Full Medical Underwriting (Germany)

Underwritten by Catlin Insurance Company (UK) Ltd

December 2015

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 6.
- 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 back to us using **one** of these options:
  - **Email:** privateclient@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 **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** or simply scan this code with your smartphone →

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

2 Your details

Policyholder details

Title

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other:

First name(s)

Surname

Date of birth (DD-MM-YYYY)

Gender

Occupation (please give full details)

Nationality

Country of residence

Email address

Home address

Postcode: Country

Correspondence address (if different)

Postcode: Country

Phone numbers

Home:

Work:

Mobile:

Fax:

Additional family member details

Please give details of any additional family members 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.

If more than four additional 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

Medical history

Please consider the following questions carefully and indicate whether any person has experienced symptoms of, been admitted to hospital for, or received any treatment / had consultations for any of the conditions below:

Copy number ☐ of ☐

Policyholder	1st family member	2nd family member	3rd family member	4th family member
Heart or vascular disorders Including coronary artery disease, chest pains, angina, circulatory problems, varicose veins, high blood pressure, high cholesterol.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Cancer, tumours, growths, cysts, moles	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Muscular or skeletal problems Including arthritis, joint pain, cartilage or ligament problems, back and neck problems, joint replacement, sciatica and fractures.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Digestive, liver and gall bladder disorders Including ulcers, recurring indigestion, irritable bowel, change in bowel habits, rectal bleeding, piles and hepatitis.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Psychiatric and psychological disorders Including depression, stress, anxiety, schizophrenia, anorexia nervosa, bulimia and compulsive disorders.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Urinary disorders Including bladder, kidney, prostate problems, urinary infections and incontinence.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Ears, nose and throat disorders Including ear infections, sinusitis and tonsillitis.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Eye disorders Including cataracts and eye infections.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Endocrine and metabolic disorders Including diabetes, thyroid and gout.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Gynaecological disorders Including heavy or irregular periods, fibroids, endometriosis and abnormal smears.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Pregnancy/complications Including delivery by caesarean section.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Neurological disorders Including stroke, migraines, recurring headaches, multiple sclerosis and epilepsy.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Respiratory disorders Including asthma, bronchitis, and shortness of breath.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Skin disorders Including eczema, psoriasis, solar keratosis.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Medical history (continued)

Copy number ☐ of ☐

Policyholder	1st family member	2nd family member	3rd family member	4th family member
Dental disorders Including impacted wisdom teeth. ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you or anyone else covered on your policy suffer from AIDS or HIV or are currently awaiting treatment, investigation, check ups or the results of investigations for AIDS or HIV? ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Please give the current height in metres and weight in kilogrammes of each applicant. ☐.☐ m ☐☐☐ kg	☐.☐ m ☐☐☐ kg	☐.☐ m ☐☐☐ kg	☐.☐ m ☐☐☐ kg	☐.☐ m ☐☐☐ kg

Current treatment and check ups

Are you receiving any other treatment of any kind other than that stated above, or taking any medication of any kind?

☐ Yes ☐ No

If yes, please give details:

Are you having regular check ups for conditions including high blood pressure, high cholesterol, raised PSA (prostate specific antigen)?

☐ Yes ☐ No

If yes, please give details:

Important notes

1. **No liability will be accepted for any medical condition which originated before the date of enrolment or which was foreseeable at the time of application** unless such medical condition has been declared to ALC Health in writing and accepted by Catlin Insurance Company (UK) Ltd.

2. Failure to notify us of a medical condition may result in claims for benefit being refused and/or cover withdrawn.

Please ensure that you fully disclose any known or suspected conditions and symptoms experienced by anybody included in this application. This applies even if professional advice has not yet been sought. Typical examples are varicose veins, allergies, backache, foot disorders (e.g. bunions), piles, gynaecological problems (including any irregularities of menstruation), complications of pregnancy (e.g. caesarian section), digestive irregularities, skin problems, trouble with heart, limbs, eyes, 'nerves' etc, any ear, nose or throat problems or any pains, swellings, lumps or fever.

Medical practitioner(s) most used over the last 5 years

Name

Email address

Telephone number

Fax number

Address

Postcode: Country

Declaring illnesses

Copy number ___ of ___

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

Full name

Brief description of illness

Period of illness (MM-YYYY)

Duration of illness (e.g. 2 weeks)

Your present state of health in respect of this illness

Full name

Brief description of illness

Period of illness (MM-YYYY)

Duration of illness (e.g. 2 weeks)

Your present state of health in respect of this illness

Full name

Brief description of illness

Period of illness (MM-YYYY)

Duration of illness (e.g. 2 weeks)

Your present state of health in respect of this illness

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Duration of illness (e.g. 2 weeks)

Your present state of health in respect of this illness

Full name

Brief description of illness

Period of illness (MM-YYYY)

Duration of illness (e.g. 2 weeks)

Your present state of health in respect of this illness

3 Data Protection Act 1998

To set up and manage your plan, ALC Health, its underwriters Catlin Insurance Company (UK) Ltd 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, Catlin Insurance Company (UK) Ltd, 20 Gracechurch Street, London EC3V OBG. 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 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 Catlin Insurance Company (UK) Ltd.
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, 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 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.
7. ALC Health is regulated by the UK Financial Conduct Authority and offers products in Germany pursuant to rights of freedom of services under the EU Insurance Mediation Directive. For the avoidance of any doubt, this policy is not a substitute for or in lieu of German Public Health Insurance. This policy is appropriate for those who are not eligible for Public Insurance and/or require additional cover.

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