Corporate healthcare application

Underwritten by AXA PPP International

ALC GLOBAL HEALTH INSURANCE

Filling out this form

- Use this form to apply for 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'd like a copy of this application form, please let us know within 3 months.

What's next?

- Send your completed form and your spreadsheet of persons to be covered back to us using **one** of these options:
  - **Email:** sales@alchealth.com
  - **Fax:** + 44 (0) 1903 879719
  - **Post:** ALC Health, Chanctonfold Barn, Chanctonfold, Horsham Road, Steyning, West Sussex BN44 3AA United Kingdom
- We'll 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 **the plans** 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** or simply scan this code with your smartphone →

Prima **Concept** ☐	Prima **Classic** ☐	Prima **Premier** ☐	Prima **Platinum** ☐
☑ In-patient, day-patient and out-patient treatment	☑ 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	☐ Evacuation or Repatriation
Area of cover: ☐ Area 1 – Europe ☐ Area 2 – Worldwide (excluding USA)	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 amount, 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'll send details following acceptance of your application.

☐ **Annually**	☐ By Cheque	*or*	☐ By Bank Transfer
☐ **Quarterly**	☐ By Cheque	*or*	☐ By Bank Transfer
☐ **Monthly**	☐ By Cheque	*or*	☐ By Bank Transfer

2 About the company (Policyholder)

Company details

Full company trading name

Address to be shown on policy

Postcode: Country

Correspondence address (if different)

Postcode: Country

Website address

Group administrator details

Give the details of the person responsible for the administration of this policy, including notification of any changes to the people insured under this policy.

Name of group administrator

Title/position

Telephone

Fax

Email address

Individual details

Please supply a spreadsheet of all individuals (including dependants, where applicable) to be covered under this policy, stating their:

- Title
- First name
- Initial
- Surname
- Gender
- Date of birth (DD-MM-YYYY)
- Residential address
- Country of residence
- Nationality
- Whether they're a Member or a Partner / Child of a Member
- Plan selected

If you're completing this form digitally, you can attach a Microsoft Excel spreadsheet when you email your form to us. Please include your full company trading name in the title.

Medical history

Which underwriting terms are required?

- ☐ Moratorium (standard) – please go to Section 3
- ☐ Transfer from another insurer (CPME)
- ☐ Medical History Disregarded (MHD) for over 10 employees

To the best of your knowledge, has any member on this scheme been diagnosed with, or received any form of treatment/ consultation for cancer in the past 5 years?

☐ 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

If you've answered **yes** to any of the questions above, please give full details on page 4.

If anyone is transferring from another insurer (CPME) there must be no break in cover and copies of each member's current Certificate of Insurance will be required.

Declaring illnesses

If you've answered **yes** to any of the questions above, you must give full details here. Please continue on a separate sheet if necessary.

Full name

Medical condition, including current prognosis

Treatment, including dates, drugs and dosages

Full name

Medical condition, including current prognosis

Treatment, including dates, drugs and dosages

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, will 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.

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 Medical Conditions is not applicable to Medical Underwriting Transfers (CPME) or Medical History Disregarded (MHD) underwriting terms.
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 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 the company is not satisfied with the content of this policy, the company may cancel the insurance within 14 days of the completion of this contract as set out in the Policy Wording.
4. I have read and received the Data Protection Act 1998 notice as contained in this Application Form.
5. 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.

Policy start date

Date (DD-MM-YYYY)

Our policies renew on the first of the month. If you'd like to start cover on a different date, a pro-rata premium will apply in the first policy year.

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.

Confirmation

Name

Position

Group administrator 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 Group administrator, I have read and understood this declaration

Documentation

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

☐ Yes ☐ No

Agency name

Agency number

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