK) Limited, Forest Road, Tunbridge Wells, Kent, TN2 5FE, UK.
- Please keep a record of all information supplied in connection with this application, including any letters you send us. We can send you a copy of this application, providing you let us know within three months.

Definitions of words and phrases

Some of the words and phrases we use on this form have a specific meaning, for example when we talk about treatment.

You and your when we use you and your, we mean the policyholder and any family members covered by your policy.

We, us and our when we use we, us or our, we mean AXA Global Healthcare (UK) Limited acting on behalf of AXA PPP healthcare Limited.

2 About the Policyholder

Please remember to use **BLACK INK** and write in **BLOCK CAPITALS** throughout

2.1 Full name and title

Please ensure you give all middle names.

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

☐ Other – please state

Forename(s) and middle name(s) in full

Surname

2.2 Sex

☐ Male ☐ Female

2.3 Date of birth

D D M M Y Y Y Y

2.4 Nationality

2.5 What is the Policyholder's principal country of residence?

This is the address where all members covered will live for most of the year once this policy has started.

2.6 Occupation

2.7 Correspondence address

This is where we will send the policy documents.

Please give full address details, including postal code and country where applicable.

Postcode

Country

2.8 Contact details

Please include country and area codes, where applicable.

Telephone (Daytime)

Telephone (Evening)

Email

3 Additional family members to be covered

3.1 Children must be living at the same address as the policyholder to be included on this plan.

☐ If this plan is only for a child or children and does not include you please tick this box.

Please note: By ticking this box you confirm that you will not be entitled to cover under this policy.

3.2 Do you wish to add any family members to the policy?

Family members can include the Policyholder's:

- spouse/partner
- any children.

☐ **No** ▶ Go to 4 **Confidential medical history**

☐ **Yes** Give details of all family members below.

If you need to add more than four family members, please use 6 **Additional Information**

3.3 Family members to be covered

i All members covered by this policy must have the same principal country of residence and residential address.

If the family member is still at school/college, please give 'student' as their occupation.

Family member 1

Full name and title

Relationship to the Policyholder

Sex ☐ Male ☐ Female

Date of birth D D M M Y Y Y Y

Nationality

Principal country of residence

Occupation

Family member 2

Full name and title

Relationship to the Policyholder

Sex ☐ Male ☐ Female

Date of birth D D M M Y Y Y Y

Nationality

Principal country of residence

Occupation

Family member 3

Full name and title

Relationship to the Policyholder

Sex ☐ Male ☐ Female

Date of birth D D M M Y Y Y Y

Nationality

Principal country of residence

Occupation

Family member 4

Full name and title

Relationship to the Policyholder

Sex ☐ Male ☐ Female

Date of birth D D M M Y Y Y Y

Nationality

Principal country of residence

Occupation

4 Confidential medical history

You must take reasonable care to provide accurate and complete answers to all questions.

If you do not take reasonable care and the information provided by you is inaccurate or incomplete then depending on the circumstances, we may take one or more of the following actions:

- Cancel your policy
- Declare your policy void (treating your policy as if it had never existed)
- Impose different terms to the cover; or
- Refuse to deal with all or part of any claim or reduce the amount of any claim payments.

We may ask you to provide further information and/or documentation to ensure that the information you provided when taking out, making changes to or renewing your policy was accurate and complete.

Please do not assume that we will carry out any searches, check our records or contact any other person to check the answers to any of the questions on this proposal form or any of the information provided in response to these questions. It remains your responsibility to complete the proposal form and check that the information within it is accurate and complete.

Please note: By treatment we mean surgical or medical services (including medication) that are needed to diagnose, relieve or cure a disease, illness or injury.

4.1 **Have you or anyone else to be insured on this policy consulted a medical practitioner, been admitted to hospital or a nursing home, or suffered from an intermittent or recurring illness in the last five years?**

In your answers, please include:

- Member name
- Symptoms / Condition / Diagnosis
- The area of the body affected (eg right leg, left eye).
- Date of onset, frequency & severity of symptoms, date of last symptoms
- Details of any past or current medication or treatment
- Current status (eg fully recovered/ on-going)

☐ **No** ▶ Go to question 4.2

☐ **Yes** Give details here

If you need more space ▶ Use 6 **Additional information**

4.2 **Have you or anyone else to be insured on this policy seen a doctor, physiotherapist, practice nurse, osteopath or chiropractor or received a prescription for medication in the last 12 months (or are you planning to seek treatment or advice)?**

In your answers, please include:

- Member name
- Symptoms / Condition / Diagnosis
- The area of the body affected (eg right leg, left eye).
- Date of onset, frequency & severity of symptoms, date of last symptoms
- Details of any past or current medication or treatment
- Current status (eg fully recovered/ on-going)

☐ **No** ▶ Go to question 4.2

☐ **Yes** Give details here

If you need more space ▶ Use 6 **Additional information**

4 Confidential medical history continued

4.3 **Have you or anyone else to be insured on this policy suffered from, orr have symptoms of, any other medical condition, disability or health problem? This includes, but is not limited to: gynaecological or menstrual problems, complications of pregnancy, signs or symptoms of varicose veins, back trouble, abnormal dental conditions, foot disorders (e.g. bunions), digestive irregularities, skin problems or trouble with heart, limbs, eyes, 'nerves'.**

In your answers, please include:

- Member name
- Symptoms / Condition / Diagnosis
- The area of the body affected (eg right leg, left eye).
- Date of onset, frequency & severity of symptoms, date of last symptoms
- Details of any past or current medication or treatment
- Current status (eg fully recovered/ on-going)

☐ **No** ▶ Go to question 4.4

☐ **Yes** Give details here

If you need more space ▶ Use 6 **Additional information**

4.4 **Have you or anyone else to be insured on this policy had cancer in the last five years or are currently awaiting treatment, investigations or checkups for cancer?**

In your answers, please include:

- Member name
- Symptoms / Condition / Diagnosis
- The area of the body affected (eg right leg, left eye).
- Date of onset, frequency & severity of symptoms, date of last symptoms
- Details of any past or current medication or treatment
- Current status (eg fully recovered/ on-going)

☐ **No** ▶ Go to question 4.5

☐ **Yes** Give details here

If you need more space ▶ Use 6 **Additional information**

4 Confidential medical history continued

4.5 **Do you or anyone else to be insured on this policy currently suffer from or have suffered from in the last five years, any of the following whether or not a doctor has been consulted: any mental health problems including depression, anxiety, stress, eating disorders, insomnia or any other mental health condition?**

In your answers, please include:

- Member name
- Symptoms / Condition / Diagnosis
- The area of the body affected (eg right leg, left eye).
- Date of onset, frequency & severity of symptoms, date of last symptoms
- Details of any past or current medication or treatment
- Current status (eg fully recovered/ on-going)

☐ **No** ▶ Go to question 4.6

☐ **Yes** Give details here

If you need more space ▶ Use 6 **Additional information**

4.6 **Have you or anyone else to be insured on this policy received any counselling, medication such as anti-depressants or sleeping tablets, or treatment for any mental health problem in the last five years?**

In your answers, please include:

- Member name
- Symptoms / Condition / Diagnosis
- The area of the body affected (eg right leg, left eye).
- Date of onset, frequency & severity of symptoms, date of last symptoms
- Details of any past or current medication or treatment
- Current status (eg fully recovered/ on-going)

☐ **No** ▶ Go to 5 **Payment options**

☐ **Yes** Give details here

If you need more space ▶ Use 6 **Additional information**

5 Payment options

5.1 How do you want to pay your premiums?

i Tick one box only.

If you choose to pay annually, you will receive a 5% discount on your premium.

Direct Debits can only be accepted from £ Sterling bank accounts with a valid UK Sort Code.

By Direct Debit

☐ Annually
☐ Quarterly
☐ Monthly

▶ Now complete DD **Direct Debit Instruction** on the next page.

By Credit Card/Debit Card

☐ Annually
☐ Quarterly
☐ Monthly

▶ To make payment by credit or debit card please call us on **+44 (0) 1892 556274** and select **option 4**. Lines are open Monday to Friday, 8am to 6pm, and Saturday 9am to 5pm (UK time).

By Cheque

☐ Annually
☐ Quarterly

▶ Now complete 7 **Declaration**.

By Bank Transfer

☐ Annually
☐ Quarterly

▶ Now complete 7 **Declaration**.

Instruction to your Bank or Building Society to pay by Direct Debit

Please fill in the whole form (including the official use box if appropriate) and send to:

AXA - Global Healthcare,
Phillips House, Crescent Road,
Tunbridge Wells, Kent TN1 2PL.

Name(s) of account holder(s):

Bank/Building Society account number:

Branch Sort Code:

Name and full postal address of your bank or building society

To The Manager: Bank/Building Society

Address:

Postcode:

Reference: (AXA membership no.)

Service User Number:

4 5 0 2 8 7

This is not part of the instruction to your Bank or Building Society.

Please complete this box if you are paying on behalf of the policyholder.

Name and address of account holder:

Telephone no:

Policyholder's name:

Instruction to your Bank or Building Society

Please pay AXA Global Healthcare (UK) Ltd Direct Debits from the account detailed in this Instruction, subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with AXA - Global Healthcare and, if so, details will be passed electronically to my Bank/Building Society

Signature(s):

Date: D D M M Y Y Y Y

Banks and building societies may not accept Direct Debit Instructions for some types of account

This guarantee should be detached and retained by the payer.

The Direct Debit Guarantee

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits.
- If there are any changes to the amount, date or frequency of your Direct Debit
- AXA Global Healthcare (UK) Limited will notify you 5 working days in advance of your account being debited or as otherwise agreed. If you request AXA Global Healthcare (UK) Limited to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit by AXA Global Healthcare (UK) Limited or your bank or building society you are entitled to a full and immediate refund of the amount paid from your bank or building society.
- If you receive a refund you are not entitled to, you must pay it back when AXA Global Healthcare (UK) Limited asks you to.
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.

6 Additional information

Please use this section if you need more space to answer any questions.

If you don't need more space ▶ Now go to 7 **Declaration**.

In your answers, please include:

- Question number
- Member name

7 Declaration

Please read the Data Protection Notice and following declarations carefully, and only sign below if you understand and accept them..

Privacy Notice

Before you sign and return this form please show the statement opposite to anyone over 16 that you wish to cover on this plan, or inform them of its contents.

By signing and returning this form you indicate that you have authority to give consent on behalf of any family members covered by your policy and, on your own and their behalf, you consent to the use of personal information as set out in the Privacy Notice opposite.

Your Personal Information

Your policy is underwritten by AXA PPP healthcare Limited and administered by AXA Global Healthcare (jointly AXA). This is a summary of our respective Privacy Policies that you can find on our websites: axaglobalhealthcare.com/en/about-us/privacy-and-legal and axappphealthcare.co.uk/privacy-policy.

Please make sure that everyone covered by this policy reads this summary and the full data privacy policies on our websites, axappphealthcare.co.uk/privacy-policy and axaglobalhealthcare.com/en/about-us/privacy-and-legal. If you would like a copy of the full Privacy Policies please call us on +44 (0) 1892 503 856 and we'll send you one.

We want to reassure you AXA never sells personal member information to third parties. We will only use your information in ways we are allowed to by law, which includes only collecting as much information as we need. We will obtain your consent to process information such as your medical information when it's necessary to do so.

We collect information about you and the family members who are covered by your plan from you, those family members, your healthcare providers, your employer (if you are on a company scheme), your insurance broker if you have one and third party suppliers of information.

We process your information mainly for managing your membership and claims, including investigating fraud. We also have a legal obligation to do things such as report suspected crime to law enforcement agencies. We also do some processing because it helps us run our business, such as research, finding out more about you, statistical analysis for example to help us decide on premiums and marketing.

We may disclose your information to other people or organizations. For example we'll do this to:

- Manage your claims, e.g. to deal with your doctors;
- Facilitate the provision of benefits or otherwise manage your policy; and
- Help us prevent and detect crime and medical malpractice by talking to other insurers and relevant agencies; and
- Allow other AXA companies to contact you if you have agreed.

In order to be able to manage your policy, we may transfer and access your information from countries anywhere in the world including India and the USA where some administration is undertaken and Switzerland where AXA has a European data centre. Before doing so we will ensure that your data is protected and disclosed only to authorised individuals solely for servicing your policy or claim. Any internal transfer of your data will be undertaken only in accordance with the relevant data protection laws and regulations.

Where our using your information relies on your consent you can withdraw your consent, but if you do we may not be able to process claims or manage your plan properly.

We will inform you if a data breach occurs and your personal and medical information are disclosed to unauthorised parties. The notification will be provided within 72 hours of the confirmation of the incident.

In some cases you have the right to ask us to stop processing your information or tell us that you don't want to receive certain information from us, such as marketing communications. You can also ask us for a copy of information we hold about you and ask us to correct information that is wrong.

If you want to ask to exercise any of your rights just call us on +44 (0) 1892 503 856 or write to us.

Declaration

a) Your policy will be insured by AXA PPP healthcare Limited and will be administered by AXA Global Healthcare (UK) Limited.

b) I declare that:
- to the best of my knowledge and belief the statements on this application form are full, true and correct
- I shall read the policy handbook when received and that I agree to be bound by it unless I cancel the enrolment within 14 days of acceptance of my application.

I agree that the acceptance of my application shall be on the basis of these statements.

c) I understand that if there are changes in the information I have given before the start date of my policy, I must inform you in writing immediately.

d) I understand that once the policy has started, you will not pay for treatment of any medical condition (or related medical condition) which the member(s) already had when they joined unless fully disclosed on this application and accepted by you. This includes any such medical condition(s) or symptoms, whether or not being treated and any previous medical condition(s) which recurs, or which I should reasonably have known about even if I had not consulted a doctor.

e) I understand that as the legal holder of this insurance policy, all correspondence about this application, including claims correspondence, will be sent to me unless I write to tell you otherwise. I also understand that policy documents, written communications and membership details will be issued in English unless you and I have specifically agreed, in writing, to communicate in a different language.

f) I understand that some countries require residents, whether expatriates or otherwise, to take out health cover through a local provider or to hold cover which meets certain compulsory requirements and that the cover provided by you may not meet these country specific requirements and therefore additional cover may be necessary. I further understand that in some situations there may be consequences in the form of tax penalties or otherwise where a resident does not hold the required local cover in addition to their international medical insurance policy. If I have any concerns about any additional cover requirements in my principal country of residence (as defined in 2 **About the Policyholder**), I understand that it will be my responsibility to check with the local authorities to determine whether there are any further healthcare requirements with which I am expected to comply.

g) By signing and returning this form I confirm that the declarations set out in this application are correct and that I have the authority to enter this policy on behalf of any family members.

Policyholder signature

(This form must be hand signed. We do not accept electronic signatures.)

Date

D D M M Y Y Y Y

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