Full Medical Underwriting (Germany)

Underwritten by XL Insurance Company SE

ALC GLOBAL HEALTH INSURANCE

Filling out this form

- Use this form to apply for one of our 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 8.
- Please write clearly using capital letters.
- If you have any questions, call us on +44 (0) 1903 817970 (UK), +852 3478 3751 (Hong Kong), +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 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
☐ £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 →	☐ 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

Female

Occupation (please give full details)

Nationality

Country of residence

Email address

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)
Relationship to policyholder	Relationship to policyholder	Relationship to policyholder	Relationship to policyholder
Occupation	Occupation	Occupation	Occupation
Nationality	Nationality	Nationality	Nationality
Country of residence	Country of residence	Country of residence	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
1) 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	☐ Yes ☐ No
2) Cancer, tumours, growths, cysts, moles				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3) 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	☐ Yes ☐ No
4) 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	☐ Yes ☐ No
5) Psychiatric and psychological disorders Including depression, stress, anxiety, schizophrenia, anorexia nervosa, bulimia and compulsive disorders.				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6) Urinary disorders Including bladder, kidney, prostate problems, urinary infections and incontinence.				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7) Ears, nose and throat disorders Including ear infections, sinusitis and tonsillitis.				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8) Eye disorders Including cataracts and eye infections.				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9) Endocrine and metabolic disorders Including diabetes, thyroid and gout.				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10) Gynaecological disorders Including heavy or irregular periods, fibroids, endometriosis and abnormal smears.				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
11) Pregnancy/complications Including delivery by caesarean section.				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
12) Neurological disorders Including stroke, migraines, recurring headaches, multiple sclerosis and epilepsy.				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
13) Respiratory disorders Including asthma, bronchitis, and shortness of breath.				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
14) Skin disorders Including eczema, psoriasis, solar keratosis.				
☐ Yes ☐ No	☐ 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
15) Dental disorders Including impacted wisdom teeth.				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
16) 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
17) 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 XL Insurance Company SE.
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 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

Date of last attendance (MM-YYYY)

☐☐ ☐☐☐☐

Address

Postcode Country

Reason for attendance

Medical Practitioner's Details (continued)

Name

Policyholder or Family Member's Name

Email address

Tel

Fax

Date of last attendance (MM-YYYY)

Address

Postcode

Country

Reason for attendance

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.

Which question does this declaration relate to?

Full name

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

Date symptoms/illness first started (MM-YYYY)

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

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

Your present state of health in respect of this illness

If you have been diagnosed with Diabetes, High Blood Pressure or High Cholesterol (whether controlled by medication or not) in addition to the above information please provide your latest readings/results

Which question does this declaration relate to?

Full name

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

Date symptoms/illness first started (MM-YYYY)

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

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

Your present state of health in respect of this illness

If you have been diagnosed with Diabetes, High Blood Pressure or High Cholesterol (whether controlled by medication or not) in addition to the above information please provide your latest readings/results

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Date symptoms/illness first started (MM-YYYY)

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

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

Your present state of health in respect of this illness

If you have been diagnosed with Diabetes, High Blood Pressure or High Cholesterol (whether controlled by medication or not) in addition to the above information please provide your latest readings/results

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Which question does this declaration relate to?

Full name

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

Date symptoms/illness first started (MM-YYYY)

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

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

Your present state of health in respect of this illness

If you have been diagnosed with Diabetes, High Blood Pressure or High Cholesterol (whether controlled by medication or not) in addition to the above information please provide your latest readings/results

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 XL Insurance Company SE (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: **compliance@axaxl.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://axaxl.com/privacy-and-cookies**

5 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/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.

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.

   We and you are entitled to choose the law that will govern this contract of insurance. We propose English law and this will apply unless otherwise agreed.

   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. 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.

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.

Documentation

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

☐ Yes ☐ No

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