Private Client application (Germany)

Underwritten by SiriusPoint International Insurance Corporation

ALC GLOBAL HEALTH INSURANCE
AN IMG COMPANY

Moratorium - We do not cover treatment of any medical conditions (or specified related condition) that existed during the five years before the start of your policy. However, after joining, all eligible pre-existing conditions may be considered if you have been treatment, medication, symptom and check-up free for a continuous period of two years. As a result, there are some ongoing or recurring medical conditions that will never be covered.

Filling out this form

- Use this form to apply for one of our 3 Prima healthcare plans.
- 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 7.
- 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
  - 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 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 and any USA territories ☐ Area 3 – Worldwide	**Area of cover:** ☐ Area 1 – Europe ☐ Area 2 – Worldwide excluding USA and any USA territories ☐ Area 3 – Worldwide	**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 options or Well-being, Optical and Vaccination 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** →	☐ Credit/Debit Card	☐ SEPA Direct Debit#	☐ Bank Transfer
☐ **Quarterly** →	☐ Credit/Debit Card	☐ SEPA Direct Debit#	☐ Bank Transfer
☐ **Monthly** →	☐ Credit/Debit Card	☐ SEPA Direct Debit#	☐ 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

1st family member	2nd family member	3rd family member	4th family member
Title	Title	Title	Title
First name(s)	First name(s)	First name(s)	First name(s)
Surname	Surname	Surname	Surname
Date of birth (DD-MM-YYYY)	Date of birth (DD-MM-YYYY)	Date of birth (DD-MM-YYYY)	Date of birth (DD-MM-YYYY)
Height (cm/ft) Weight (kg/lbs)	Height (cm/ft) Weight (kg/lbs)	Height (cm/ft) Weight (kg/lbs)	Height (cm/ft) Weight (kg/lbs)
Relationship to policyholder	Relationship to policyholder	Relationship to policyholder	Relationship to policyholder
Industry	Industry	Industry	Industry
Occupation	Occupation	Occupation	Occupation
Nationality	Nationality	Nationality	Nationality
Country of residence	Country of residence	Country of residence	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

Policyholder or Family Member's Name

Email address

Tel

Fax

Address

Postcode

Country

Name

Policyholder or Family Member's Name

Email address

Tel

Fax

Address

Postcode

Country

Name

Policyholder or Family Member's Name

Email address

Tel

Fax

Address

Postcode

Country

Name

Policyholder or Family Member's Name

Email address

Tel

Fax

Address

Postcode

Country

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

1) Since the original start date of the medical plan you are looking to transfer from have you been diagnosed with, had treatment, medication or symptoms related to:
   a) Cancer (whether in active or if in remission) b) Heart c) Stroke d) Diabetes, hyperglycemia or hypoglycemia
   e) Back/joint disorders f) Anxiety/depression/psychiatric condition g) Asthma or Allergies

	Policyholder	1st family member	2nd family member	3rd family member	4th family member
a)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

2) Are you currently on any medications (whether prescribed or not)?

Policyholder	1st family member	2nd family member	3rd family member	4th family member
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

3) Do you have any ongoing medical conditions, or do you have an illness which keeps reoccurring?

Policyholder	1st family member	2nd family member	3rd family member	4th family member
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

4) Do you have any hospital stay either planned or pending?

Policyholder	1st family member	2nd family member	3rd family member	4th family member
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

5) Do you have any treatment, consultation, investigations, diagnostic tests or check-ups planned, pending or awaiting results?

Policyholder	1st family member	2nd family member	3rd family member	4th family member
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If the answer to any of the above questions is YES, please give full details and complete 'Declaring illness'. In addition, we reserve the right to review and consider any other relevant information we have such as previous declarations or claims submitted.

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

Declaring illnesses

If you've answered **yes** to any of the questions above, you must give full details here. In addition, we reserve the right to review and consider any other relevant information we have such as previous declarations or claims submitted.

Which question does this declaration relate to?

Full name

Date symptoms/illness first started (MM-YYYY)

Duration of illness (e.g two weeks) or is it still ongoing

Your present state of health in respect of this illness

Brief description of illness or name of condition/diagnosis (if known)

Details of treatment/medication received, current medication/ types and dosages, and details of any future consultations/ treatment anticipated or planned

If you have been diagnosed with Diabetes, High Blood Pressure or High Cholesterol (whether controlled by medication or not) in addition to the above please provide your last three tests results (including dates) together with confirmation of how often you have to follow up with your medical practitioner

Which question does this declaration relate to?

Full name

Date symptoms/illness first started (MM-YYYY)

Duration of illness (e.g two weeks) or is it still ongoing

Your present state of health in respect of this illness

Brief description of illness or name of condition/diagnosis (if known)

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Which question does this declaration relate to?

Full name

Date symptoms/illness first started (MM-YYYY)

Duration of illness (e.g two weeks) or is it still ongoing

Your present state of health in respect of this illness

Brief description of illness or name of condition/diagnosis (if known)

Details of treatment/medication received, current medication/ types and dosages, and details of any future consultations/ treatment anticipated or planned

If you have been diagnosed with Diabetes, High Blood Pressure or High Cholesterol (whether controlled by medication or not) in addition to the above please provide your last three tests results (including dates) together with confirmation of how often you have to follow up with your medical practitioner.

If there is insufficient space on this form please provide details on a separate sheet and attach it to this declaration.

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**

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).

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

7 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

Coverage End Date

8 Your declaration

1. I have received and read the full Definitions, Benefits, Exclusions and Condition 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 or Declaration of Insurance (if outside the EEA or UK) 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 Certification/Declaration of Insurance.
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 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.
   - 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 (publ) 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 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.

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 60 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

CM00501950A221205