Flying Colours

Application Form (Medical History Disregarded)

ALC GLOBAL HEALTH INSURANCE

Underwritten by AXA PPP International

Filling out this form

- Use this form to apply for one of our Prima healthcare plans.
- Please take care to provide accurate and complete answers for all members who are to be insured under this plan and sign the Declaration on page 4.
- Please write clearly using capital letters.
- If you have any questions, call us on +44 (0) 1903 817970 (UK), +34 952 93 16 09 (Spain) or +350 2000 77731 (Gibraltar).
- If you would like a copy of this application form, please let us know within 3 months.

What's next?

- Send your completed form back to us using **one** of these options:
  - **Email:** flyingcolours@alchealth.com
  - **Fax:** + 44 (0) 1903 879719
  - **Post:** ALC Health, Chanctonfold Barn, Chanctonfold, Horsham Road, Steyning, West Sussex BN44 3AA United Kingdom
- We will write to you with your terms and requesting payment within 5 working days.
- Then, once we've received your payment, we'll send your policy documentation.

1 Choosing your level of cover

Please select **one plan** below to cover everyone on this application, then tick the boxes to choose your level of cover.
For more information on our plans, visit **www.alchealth.com/flyingcolours**

Prima **Classic** ☐	Prima **Premier** ☐	Prima **Platinum** ☐
☑ In-patient, day-patient and out-patient treatment	☑ In-patient and day-patient treatment ☐ Out-patient treatment	☑ In-patient, day-patient and out-patient treatment
Routine pregnancy and childbirth limit: ☐ £3,000 : €3,600 : US$4,500 ☐ £5,000 : €6,000 : US$7,500	**Routine pregnancy and childbirth limit:** ☐ £3,000 : €3,600 : US$4,500 ☐ £5,000 : €6,000 : US$7,500 ☐ £7,500 : €9,000 : US$11,250 ☐ £10,000 : €12,000 : US$15,000	**Routine pregnancy and childbirth limit:** ☐ £3,000 : €3,600 : US$4,500 ☐ £5,000 : €6,000 : US$7,500 ☐ £7,500 : €9,000 : US$11,250 ☐ £10,000 : €12,000 : US$15,000 ☐ £20,000 : €24,000 : US$30,000
☐ Dental treatment	☐ Dental treatment	☐ Dental treatment
☐ Evacuation or Repatriation	☐ Evacuation or Repatriation	☐ Evacuation or Repatriation
Area of cover: ☐ Area 1 – Europe ☐ Area 2 – Worldwide excluding USA ☐ Area 3 – Worldwide	**Area of cover:** ☐ Area 1 – Europe ☐ Area 2 – Worldwide excluding USA ☐ Area 3 – Worldwide	**Area of cover:** ☐ Area 1 – Europe ☐ Area 2 – Worldwide excluding USA ☐ Area 3 – Worldwide

In which currency would you like to pay your premium? Your policy benefits will also be in this currency.

☐ GB£ ☐ Euro€ ☐ US$

How much excess would you like to pay? Excess is per person per policy year and does not apply to Routine Pregnancy & Childbirth, Dental Treatment, Evacuation or Repatriation options or Well-being, Optical and Vaccination benefits. To reduce your premium, choose a higher policy excess.

☐ Nil
☐ £500 : €600 : US$750
☐ £7,500 : €9,000 : US$11,250
☐ £50 : €60 : US$75
☐ £1,000 : €1,200 : US$1,500
☐ £150 : €180 : US$225
☐ £2,500 : €3,000 : US$3,750
☐ £300 : €360 : US$450
☐ £5,000 : €6,000 : US$7,500

How would you like to pay your premium? We will send details following acceptance of your application.

☐ **Annually**	→	☐ Credit / Debit Card	*or*	☐ Cheque	*or*	☐ Bank Transfer
☐ **Quarterly**	→	☐ Credit / Debit Card	*or*	☐ Direct Debit*		
☐ **Monthly**	→	☐ Credit / Debit Card	*or*	☐ Direct Debit*		

*Direct Debit payments from UK bank accounts only

2 Your details

Policyholder details

Title

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other:

First name(s)

Surname

Date of birth (DD-MM-YYYY)

Gender

Female

Occupation ☐ Pilot ☐ Cabin Crew

Other

Nationality

Country of residence

Email address

Home address

Postcode: Country

Correspondence address (if different)

Postcode: Country

Phone numbers

Home:

Work:

Mobile:

Fax:

Family members to be added to this policy

Please give details of all dependants to be covered by this policy. This includes 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. Additional family members must be added at the same time as the policyholder otherwise moratorium underwriting will be offered. Please see page 3 for definition of Moratorium Underwriting.

If more than four family members are to be covered, please photocopy this page before you start filling in this section, and number each sheet using the boxes on the right to help us keep track.

Copy number of

1st family member

Title

First name(s)

Surname

Date of birth (DD-MM-YYYY)

Relationship to policyholder

Occupation

Nationality

Country of residence

2nd family member

Title

First name(s)

Surname

Date of birth (DD-MM-YYYY)

Relationship to policyholder

Occupation

Nationality

Country of residence

3rd family member

Title

First name(s)

Surname

Date of birth (DD-MM-YYYY)

Relationship to policyholder

Occupation

Nationality

Country of residence

4th family member

Title

First name(s)

Surname

Date of birth (DD-MM-YYYY)

Relationship to policyholder

Occupation

Nationality

Country of residence

Dependants

Dependants can only be added at a later date if any of the following life events have occurred:

- Baby being born (added within 30 days of birth for Medical History Disregarded underwriting otherwise Moratorium underwriting will apply).
- A new adult spouse/partner living with the policyholder. Stepchild of the new spouse/adult partner, legally adopted or foster child.

An Addition of Dependants form will need to be completed to determine which underwriting will be applied.

Medical history

Please answer the following questions and make sure you have permission to advise us of the medical details for all dependants over the age of 16 you wish to include in the Application.

Copy number ☐ of ☐

Policyholder	**1st family member**	**2nd family member**	**3rd family member**	**4th family member**
To the best of your knowledge has any member of this policy been diagnosed with, or received any form of treatment/ consultation for cancer in the past 5 years?				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
To the best of your knowledge, does any member of this policy have any medical condition that is likely to result in the need for an in-patient stay in hospital?				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

By treatment we mean surgical or medical intervention including drugs prescribed by a doctor, that are needed to diagnose, relieve or cure a disease, illness or injury. A specialist is any doctor, including psychiatrist who is not your medical practitioner.

Declaring illnesses

If you have answered yes to either of the questions above, you will be offered Moratorium Underwriting terms as set out below:

Moratorium Underwriting

Any medical condition or specified related condition for which you have received medical treatment, had symptoms (whether investigated or not) or sought advice in the 5 years prior to your date of entry (pre-existing medical condition) will be excluded. However, after a continuous period of 2 years as an insured person, all pre-existing conditions will become eligible for benefit provided you have not:

a. consulted a medical practitioner or specialist for medical treatment or advice; or
b. suffered symptoms; or
c. taken medication (including drugs, medicines, special diets or injections) for that condition for a continuous period of two years after the date of entry.

If your pre-existing condition is one of those shown below, we will also exclude treatment for the specified related conditions shown:

If you have the following pre-existing condition:	We will not pay for treatment of the following specified related conditions:
have been diagnosed with diabetes	• Diabetes • Ischaemic heart disease • Cataract • Diabetic retinopathy • Diabetic renal disease • Arterial disease • Stroke
are currently undergoing treatment for raised blood pressure (hypertension)	• Raised blood pressure (hypertension) • Ischaemic heart disease • Stroke • Hypertensive renal failure
are under investigation, having treatment or undergoing monitoring as a result of a Prostate Specific Antigen (PSA) test	• Any disorder of the prostate

Top-up Policy

☐ Please tick if you have a local health insurance policy through your employer. You can buy an ALC Health policy and use the eligible claims you make on your local health insurance policy to use up the excess on your ALC Health policy.

3 Data Protection Act 1998

To set up and manage your plan, ALC Health, its underwriters AXA PPP International and its appointed claims handlers Healix International, willl hold and use information about you and anyone included under the plan. This information may have been supplied by you, family members covered under the plan, or healthcare providers. Please only provide healthcare providers with sensitive information (such as health information) about family members aged over 16, covered under the plan, if you have their consent to do so. If you give us this information we'll take this as confirmation that you have their consent.

Before you sign and return this form it is important that anyone over the age of 16 that you wish to include under your policy, understands the terms and conditions that apply to the plan.

ALC Health, its underwriters or its claims handlers may employ other organisations to undertake some of their work for them and to run and improve their computer systems. As well as communication with your healthcare providers, ALC Health's underwriters and/or its claims handlers will share information with each other and with ALC Health in order to manage your claims. ALC Health, its underwriters or its claims handlers may transfer information to countries outside the European Economic Area (EEA) where the laws protecting personal information are not as strong as in the EEA. They will always take steps to ensure that all organisations working for them provide an appropriate level of protection.

The policyholder is the legal owner of the plan. ALC Health and its underwriters will send most of their written communications about the plan and about any claims to the policyholder. If any person over 18 that you intend to cover under the plan does not wish them to do this, that person should apply for their own plan.

By signing this form the policyholder confirms that:

- anyone included on the plan has agreed that the policyholder has their permission to act for them to set up this plan
- the policyholder consents on behalf of those family members and themselves to ALC Health, its underwriters and its claims handlers using personal information in the ways described above.

ALC Health, its underwriters and/or its claims handlers may pass information directly to third parties or by using shared databases. These third parties will include other insurers and law enforcement agencies. This is to prevent or investigate crime, including fraudulent or other improper claims. In some circumstances ALC Health, its underwriters or its claims handlers must provide information about their suspicions of crime to law enforcement agencies and will let the relevant regulatory body know when it has good reason to question a healthcare provider's fitness to practice.

If any person would like details of the information that ALC Health holds about them they should contact ALC Health. If they would like details of the information that the underwriter holds about them they should write to the Data Protection Manager, AXA PPP healthcare Limited, PPP House, Vale Road, Tunbridge Wells, Kent TN1 1BJ. If they would like details of the information that the claims handlers hold about them, they should write to Healix International, Healix House, Esher Green, Esher, Surrey KT10 8AB. ALC Health, its underwriters and/or its claims handlers may charge a fee for this service.

☐ By signing and returning this form you agree that ALC Health, its underwriters, its claims handlers and any other organisations authorised by ALC Health may use the information you have provided to inform you by letter, telephone, email or mobile message of products, services and healthcare information unless you tick this box to show otherwise. You may change your mind at any time by contacting us.

Policy start date

Date (DD-MM-YYYY)

Your policy cannot start until we receive and accept this form. If you'd like your cover to start at a future date, you must let us know if there are any changes to the information given in this form – you cannot apply for cover more than 60 days in advance of completion of this form.

Documentation

Would you like to receive all policy documentation and future correspondence by email? We'll use the address from page 2.

☐ Yes ☐ No

4 Your declaration

1. I have received and read the full Definitions, Benefits, Exclusions and Conditions of this Policy including General Exclusion 1 relating to Pre-existing Conditions and 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 where medical history disregarded is agreed. Where it is not agreed, General Exclusion 1 will apply.
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.
6. If you don't take reasonable care and the information you give us is inaccurate or incomplete then we may take one or more of the following actions:
   (i) Cancel your plan;
   (ii) Declare your membership void (treating your plan as if it had never existed);
   (iii) Change the terms of your plan; or
   (iv) Refuse to deal with all or part of any claim or reduce the amount of any claims payments.

   We may ask you to provide further information and/or documentation to make sure that the information you gave us when taking out, making changes to or renewing your plan was accurate and complete.

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

Confirmation

Policyholder signature

Date signed (DD-MM-YYYY)

If you're completing a digital version of this form, please tick the box below to acknowledge the declaration.

☐ I confirm, as the policyholder, I have read and understood this declaration

Agency name

Agency number

ALC5372B 06/07/16