Malta Denplan Corporate Scheme Application Form

For office use only
Date received by Atlas Healthcare Insurance Agency

Intermediary

IMPORTANT – Please complete in BLOCK CAPITALS.

You are advised to keep a record of all information supplied in connection with this application. If you would like a copy of this application form please let us know. The completed application form is to be sent to our offices immediately. 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.

Your personal details

Title Name Surname

Gender M F Date of Birth D D M M Y Y Y Y Identity Card No./Passport No.

Date passport issued D D M M Y Y Y Y Place of passport issue

Address

Telephone: Daytime Evening Mobile

Occupation Email

Name and Address of Employer University of Malta/Junior College/University Broadcasting/University Consultancy/University Residence

Name and Address of Dentist

For how many years have you been using this dentist?

Has any member of your family (including yourself) to be included in this application used a different dentist in the last five years? Yes No

If YES please give name/s and address/es of dentist/s

Additional family members to be covered

	Title	Name and Surname	Gender	Date of Birth	Identity Card No.
Spouse/Partner					
Child 1					
Child 2					
Child 3					

Details of residency and nationality

Principal country of residence (The country where you live for at least 245 days in any year) Nationality

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

Your choice of plan

Essential Extensive Superior

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

Medical History Declaration

IMPORTANT – Please ensure that all statements are answered.

I/we confirm that I/we are not currently undergoing any dental treatment and that no treatment is prescribed or planned other than what I/we have indicated below. I/we understand that if I/we have not been to a dentist and had an exam in the past two years, any restorative treatment identified as necessary at a first dental examination after my/our registration date will not be covered by this policy.

For the avoidance of any delays at claims stage, members who have not had a dental examination in the past 2 years may wish to be examined and present a report with their application. The cost of any medical reports cannot be claimed for.

Please complete for each person to be covered. Use extra space overleaf if required:

	You	Spouse/Partner	Child 1	Child 2	Child 3
Date of last dental x-ray	DD MM YYYY	DD MM YYYY	DD MM YYYY	DD MM YYYY	DD MM YYYY
Treating dentist					
Date of last dental visit	DD MM YYYY	DD MM YYYY	DD MM YYYY	DD MM YYYY	DD MM YYYY
Treating dentist					
Treatment carried out					
Planned treatment					

Other

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

- any private health or dental insurance (including with AXA PPP healthcare or any other member of the AXA Group)? Y ☐ N ☐ and/or
- any private health or dental insurance or any life, accident or sickness insurance declined? Y ☐ N ☐ and/or
- had any special terms imposed? Y ☐ N ☐ and/or
- been asked to pay a higher than standard rate of premium? Y ☐ N ☐

If you have answered YES to any of the above, please give full details including dates of cover and previous membership numbers if applicable.

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/our dependents and that no material fact that can influence the acceptance or assessment of the 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 agreement and be bound by the conditions of the said agreement.

Data Protection Declaration – To provide your plan Atlas Healthcare Insurance Agency Limited will hold and use information supplied by you and those people included in your application as long as this relates to the administration of the insurance policy including the processing of claims, the prevention of fraud and the recording of statistics. By signing this form you confirm that all those included in your application consent to such use of this personal data. You also authorise for the same purposes Atlas Healthcare and any dentist, doctor, hospital, laboratory or health insurance provider to provide full dental information concerning yourself or minor patients of whom you are a guardian and who are registered under this agreement. Telephone calls to or from Atlas Healthcare Insurance Agency may be recorded for training and quality control purposes.

Signature of subscriber ______ Date D D M M Y Y Y Y

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

Signature ______ Date D D M M Y Y Y Y

Signature ______ Date D D M M Y Y Y Y

Signature ______ Date D D M M Y Y Y Y

Extra space if needed:

Contact us:

Atlas Healthcare Insurance Agency Limited
Abate Rigord Street Ta' Xbiex XBX 1121

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www.atlas.com.mt/denplan

Calls may be recorded for security and training purposes.

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