

# Bronze Application (Germany)

Underwritten by SiriusPoint International Insurance Corporation

Pre-existing Conditions – We do not cover treatment of any medical conditions (or specified condition) that existed before the start of your policy

## Filling out this form

- Use this form to apply for our Bronze Global Prima Medical Insurance Plan.
- You must take care in answering all the following questions which are relevant to us in providing this insurance and setting the terms and premium. Please contact us if you do not understand the question or the nature of the information required or please seek guidance from your broker. Failure to provide information or the provision of incomplete or inaccurate information may result in the loss of cover or other remedies. Remember to sign the Declaration on page 6.
- Please write clearly using capital letters.
- If you are transferring from another insurer or from an ALC Health group policy, you must attach a copy of your current Certificate of Insurance.
- If you have any questions, call us on +44 (0) 1903 817970 (UK).
- 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](mailto:privateclient@alchealth.com)
  - **Post:** ALC Health, 3rd Floor, Fitzalan House, Fitzalan Court, Cardiff, CF24 0EL, 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 tick the boxes to choose your level of cover for the Bronze plan.

For more information on our plans, visit [www.alchealth.com](http://www.alchealth.com) or simply scan this code with your smartphone →



### BRONZE

- In-patient, day-patient, and out-patient treatment  
 Evacuation or Repatriation

Routine Pregnancy & Childbirth limit:

- £5,000/€5,000/US\$5,000  
 £10,000/€10,000/US\$10,000  
 £20,000/€20,000/US\$20,000

Dental Treatment Limit

- £1,000/€1,000/US\$1,000  
 £2,000/€2,000/US\$2,000

Area of cover:

- Area 1 – Europe  
 Area 2 – Worldwide excluding USA and any USA territories.  
 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 option or Well-being, Optical and Vaccinations benefits. To reduce your premium amount, choose a higher policy excess.

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Nil                     | <input type="checkbox"/> £50/€50/US\$50          | <input type="checkbox"/> £150/€150/US\$150       | <input type="checkbox"/> £250/€250/US\$250       |
| <input type="checkbox"/> £500/€500/US\$500       | <input type="checkbox"/> £1,000/€1,000/US\$1,000 | <input type="checkbox"/> £2,500/€2,500/US\$2,500 | <input type="checkbox"/> £5,000/€5,000/US\$5,000 |
| <input type="checkbox"/> £7,500/€7,500/US\$7,500 |  |  |  |

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

- |                                    |   |  |  |  |
|------------------------------------|---|--|--|--|
| <input type="checkbox"/> Annually  | → | <input type="checkbox"/> Credit/Debit Card | <input type="checkbox"/> SEPA Direct Debit | <input type="checkbox"/> Bank Transfer |
| <input type="checkbox"/> Quarterly | → | <input type="checkbox"/> Credit/Debit Card | <input type="checkbox"/> SEPA Direct Debit | <input type="checkbox"/> Bank Transfer |
| <input type="checkbox"/> Monthly   | → | <input type="checkbox"/> Credit/Debit Card | <input type="checkbox"/> SEPA Direct Debit | <input type="checkbox"/> Bank Transfer |

# SEPA Direct Debit payments from EU/EEA 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

Height (cm/ft)

Weight (kg/lbs)

Industry

Occupation (please give full details)

Nationality

Email address

Country of Residence

Is the Policyholder to be insured under this policy?  Yes  No

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

#### 1<sup>st</sup> family member

Title

First name(s)

Surname

Date of birth (DD-MM-YYYY)

Height (cm/ft) Weight (kg/lbs)

Relationship to policyholder

Industry

Occupation

Nationality

Country of residence

#### 2<sup>nd</sup> family member

Title

First name(s)

Surname

Date of birth (DD-MM-YYYY)

Height (cm/ft) Weight (kg/lbs)

Relationship to policyholder

Industry

Occupation

Nationality

Country of residence

#### 3<sup>rd</sup> family member

Title

First name(s)

Surname

Date of birth (DD-MM-YYYY)

Height (cm/ft) Weight (kg/lbs)

Relationship to policyholder

Industry

Occupation

Nationality

Country of residence

#### 4<sup>th</sup> family member

Title

First name(s)

Surname

Date of birth (DD-MM-YYYY)

Height (cm/ft) Weight (kg/lbs)

Relationship to policyholder

Industry

Occupation

Nationality

Country of residence

## Medical Practitioner's Details

Please provide details of your current medical practitioner or the one who is most familiar with your medical history.

Name	<input type="text"/>	Address	<input type="text"/>
Policyholder or Family Member's Name	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>	Postcode	Country
Tel	<input type="text"/>	Fax	<input type="text"/>

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Name	<input type="text"/>	Address	<input type="text"/>
Policyholder or Family Member's Name	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>	Postcode	Country
Tel	<input type="text"/>	Fax	<input type="text"/>

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Name	<input type="text"/>	Address	<input type="text"/>
Policyholder or Family Member's Name	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>	Postcode	Country
Tel	<input type="text"/>	Fax	<input type="text"/>

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Name	<input type="text"/>	Address	<input type="text"/>
Policyholder or Family Member's Name	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>	Postcode	Country
Tel	<input type="text"/>	Fax	<input type="text"/>

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## Health Declaration

Please answer for each person applying for cover

Copy number  of

Policyholder	1 <sup>st</sup> family member	2 <sup>nd</sup> family member	3 <sup>rd</sup> family member	4 <sup>th</sup> family member
1) Are you or any other applicant presently hospitalised, or scheduled on a waiting list for or in need of hospitalisation or surgery?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Are you currently receiving active treatment for any form of cancer or had a diagnosis in the last twelve months?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Have you or any other applicant at any time ever tested positive for, been diagnosed with, or been treated for any Immune System Disorder, including Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV)?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please note if a person has answered YES to any question above, he or she does not qualify for this insurance.

### 3 General Data Protection Regulation (GDPR)

This is only a summary of ALC's privacy policy and your rights under GDPR. For a complete explanation of how we gather and use your personal information and your corresponding rights, please review our complete Privacy Policy, which is available at <https://www.alchealth.com/privacy.htm>

ALC collects many kinds of information in order to operate effectively and provide you the best products, services and experiences we can. Regardless of the source, we believe it is important to treat that information with care and to help you maintain your privacy.

When you provide data processing consent, we will process your personal information in order to provide the services you have purchased, including to administer claims, and to receive member communications, in accordance with our Privacy Policy. If you provide marketing consent, we will send you relevant information and future marketing materials regarding products or services in which you may have interest, and for all other purposes set forth in our Privacy Policy. You may withdraw your consent at any time.

By providing marketing consent, we may gather information about you from third parties to help us identify insurance products and services in which you may have interest, and share information with third parties, such as web analytics tools, in order to send you relevant information and future marketing materials, and for all other purposes set forth in our Privacy Policy. You may withdraw your consent at any time.

We may share your information with third parties who provide services on our behalf to help with our business activities. These companies are authorized to use your personal information only as necessary to provide these services to us. When we share information with these other companies to provide services for us, they are not allowed to use it for any other purpose and must keep it confidential. These services may include:

- Adjudicating and managing the claims process
- Payment processing to healthcare providers
- Providing customer service

In certain situations, ALC may be required to disclose personal data in response to lawful requests by public authorities, including to meet national security or law enforcement requirements.

### 4 Fair Processing Notice

This Privacy Notice describes how SiriusPoint International Insurance Corporation (publ) (for the purpose of this notice "we", "us" or the "Insurer") collect and use the personal information of insureds, claimants and other parties (for the purpose of this notice "you") when we are providing our insurance and reinsurance services.

The information provided to the Insurer, together with medical and any other information obtained from you or from other parties about you in connection with this policy, will be used by the Insurer for the purposes of determining your application, the operation of insurance (which includes the process of underwriting, administration, claims management, analytics relevant to insurance, rehabilitation and customer concerns handling) and fraud prevention and detection. We may be required by law to collect certain personal information about you, or as a consequence of any contractual relationship we have with you. Failure to provide this information may prevent or delay the fulfilment of these obligations.

Information will be shared by the Insurer for these purposes with group companies and third party insurers, reinsurers, insurance intermediaries and service providers. Such parties may become data controllers in respect of your personal information. Because we operate as part of a global business, we may transfer your personal information outside the European Economic Area for these purposes.

You have certain rights regarding your personal information, subject to local law. These include the rights to request access, rectification, erasure, restriction, objection and receipt of your personal information in a usable electronic format and to transmit it to a third party (right to portability).

If you have questions or concerns regarding the way in which your personal information has been used, please contact: [DPOLondon@siriuspt.com](mailto:DPOLondon@siriuspt.com)

We are committed to working with you to obtain a fair resolution of any complaint or concern about privacy. If, however, you believe that we have not been able to assist with your complaint or concern, you have the right to make a complaint to the UK Information Commissioner's Office.

For more information about how we process your personal information, please see our full privacy notice at: <https://www.siriuspt.com/legal/website-privacy-policy-final.pdf>

## 5 Language

The language of this insurance contract is English and all correspondence between us will be in English.

Please tick to confirm that you accept this statement.

If you do not wish the language to be English, please contact your broker or telephone us on +44 (0) 1903 817970 (UK).

## 7 Previously Insured

Have you or any family member applying for coverage ever purchased insurance through IMG, IMG Europe, or ALC?

Yes  No

Certificate/Policy Number:

(If yes: please provide certificate number, if any, and details. By selecting yes, you agree to the following: you acknowledge that you are applying for an entirely new certificate of coverage and not a renewal or reinstatement of any prior certificate(s) that you may have purchased through IMG, IMG Europe, or ALC in the past, and that, should IMG accept your new application, this would start a brand new coverage period under the terms, conditions and provisions of the new insurance certificate (including, but not limited to, all eligibility requirements, pre-existing condition and other exclusions, waiting periods, and benefit limits and sub-limits of the plan), and your new coverage will not qualify for any benefits of continuous coverage based upon your prior lapsed coverage.)

Have you or any family member applying for coverage ever been accepted with special terms or rates, been declined cover or had a policy cancelled under any health/medical, life or disability insurance plan?

Yes  No

Details:

## 6 Documentation

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

Yes  No

## 8 Other Health Insurance

Do you hold any other insurance plan or policy that provides cover for medical costs?

Yes  No

Policy Certificate or ID Numbers:

Private insurance or government plan name

Insurer or government entity providing the plan

Coverage Start Date (DD-MM-YYYY)

Coverage End Date (DD-MM-YYYY)

## 9 Your declaration

1. I have received and read the full Definitions, Benefits, Exclusions and Condition of this Policy including General Exclusion 62 relating to Pre-existing Conditions and General Condition 8 relating to Governing Law.
  2. I/we declare that the information disclosed in this proposal is, to the best of my/our knowledge and belief, both accurate and complete. I/we have taken care not to make any misrepresentation in the disclosure of this information and understand that all information provided is relevant to the acceptance and assessment of this insurance, the terms on which it is accepted and the premium charged.
  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. By signing this form as the policyholder, I confirm 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.
    - If applying for coverage with a country of residence outside of the EEA and UK or at any time move to a location outside the EEA or UK, the policyholder acknowledges and agrees to elect the Trust: the policyholder hereby applies and subscribes, for and on behalf of each individual enrolled, to the Conyers Trust Company (Bermuda) Limited, Richmond House, 12 Par-la-Ville Road Hamilton HM 08, Bermuda, or its successors, for the insurance coverage requested above and as underwritten and offered by Sirius International Insurance Corporation on the date of its receipt hereof, and as administered by ALC Health.
  6. If you are arranging this insurance via a broker the policyholder understands, acknowledges and agrees that ALC Health will pay commission to the broker at inception and renewal.
  7. I have read the General Data Protection Regulation (GDPR) notice as contained in this Application Form and the Privacy Policy which is available at <https://www.alchealth.com/privacy.htm>
  8. 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.
- No cover is in force until this proposal is accepted by the insurer and the premium is paid. The insurer reserves the right to decline any insurance proposal or to offer different premium and terms from those quoted dependent on the information you have provided.

9. London Global S.r.l. trading as à la carte healthcare authorised and regulated by IVASS, Italy (A000620496) and the Financial Conduct Authority (849073), offers products in Germany pursuant to rights of freedom of services under the EU Insurance Distribution 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.

### Consent

Yes  No

I agree to the processing of my personal information to provide the services I have purchased, including to administer claims, and to receive member communications, in accordance with ALC Health's Privacy Policy

Yes  No

I agree to receive relevant information and other communications from ALC Health about insurance coverages and service options. I understand that I can withdraw my consent at any time

### 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 30 days in advance of completion of this form.

### Confirmation

Policyholder signature

Signing this Application does not bind you to enter into this insurance.

Please PRINT name in full

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

Broker name

Broker number

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