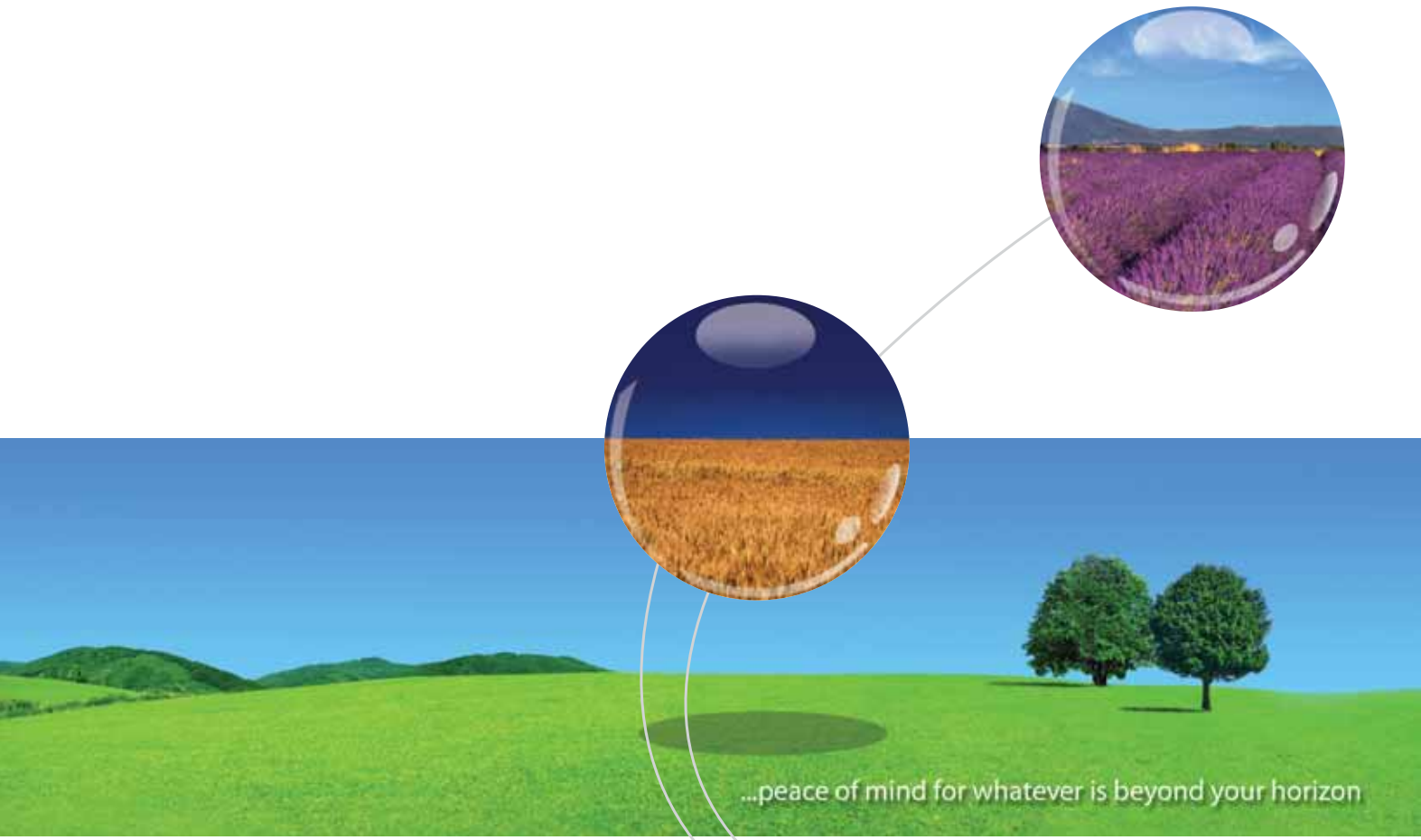
Please complete and press the submit button on the last page to email your application form back to us. Thank you.

# Private Client
German Application

## Prima Premier

## Prima Classic

**your** health **your** choice **your** plan




aLC
GLOBAL HEALTH INSURANCE

## Details of Policyholder

Please print clearly in capital letters

| | | | |
|---|---|---|---|
| Title (Mr/Mrs/Ms/Miss/Other) | | First Name | |
| Other Initials | | Surname | |
| Residential Address | | | |
| | | Postcode | |
| Country | | | |
| Correspondence/Postal Address (if different from above) | | | |
| | | Postcode | |
| Email address | | | |
| Telephone Number Home | | Office | |
| Mobile | | Fax | |

## Medical Underwriting Terms

**Please tick to indicate the underwriting terms applicable to you.**

Moratorium (standard) ☐ Applying to transfer from another insurer or from an ALC Health group policy ☐

Please note that the transfer option is subject to the following terms:

1 There must be no break in cover from previous insurer
2 A copy of your previous Certificate of Insurance is required
3 A completed Health Declaration which is subject to acceptance by underwriters

## Details of all persons to be covered

**Please enter the details of all persons to be covered under this policy, including the policyholder if applicable.** (This can include 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.)

| | 1st Person | 2nd Person |
|---|---|---|
| Title (Mr/Mrs/Ms/Miss/Other) | | |
| First Name | | |
| Other Initials | | |
| Surname | | |
| Gender | | |
| Date of Birth dd/mm/yy | | |
| Relationship to Policyholder | | |
| Occupation | | |
| Nationality | | |
| Country of Residence | | |

| | 3rd Person | 4th Person |
|---|---|---|
| Title (Mr/Mrs/Ms/Miss/Other) | | |
| First Name | | |
| Other Initials | | |
| Surname | | |
| Gender | | |
| Date of Birth dd/mm/yy | | |
| Relationship to Policyholder | | |
| Occupation | | |
| Nationality | | |
| Country of Residence | | |

If there is insufficient space on this form, please supply details on a separate sheet and attach it to this Application.

## Cover required

**Please tick to indicate your preferred plan:**

Prima Premier ☐ Prima Classic ☐

**Please tick to indicate the level of cover you require:**

| Prima Premier | | Prima Classic | |
|---|---|---|---|
| In-patient/day-patient Treatment | ✓ | In-patient/day-patient/out-patient Treatment | ✓ |
| Out-patient Treatment | ☐ | | |
| **Routine Pregnancy & Childbirth** | | **Routine Pregnancy & Childbirth** | |
| Limited to £3,000: €3,600: US$4,500 | ☐ | Limited to £3,000: €3,600: US$4,500 | ☐ |
| Limited to £5,000: €6,000: US$7,500 | ☐ | Limited to £5,000: €6,000: US$7,500 | ☐ |
| Limited to £7,500: €9,000: US$11,250 | ☐ | | |
| Limited to £10,000: €12,000: US$15,000 | ☐ | | |
| Dental Treatment | ☐ | Dental Treatment | ☐ |
| Evacuation or Repatriation | ☐ | Evacuation or Repatriation | ☐ |

The level of cover selected can be amended at any renewal date.

## Area of Cover

Prima Premier and Prima Classic **Area 1** ☐ Europe **Area 2** ☐ Worldwide excluding USA **Area 3** ☐ Worldwide

## Currency

**Please tick to indicate the currency in which you wish to pay your premium and receive your benefits:**

Prima Premier and Prima Classic Sterling (£) ☐ Euro (€) ☐ Dollars (US$) ☐

## Policy excess

Our Prima Premier and Prima Classic have a standard policy excess of £150: €180: US$225 which applies per person per policy year to both in-patient and out-patient expenses. You can amend this by ticking an alternative excess as detailed below. If no box is ticked then the policy will be issued in the standard excess applicable to your chosen policy. The policy excess currency must be the same as detailed above.

Prima Premier and Prima Classic (standard policy excess £150: €180: US$225)

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

## Method of payment

Premiums are payable Annually or Quarterly. Please tick which method you wish to use.

☐ Annually By Credit / Debit Card, Cheque or Bank Transfer (Details to be provided upon acceptance)

☐ Quarterly By Credit / Debit Card or Direct Debit (sterling bank accounts only with a valid UK sort code)

All cheque payments must be in favour of **AXA PPP-ALC Health**. ALC Health do not accept liability for any payments made by other methods or for any payment which does not clearly identify the policyholder.

If you wish to pay your premiums by credit card, debit card or DDM, annually or quarterly, at your policy renewal date we will automatically collect your premium from the card details already notified to us or by DDM, unless you instruct us to the contrary. If you have chosen to pay by credit /debit card please supply the following information:

Card Type AMEX ☐ MasterCard ☐ Delta ☐ Switch ☐ VISA ☐

Card Number _____ Name on Card _____

Address# _____

_____ Postcode _____

Issue Date (mm/yy) _____ Expiry Date (mm/yy) _____

Switch Issue Number* _____

# Address to which card registered (if different from Residential Address)

* This is the number on the front of SWITCH cards.

## Commencement date

Date on which you wish this policy to commence.

Day | Month | Year

Cover under this policy cannot commence until such time as we receive and accept this Application Form.

If you wish your cover to commence at a future date, you must notify us of any material change to the information provided in this Application Form. You cannot apply for cover to commence more than 60 days in advance of completion of this Application Form.

## Data Protection Act 1998

We and the underwriters, AXA PPP International, will collect certain information about you in the course of considering your application and, if a policy is issued to you, conducting our relationship with you. This information will be processed for the purposes of underwriting your insurance coverage, managing any policy issued and administering claims. Your information may be passed to Underwriters, Medical Practitioners, Medical Assistance Companies and Claims Administrators for these purposes. This may involve the transfer of your information to countries that do not have data protection laws. The same duty of confidentiality is required of any third parties to whom the administration of your policy may be subcontracted. Your name and contact details will not be disclosed to other organisations (except as stated above).

You may have a right of access to, and correction of, information that we hold about you. Please contact us if you would like to exercise either of these rights. Some of the information we collect about you may be classified as 'sensitive' – that is information about racial or ethnic origin and physical or mental health. Data protection laws impose specific conditions in relation to sensitive information, including in some circumstances the need to obtain your explicit consent before we process the information. By signing this proposal form you consent to the processing and transfer of information (including sensitive information) described in this notice. Without this consent we will not be able to consider your application.

## Declaration by Policyholder

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.

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 dependents 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.

I confirm as the policyholder I have read and understood the Declarations as noted above ☐

Date DD | MM | YYYY

**I wish to receive all policy documentation and future correspondence electronically from ALC Health** ☐

Agency Name

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August Thyssen Str 2-4, Geilenkirchen, 52511, Germany
T: +49 2451 910 94 50 F: +49 2451 910 94 52
Email: info@ericon-broker.com

Agency Number

GEA407/sp

Submit your form


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