Health Insurance Application Form

Please keep a record of all the information you have supplied. Copies of this application are available on request as are copies of the policy terms. To join a group scheme, pass this application back to your group secretary in a sealed envelope if you prefer. **Please complete in BLOCK CAPITALS throughout.** Use extra space on reverse if needed.

1. Your Personal Details

Title: Name: Surname:

Gender: Date of birth: DDMMYYYY ID/Passport No:

Date passport issued: DDMMYYYY Place of issue:

Address:

Telephone (daytime): Telephone (evening): Mobile:

Occupation: Email:

Name of employer (if group scheme):

Name and address of family doctor: For how many years have you been using this family doctor:

If you have used another family doctor or other medical practitioner in the last five years, please give names and address

Does any member of your family use a different family doctor? Yes ☐ No ☐
If you have answered Yes, please give name/s and address/es of family doctor/s:

2. Additional family members to be covered

	Title:	Name and surname:	Gender:	Date of birth:	Occupation:	Contact telephone number for adult family member/s if different from your own:
Spouse/ Partner:			M/F	DDMMYYYY		
Child 1:			M/F	DDMMYYYY		
Child 2:			M/F	DDMMYYYY		
Child 3:			M/F	DDMMYYYY		
Child 4:			M/F	DDMMYYYY		
Child 5:			M/F	DDMMYYYY		

3. Details of Residency and Nationality

Principal country of residence Nationality:
(The country where you live for at least 180 days in any year):

Is anyone listed in this application away from the principal country of residence listed above for more than 120 days in one year? Yes ☐ No ☐
If Yes give details:

4. Your choice of plan (please leave unanswered if you are joining a group scheme)

International Plan: Full cover ☐ Value option ☐
Private Hospital Plan: Full cover ☐ Value option ☐
Private Clinic Plan: Full cover ☐ Value option ☐

Optional extra benefits available:
Routine maternity for groups*: ☐ Preventive Care: ☐ Preventive Care Plus: ☐
Personal Case Management and Wellbeing Cover: ☐
*only available for company paid groups of ten or more subscribers

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5. Preferred start date of your policy

DDMMYYYY

No insurance is in force until we accept this application in writing.
Payment of premium does not mean that cover is in force.

6. Your method of payment (please leave unanswered if you are joining a group scheme. Charges will apply except if paying annually)

Variable direct debit on bank account which is within the Single Euro Payments Area (SEPA). If you wish to pay by this method, please ask us for a SEPA Direct Debit Mandate form.

Annually ☐ Half Yearly ☐ Quarterly ☐ Monthly (Only available for International Plan) ☐

Cash/Cheque/Credit or Debit card issued by Malta bank/internet banking (please ask for separate credit card application)

Annually ☐

7. Medical History Declaration

IMPORTANT – Please ensure that all eight statements are answered.
Please note (i) 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 and accepted by AXA PPP healthcare. (ii) **Failure to notify Atlas Healthcare or AXA PPP healthcare of a medical condition may result in your policy being invalidated.** If you are in any doubt you must disclose the medical condition. Do not answer with generic replies like "minor ailments". Specific references to each condition must be made such as but not limited to gynaecological or menstrual problems e.g. irregular or painful menstruation, complications of pregnancy/childbirth, abnormal dental conditions, bunions or any other foot disorders, heart or back problems, digestive irregularities, varicose veins, piles, allergies, influenza, tonsillitis, any pains or lumps or other skin problems, problems with limbs or eyes, depression or other "nerve" problems or 'alcohol related' problems.
Full and complete details must be given in respect of each person to be covered. Use extra space overleaf if required. This section needs to be completed even if you have been insured with us or anyone else before.

	You	Spouse/ partner	Child 1	Child 2	Child 3	Child 4	Child 5
1) Present physical defects, infirmities, symptoms or medical conditions (such as but not limited to asthma, diabetes, hypertension, high cholesterol levels, problems from past injuries etc.) even if no medical advice has been sought. *Give (i) names of medical conditions or symptoms (ii) dates of any treatment given (iii) treatment received including drugs (iv) present state of health (v) foreseeable need for further treatment or consultation for each condition.*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*
2) Any admittance to hospitals or nursing homes in the last five years. *Give (i) names of medical conditions (ii) dates of any admittances (iii) treatment received including drugs (iv) present state of health (v) foreseeable need for further treatment or consultation for each condition.*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*
3) Consultations with specialists or any other practitioner (e.g. for physiotherapy, psychology, alternative treatment) in the last five years. *Give (i) names of medical conditions (ii) dates of any consultations (iii) treatment received including drugs (iv) present state of health (v) foreseeable need for further treatment or consultation for each condition.*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*
4) Consultations with any family doctor in the last two years. *Give (i) names of medical conditions (ii) dates of any consultations (iii) treatment received including drugs (iv) present state of health (v) foreseeable need for further treatment or consultation for each condition.*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*
5) Have you ever given birth by caesarean section? (if applicable)	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*
6) Routine checks within the last five years, e.g. routine cervical cancer screening, colonoscopies, bone densitometry, mammography, electrocardiogram (ECG), prostate, cholesterol etc. *Give (i) type of check (ii) dates (iii) results in each case.*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*
7) Do you smoke or have you ever smoked? *If Yes give details i.e. dates and how many per day.*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*
8) Height (cm) Weight (kg)	Height ☐ Weight ☐	Height ☐ Weight ☐	Height ☐ Weight ☐	Height ☐ Weight ☐	Height ☐ Weight ☐	Height ☐ Weight ☐	Height ☐ Weight ☐

If there is any major condition falling outside the five year period mentioned above that we should know about in good faith you must declare it.

8. Other

Have you or any other person applying to be covered had:

1. any private health insurance (including AXA PPP healthcare or any other member of the AXA Group) Yes ☐ No ☐
   and/or
2. any private health insurance or any life, accident or sickness insurance declined Yes ☐ No ☐
   and/or
3. had any special terms imposed Yes ☐ No ☐
   and/or
4. been asked to pay a higher than standard rate of premium? Yes ☐ No ☐
   and/or
5. Are you or any applicant aware that you are or may be pregnant at the time of making this application? Yes ☐ No ☐

(If you have answered yes to any of the above, please give full details including dates of cover and previous membership numbers if applicable. Please attach a copy of your last Certificate of Insurance or Membership Statement if previously insured.)

Declaration

I/We declare that I/we have read this application and to the best of my/our knowledge and belief all statements are true and correct whether they relate to me/us or my dependants, and that no material fact that can influence the acceptance or assessment of this insurance has been withheld. (**If you are in any doubt as to whether a fact is material you must disclose it).** This declaration and the information given on this application shall be the basis of the contract between me/us and the Company. If this form has been completed by another person on my/our behalf this person shall be my/our agent and not the agent of the Company. I/We agree to read my/our Membership Handbook and be bound by the conditions of the said agreement unless I/we cancel my/our enrolment within 15 days of acceptance.

Data Protection Statement – you will see this sign where we ask you to give personal or sensitive information.

Please make sure that everyone covered by this policy reads this summary and the full data privacy notices on Atlas' and AXA's websites: www.atlas.com.mt/legal/data-protection or www.axapppphealthcare.co.uk/privacynotice

AXA PPP healthcare limited (hereinafter referred to as 'we', 'us', 'our'), Atlas Healthcare Insurance Agency Limited (hereinafter referred to as 'Atlas') and/or any other subsidiary companies of Atlas Holdings Limited want to reassure you we never sell personal member information to third parties. We will only use your information in ways we are allowed to by law, which includes only collecting as much information as we need. We will get your consent to process information such as your medical information when it's necessary to do so.

We and Atlas are the controllers of personal data held about you or relating to you and/or any other person/s whom you insure with us (family members), under the terms of the Data Protection Act (hereinafter the 'Act').

In all forms that you complete in relation to this policy, you and other family members are deemed to accept the terms of this statement. You hereby warrant that you have presented this statement to the other family members and have obtained their necessary explicit verbal consent to:

- Allow us or Atlas to obtain information about you and the family members who are covered by your policy from you, those family members, your healthcare providers, hospitals, laboratories and other medical facilities, your employer (if you are on a company scheme), your insurance broker or intermediary if you have one, from other insurance providers, and third party suppliers of information, such as credit reference agencies, and which you hereby authorise to provide the information.
- Allow us or Atlas to process your information mainly for the purpose of preparing quotations, managing your membership, underwriting and settling of claims, including detecting, preventing and/ or suppressing and/or investigating fraud. We also have a legal obligation to do things such as report suspected crime to law enforcement agencies. This processing may be carried out by us or any other AXA companies possibly outside the EU, and/ or by Atlas or any other subsidiary companies of Atlas Holdings Limited (Atlas Group). We also do some processing because it helps us run our business, such as research, finding out more about you, statistical analysis for example to help us decide on premiums and marketing. We do record calls and these may be monitored for training, quality and regulatory purposes.
- Allow us or Atlas or a member of the Atlas Group to disclose your information to other people or organisations. For example to:
  - manage your claims, by for example dealing with your medical advisers;
  - manage your policy with your insurance broker or intermediary;
  - help us prevent and detect crime and medical malpractice by talking to other insurers or to persons acting on their behalf and/ or instructions including (but not limited to) the Malta Insurance Association, relevant agencies such as credit reference agencies, the Malta Insurance Fraud Platform and other appointed experts together with the Commissioner of Police and any public or private hospital or clinic, other healthcare provider of any kind or any person, body or authority authorised by law to receive personal data; and
  - Allow other AXA companies possibly outside the EU and other subsidiaries or any daughter companies of Atlas Holdings Limited to contact you if you have agreed.

Where our using your information relies on your consent you can withdraw your consent, but if you do we may not be able to process your claims or manage your plan properly.

In some cases you have the right to ask us to stop processing your information or tell us that you do not want to receive certain information from us, such as marketing communications. You can also ask us for a copy of information we hold about you and ask us to correct information which you believe is inaccurate or out of date. You have the right to transfer your personal data to another Data Controller. If you want to ask to exercise any of your rights please write to the Data Protection Officer at the following address:

The Data Protection Officer, Atlas Healthcare Insurance Agency Limited, Abate Rigord Street, Ta' Xbiex, XBX 1121, Malta, email: dpo@atlas.com.mt. A request will be dealt with as soon as possible and will not take more than 30 days to process.

Please tick the boxes below to choose how you would like to receive updates about our products and services, promotions, special offers and news from Atlas Healthcare Insurance Agency Limited and/or any other subsidiary companies of Atlas Holdings Limited:

Email ☐ Telephone ☐ Post ☐ SMS ☐

By ticking the boxes above you are giving us permission to use the information supplied to contact you with relevant marketing information. The companies that we mean by us may change from time to time. You may contact us at any time if you change your mind.

We are obliged to retain your records for a minimum period of ten years from the date the insurance relationship ends. We will not retain your data for longer than necessary and will hold it only for the purposes for which it was obtained.

If you consider that the processing of your personal data by us is not in compliance with the provisions of the General Data Protection Regulation (GDPR), you may lodge a complaint with the Office of the Information and Data Protection Commissioner which will investigate your allegations independently.

If you wish to view Atlas' and/or AXA's privacy policy, which explains how we use your data and which change from time to time, please visit: www.atlas.com.mt/legal/data-protection or www.axappphealthcare.co.uk/privacynotice.

Signature of subscriber: _____ Date: DDMMYYYY

Please note that all persons aged 18 or over must sign and date this form.

Signature: _____ Date: DDMMYYYY

Signature: _____ Date: DDMMYYYY

Signature: _____ Date: DDMMYYYY

Please note: You are advised to keep a record of all information supplied in connection with this application including any letters you send to us in connection with it. If you would like a copy of this application form please let us know. Calls may be recorded for quality and assurance purposes. **The completed application form is to be sent to our offices immediately or if you are looking to join a group scheme, pass this application back to your group secretary in a sealed envelope if you prefer. If received more than three weeks after completion a new form will be required. Should there be any material change in answers given in this application before you receive notice of cover, we must be advised immediately.**

Additional notes

For office use only

Basis of underwriting:

Intermediary:

Office Address: Abate Rigord Street Ta' Xbiex XBX 1121 Malta
Tel (356) 21 322 600 Fax (356) 23 265 601
Registered Office: 47-50 Ta' Xbiex Seafront Ta' Xbiex XBX 1021
Tel (356) 23 43 53 63 Fax (356) 21 344 666
Email: health@atlas.com.mt **Website:** www.atlas.com.mt

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