Islands health plan: Corporate

Underwritten by AXA PPP healthcare Limited

Member application form

Full Medical Underwriting (FMU)

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 company's name and group membership number

The Group Secretary can give you this if applicable.

Company name

Group membership number

PB62725ed/02.21

Notes to help you with your application

We aim to make it as easy as possible for you to apply for your company's health insurance, so please read the following notes before you start. If you have any questions, please contact the Group Secretary 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 group 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.

- This form is only applicable to employees under a Corporate policy, where your company has selected Full Medical Underwriting (FMU) as the underwriting style of the group.
- Your company will complete a 'Corporate member registration sheet' to accompany this form which lists your details, family members to be covered and type of cover required for each member. Please contact the Group Secretary if you want to know more about the policy details.
- ✕ This policy is not applicable to **American or Canadian citizens** whose principal country of residence is the USA or Canada. If this applies to any person to be covered, or they are applying for citizenship, please contact the Group Secretary.
- ✕ **Please do not use this form** if you are applying for an individual policy, or if your company has chosen Moratorium or Continued Medical Underwriting (CME) as the underwriting on the group scheme.
- 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 1 **About the lead member** must be an employee of the company given on page 1 and will be the lead member.
  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.
- A number of 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. This cover may not meet these country specific requirements and therefore additional cover may be necessary. 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. Please speak to your company's group secretary if you have any concerns about any additional cover requirements in your principal country of residence (as defined in 1 **About the lead member**), as it will be your company's obligation to ensure that each of its employees and their family members hold the cover required by their principal country of residence (as defined in 1 **About the lead member**).

Tips for completing this application form

- If you are completing this form digitally, please print it out once completed and sign the 5 **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 the 5 **Declaration** at the end. Your Intermediary is acting on your behalf in this respect.
- If you need extra space, please use 4 **Additional Information**.

To complete this application form you will need

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

Once you've completed your application

- Please check your details carefully and make sure you have signed and dated the 5 **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 5 **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 lead member 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.

1 About the lead member

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

1.1 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

1.2 Sex

☐ Male ☐ Female

1.3 Date of birth

D D M M Y Y Y Y

1.4 Nationality

1.5 What is the lead member's principal country of residence?

This is the address where all members covered will spend the majority of the year once this policy has started.

1.6 Position in company

The lead member must be an employee of the company given on page 1

1.7 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

1.8 Contact details

Please include country and area codes, where applicable.

Please give the Parent or Legal Guardian's details if the lead member is under 18.

Telephone (Daytime)

Telephone (Evening)

Email

2 Additional family members to be covered

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

Family members can include the lead member's:

- spouse/partner
- any children.

☐ **No** ▶ Go to 3 **Confidential medical history**

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

If you need to add more than four family members, please use 4 **Additional Information**

2.2 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 lead member

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 lead member

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 lead member

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 lead member

Sex

☐ Male ☐ Female

Date of birth

D D M M Y Y Y Y

Nationality

Principal country of residence

Occupation

3 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.

3.1 **Have you or anyone else to be insured on this policy consulted with a medical practitioner, been admitted to hospital or a nursing home, or suffered from an intermittent or recurring illness during 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 3.2

☐ **Yes** Give details here

If you need more space ▶ Use 4 **Additional information**

3.2 **Have you or anyone else to be insured on this policy consulted with a medical practitioner in the past year?**

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 3.3

☐ **Yes** Give details here

If you need more space ▶ Use 4 **Additional information**

3 Confidential medical history continued

3.3 **Have you or anyone else to be insured on this policy 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 (e.g. bunions), indigestion or bowel problems, abdominal pain, skin problems, allergies, anxiety, depression or other psychiatric problems, trouble with heart, limbs, ears, eyes, urination?**

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 **Declaration**

☐ **Yes** Give details here

If you need more space ▶ Use 4 **Additional information**

4 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 5 **Declaration**.

In your answers, please include:

- Question number
- Member name

5 Declaration

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

Privacy Notice

i 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.

i 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 Employees' 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 axapphealthcare.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, axaglobalhealthcare.com/privacy-ie 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 your employees and their family members who are covered by your plan from your employees and their 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 employees' 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 employees' 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 employees' 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 employees' information relies on their consent they can withdraw their consent, but if they 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 employees' 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 employees' 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 your employees' 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 lead member**), 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.

Lead member 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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