Private Client application
Prima Ibérica

Underwritten by AXA PPP International

Filling out this form

- 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 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 tick the boxes below to choose the level of cover for everyone on this application.
For more information on our plan, visit **www.prima-iberica.eu** or simply scan this code with your smartphone →

Prima **Ibérica**

☑ In-patient, day-patient and out-patient treatment

Routine pregnancy and childbirth limit:
☐ €3,600 : £3,000 : US$4,500 ☐ €6,000 : £5,000 : US$7,500

☐ Dental treatment

☐ Evacuation or Repatriation

Area of cover:
☐ Area 1 – Europe
☐ Area 2 - Worldwide (excluding USA)

In which currency would you like to pay your premium? Your policy benefits will also be in this currency.
☐ Euro € ☐ GB £ ☐ 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 and Optical benefits. To reduce your premium amount, choose a higher policy excess.

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

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 *or* ☐ By Direct Debit*
☐ **Monthly** → ☐ By Credit / Debit Card *or* ☐ By 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

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:

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

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

Are you transferring from another insurer or from an ALC Health group policy? There should be no break in cover from your previous insurer.

- ☐ No – please go to section 3
- ☐ Yes – please complete the questions below and attach a copy of your current Certificate of Insurance

Please make sure you have permission to advise us of all the medical details for all family members you wish to add to this plan.

Copy number ☐ of ☐

Policyholder	1st family member	2nd family member	3rd family member	4th family member
Have you had cancer in the last 5 years?				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you have any treatment, consultations, investigations, diagnostic tests or check-ups planned or pending for cancer?				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you had any treatment in hospital or consulted a doctor, medical practitioner or specialist in the last 12 months?				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you have any treatment, consultations, investigations, diagnostic tests or check-ups, planned or pending?				
☐ 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'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

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

Top-up Policy

☐ Please tick if you have a local health insurance policy. You can 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, 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.

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 medical underwriting transfers. 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 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

ALC5276D 27/06/16