

# Private Client application

Underwritten by XL Insurance Company SE



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), +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](mailto: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](http://www.alchealth.com) or simply scan this code with your smartphone →



Prima Classic	Prima Premier	Prima Platinum
<input checked="" type="checkbox"/> In-patient, day-patient and out-patient treatment	<input checked="" type="checkbox"/> In-patient and day-patient treatment <input type="checkbox"/> Out-patient treatment	<input checked="" type="checkbox"/> In-patient, day-patient and out-patient treatment
<b>Routine pregnancy and childbirth limit:</b> <input type="checkbox"/> £3,000 : €3,600 : US\$4,500 <input type="checkbox"/> £5,000 : €6,000 : US\$7,500	<b>Routine pregnancy and childbirth limit:</b> <input type="checkbox"/> £3,000 : €3,600 : US\$4,500 <input type="checkbox"/> £5,000 : €6,000 : US\$7,500 <input type="checkbox"/> £7,500 : €9,000 : US\$11,250 <input type="checkbox"/> £10,000 : €12,000 : US\$15,000	<b>Routine pregnancy and childbirth limit:</b> <input type="checkbox"/> £3,000 : €3,600 : US\$4,500 <input type="checkbox"/> £5,000 : €6,000 : US\$7,500 <input type="checkbox"/> £7,500 : €9,000 : US\$11,250 <input type="checkbox"/> £10,000 : €12,000 : US\$15,000 <input type="checkbox"/> £20,000 : €24,000 : US\$30,000
<input type="checkbox"/> Dental treatment	<input type="checkbox"/> Dental treatment	<input type="checkbox"/> Dental treatment
<input type="checkbox"/> Evacuation or Repatriation	<input type="checkbox"/> Evacuation or Repatriation	<input type="checkbox"/> Evacuation or Repatriation
<b>Area of cover:</b> <input type="checkbox"/> Area 1 – Europe <input type="checkbox"/> Area 2 – Worldwide excluding USA and any USA territories <input type="checkbox"/> Area 3 – Worldwide	<b>Area of cover:</b> <input type="checkbox"/> Area 1 – Europe <input type="checkbox"/> Area 2 – Worldwide excluding USA and any USA territories <input type="checkbox"/> Area 3 – Worldwide	<b>Area of cover:</b> <input type="checkbox"/> Area 1 – Europe <input type="checkbox"/> Area 2 – Worldwide excluding USA and any USA territories <input type="checkbox"/> Area 3 – Worldwide
<b>In which currency would you like to pay your premium?</b> Your policy benefits will also be in this currency. <input type="checkbox"/> GB£ <input type="checkbox"/> Euro€ <input type="checkbox"/> US\$		
<b>How much excess would you like to pay?</b> 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. <input type="checkbox"/> Nil <input type="checkbox"/> £50 : €60 : US\$75 <input type="checkbox"/> £150 : €180 : US\$225 <input type="checkbox"/> £300 : €360 : US\$450 <input type="checkbox"/> £500 : €600 : US\$750 <input type="checkbox"/> £1,000 : €1,200 : US\$1,500 <input type="checkbox"/> £2,500 : €3,000 : US\$3,750 <input type="checkbox"/> £5,000 : €6,000 : US\$7,500 <input type="checkbox"/> £7,500 : €9,000 : US\$11,250		
<b>How would you like to pay your premium?</b> We'll send details following acceptance of your application. <input type="checkbox"/> <b>Annually</b> → <input type="checkbox"/> Credit/Debit Card <input type="checkbox"/> SEPA Direct Debit# <input type="checkbox"/> Bank Transfer <input type="checkbox"/> <b>Quarterly</b> → <input type="checkbox"/> Credit/Debit Card <input type="checkbox"/> SEPA Direct Debit# <input type="checkbox"/> Bank Transfer <input type="checkbox"/> <b>Monthly</b> → <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

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

Home address

(Country of Residence - address where you currently live)

Postcode:

Country

Correspondence address (if different)

Postcode:

Country

Phone numbers

Home:

Work:

Mobile:

Fax:

### Declaration of Policy Location

You are required to declare your policy location for the purposes of this policy. Your choice will determine whether we can insure you and any taxes that apply.

This forms part of the information you provide to the Insurer as part of your application.

Unless we request it, you will not need to provide any further information.

I declare that my policy location is:

I confirm that my declaration of 'Policy Location' applies to all other individuals under this policy.

Please tick that **at least one** of the following applies to the country that you have declared as your policy location for the purpose of this policy.

I am a citizen or permanent resident of this country

I currently live in this country

I have continuing family ties to this country

I intend to return to this country at the end of any overseas assignment

Policy Location address

(if different from home or correspondence address)

Postcode:

Country

## 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

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	1 <sup>st</sup> family member	2 <sup>nd</sup> family member	3 <sup>rd</sup> family member	4 <sup>th</sup> family member
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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 b) Heart c) Stroke d) Diabetes e) Back/joint disorders f) Anxiety/depression/psychiatric condition

- |   |   |   |   |   |
|---|---|---|---|---|
| a) <input type="checkbox"/> Yes <input type="checkbox"/> No | a) <input type="checkbox"/> Yes <input type="checkbox"/> No | a) <input type="checkbox"/> Yes <input type="checkbox"/> No | a) <input type="checkbox"/> Yes <input type="checkbox"/> No | a) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) <input type="checkbox"/> Yes <input type="checkbox"/> No | b) <input type="checkbox"/> Yes <input type="checkbox"/> No | b) <input type="checkbox"/> Yes <input type="checkbox"/> No | b) <input type="checkbox"/> Yes <input type="checkbox"/> No | b) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c) <input type="checkbox"/> Yes <input type="checkbox"/> No | c) <input type="checkbox"/> Yes <input type="checkbox"/> No | c) <input type="checkbox"/> Yes <input type="checkbox"/> No | c) <input type="checkbox"/> Yes <input type="checkbox"/> No | c) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d) <input type="checkbox"/> Yes <input type="checkbox"/> No | d) <input type="checkbox"/> Yes <input type="checkbox"/> No | d) <input type="checkbox"/> Yes <input type="checkbox"/> No | d) <input type="checkbox"/> Yes <input type="checkbox"/> No | d) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e) <input type="checkbox"/> Yes <input type="checkbox"/> No | e) <input type="checkbox"/> Yes <input type="checkbox"/> No | e) <input type="checkbox"/> Yes <input type="checkbox"/> No | e) <input type="checkbox"/> Yes <input type="checkbox"/> No | e) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f) <input type="checkbox"/> Yes <input type="checkbox"/> No | f) <input type="checkbox"/> Yes <input type="checkbox"/> No | f) <input type="checkbox"/> Yes <input type="checkbox"/> No | f) <input type="checkbox"/> Yes <input type="checkbox"/> No | f) <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

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

- |  |  |  |  |  |
|--|--|--|--|--|
| <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 |
|--|--|--|--|--|

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

- |  |  |  |  |  |
|--|--|--|--|--|
| <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 |
|--|--|--|--|--|

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

- |  |  |  |  |  |
|--|--|--|--|--|
| <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 |
|--|--|--|--|--|

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/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 information please provide your latest readings/results

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/ 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 information please provide your latest readings/results

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/ 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 information please provide your latest readings/results

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/ 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 information please provide your latest readings/results

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 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: [legalcompliance@axaxl.com](mailto:legalcompliance@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: <http://axaxl.com/privacy-and-cookies>

### 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), +852 3478 3751 (Hong Kong), +34 952 93 16 09 (Spain) or +350 2000 77731 (Gibraltar).

### 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 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.

## 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 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

### 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.

- 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.

### 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

XL Insurance Company SE is a European public limited liability company and is regulated by the Central Bank of Ireland. Registered Office 8 St. Stephen's Green, Dublin 2 D02 VK30, Ireland. Registered in Ireland Number 641686.

Global Response Ltd. Registered office: 254 Upper Shoreham Road, Shoreham-By-Sea, West Sussex BN43 6BF. Registered in England and Wales. Registered number 05830667.

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London Global S.r.l. trading as à la carte healthcare. Trading address Chanctonfold Barn Chanctonfold Horsham Road Steyning West Sussex BN44 3AA United Kingdom. London Global S.r.l. trading as à la carte healthcare authorised and regulated by IVASS, Italy (A000620496) and the Financial Conduct Authority (849073).

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