

This section to be completed by AXA PPP International

Customer number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Effective date

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

International Health Plan Individual application form

Please complete this form using block capitals and by ticking the relevant boxes. It is important that you provide the following information so that we can properly assess your application. If therefore, you do not answer the questions, we shall take that failure to answer to mean that you have nothing to disclose. **We cannot insure you if you are a national of your principal country of residence.**

1. Your personal details

Surname: (Mr/Mrs/Miss/Ms/Dr)		Full forenames:																					
Address:																							
Country code: Area code: Number:		Country:	Postcode:																				
Country code: Area code: Number:		Country code: Area code: Number:																					
Telephone no:	Fax no:		Date of birth: Day: Month: Year:																				
This is the number that is most appropriate to contact you on, Monday to Friday between 9am and 5pm (GMT).																							
Occupation:	Principal country of residence (not UK)																						
E-mail:																							
Nationality:	If your principal country of residence is the United States of America or Canada, this policy will terminate at the end of the first year. American and Canadian citizens whose principal country of residence is either the USA or Canada are not eligible to apply for an International Health Plan.																						
Are you applying for permanent residency/citizenship in the USA/Canada (please tick box) Yes <input type="checkbox"/> No <input type="checkbox"/>		Customer number if a member of AXA PPP International:																					
		<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																					

2. Additional family members to be included in the plan

Please give names in full	Relationship to policyholder:	Date of birth:			Nationality
		Day	Month	Year	
1					
2					
3					
4					
5					

3. Your choice of currency for your policy

GBP (£) USD (\$) EUR (€)

4. Type of cover required

(a) Choose your area of cover and tick the relevant box:
Worldwide **Worldwide excluding the USA** (Please note you must be out of the UK for more than 6 months a year)

(b) Choose the level of cover you require and tick the relevant box:
Prestige **Comprehensive** **Standard**
 (Inc. Travel Insurance)

(c) Choose the excess level you require: (This must be the same currency as your choice above)

£0 <input type="checkbox"/>	Option 1 – £100 <input type="checkbox"/>	Option 2 – £250 <input type="checkbox"/>	Option 3 – £500 <input type="checkbox"/>	Option 4 – £1,000 <input type="checkbox"/>	Option 5 – £2,000 <input type="checkbox"/>
\$0 <input type="checkbox"/>	Option 1 – \$160 <input type="checkbox"/>	Option 2 – \$400 <input type="checkbox"/>	Option 3 – \$800 <input type="checkbox"/>	Option 4 – \$1,600 <input type="checkbox"/>	Option 5 – \$3,200 <input type="checkbox"/>
€0 <input type="checkbox"/>	Option 1 – €125 <input type="checkbox"/>	Option 2 – €320 <input type="checkbox"/>	Option 3 – €640 <input type="checkbox"/>	Option 4 – €1,275 <input type="checkbox"/>	Option 5 – €2,550 <input type="checkbox"/>

Please include Travel Insurance cover for all persons covered in this application form (please tick).

Note: Travel Insurance is available at extra cost except on Prestige option and must cover all persons in this application form.

5. Preferred start date

Date: day: Month: Year:

6. Paying your premium

(a) I would like to pay my premium:	Annually <input type="checkbox"/>	Quarterly <input type="checkbox"/>	Monthly <input type="checkbox"/>
(b) I would like to pay my premium by:	Direct Debit <input type="checkbox"/> (UK Banks only) (Refer to section 8)	Credit card <input type="checkbox"/> (Refer to section 9)	Cheque/sterling bankers draft <input type="checkbox"/> Please make your cheque payable to AXA PPP International (annual or quarterly payments only)

7. Confidential medical history

Please answer all the questions in full and to the best of your knowledge and belief. If you have any doubts whether something may influence how we deal with your application (we call these material facts), you should include it as your policy may be invalid entirely if you fail to disclose any material facts. If for any reason you do not answer a question, we shall take that as meaning you have nothing to disclose. You do not need to tell us about any genetic test results. Please note, once you have joined we do not pay for treatment of any medical condition (or treatment of any medical condition arising from or associated with such a medical condition) which you already had when you joined and which you should have told us about but did not tell us at all or did not tell us everything unless you have declared it and we have not excluded it. This includes any such medical condition(s) or symptoms, whether or not being treated and any previous medical condition(s) which recurs or which you should reasonably have known about even if you had not consulted a doctor.

Please give details of all those individuals who answer 'Yes' to any questions.

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 within three months.

Part A. You must declare your medical history even if you have been insured with us or anyone else before.

	You	Spouse/Partner	Child 1	Child 2	Child 3	Child 4
1) Have you or any members of your family (if included in this application) consulted with a medical practitioner, been admitted to hospital or nursing home, or suffered from an intermittent or recurring illness during the last five years?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
2) Have you or any members of your family (if included in this application) consulted with a medical practitioner in the past year?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
3) Have you or any members of your family (if included in this application) had any medical condition, disability or health problem, not mentioned above, whether or not a doctor has been consulted, for example, gynaecological or menstrual problems, complications of pregnancy, signs or symptoms of varicose veins, back trouble, joint disorders, joint replacements, foot problems (eg bunions), indigestion or bowel problems, abdominal pain, skin problems, allergies, anxiety, depression or other psychiatric problems, trouble with heart, limbs, ears, eyes, urination etc, and is there any other information which you should, in good faith, disclose?	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

Part B. Additional information (Please continue on a separate sheet if necessary. Tick this box if attached)

If you have answered yes to any of the questions in part A please give full details here or anything else you should disclose to us in good faith.

Statement No.	Name of patient	Nature of illness	Period of illness Month/Year duration	Present state of health in this respect

You must declare any condition you or any applicant has had during your/their lifetime which may have an impact on your/their future health. If you are in any doubt as to whether a condition may be relevant to this application, you must declare it in good faith.


8. Your signature and declaration

Declaration: I declare that I spend six or more months of the year outside the UK. I also declare that to the best of my knowledge and belief the statements on this application form are full, true and correct, that I shall read the policy handbook when received and that I agree to be bound by it unless I shall cancel the enrolment within 30 days of acceptance of my application. I agree that the acceptance of my application shall be on the basis of these statements. I understand that you will issue policy documents, written communications and membership details in English unless you and I have specifically agreed, in writing, to communicate in a different language. I also understand that you will send all correspondence about this application to the main policyholder unless I write to tell you otherwise.

Please remember: If there are changes in the information you have given before we have told you that your family member(s) has or have been added to your policy, you must tell us in writing immediately.

Signature:

Date:

 Please make sure that you either show this statement to anyone covered by this policy, or inform them of its contents before you return this form.

To set up and administer your policy AXA PPP healthcare limited will hold and use information about you and any family members covered by your policy, supplied by you, those family members, medical providers or your employer. Please ensure that you only provide us with sensitive personal information, such as health information, about other people with their agreement. When you give us this information we will take this as confirmation that you have consent to do so.

We send personal and sensitive personal information in confidence for processing by other companies and intermediaries, including those located outside the European Economic Area.

As you act on behalf of any family member covered by this policy, we send correspondence about the policy, including claims correspondence, to you unless we are advised to do otherwise.

By signing and returning this form you indicate that you have authority to give consent on behalf of any family members covered by your policy and on your own and their behalf you consent to the use of personal information in the ways described above.

We are required by law, in certain circumstances, to disclose information to law enforcement agencies about suspicions of fraudulent claims and other crime. We will disclose information to third parties including other insurers for the purposes of prevention or investigation of crime including reasonable suspicion about fraud or otherwise improper claims. This may involve adding non-medical information to a database that will be accessible by other insurers and law enforcement agencies. We are obliged to notify the General Medical Council or other relevant regulatory body about any issue where we have reason to believe a medical provider's fitness to practice may be impaired.

AXA PPP International, SecureHealth and Denplan ("we") are members of the AXA UK Group of companies. We would like to use the contact details obtained as a result of this application, to inform you by letter, telephone or email of other products and services. AXA PPP healthcare would also like to share these contact details with further members of the AXA UK1 Group and carefully selected third parties based within the European Economic Area so that they can let you know about their products and services by letter or telephone and, if appropriate, to administer them. By signing and returning this form you will be consenting to these uses to enable you to receive marketing information from AXA PPP healthcare, Securehealth and Denplan as well as from other AXA UK Group companies and/or third party companies unless you tick the box to indicate that you do not consent .

You may change your mind at any time by writing to the address on the back of the [Membership Information Booklet] [Membership Handbook].

After completing this application form and signing the declaration, please return to: **AXA PPP healthcare, Phillips House, Crescent Road, Tunbridge Wells, Kent TN1 2PL, UK**

(For UK Intermediary use only)

In the event that the above applicant is resident/registered in an EEA country other than the UK, I/we confirm that I/we hold the appropriate FSA permissions to passport business into the UK from that country.

Signature:

Date:

9. Instructions to your bank

Instruction to your Bank or Building Society to pay by Direct Debit

Please fill in the whole form (including the official use box if appropriate) and send to:

**AXA PPP healthcare limited, Phillips House, Crescent Road,
Tunbridge Wells, Kent TN1 2PL.**

Name(s) of account holder(s):

Bank/Building Society
account number:

Branch Sort Code:

Name and full postal address of your bank or building society

To The Manager: Bank/Building Society

Address:

Postcode:

Reference:

Service User
Number:



For AXA PPP healthcare limited official use only

This is not part of the instruction to your Bank or Building Society.

Instruction to your Bank or Building Society

Please pay AXA PPP International Direct Debits from the account detailed in this Instruction, subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with AXA PPP International and, if so, details will be passed electronically to my Bank/Building Society

Signature:

Date:

Banks and building societies may not accept Direct Debit Instructions for some types of account

This guarantee should be detached and retained by the payer.

The Direct Debit Guarantee

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits
- If there are any changes to the amount, date or frequency of your Direct Debit AXA PPP healthcare limited will notify you 7 working days in advance of your account being debited or as otherwise agreed. If you request AXA PPP healthcare limited to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit, by AXA PPP healthcare limited or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society – If you receive a refund you are not entitled to, you must pay it back when AXA PPP healthcare limited asks you to
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.



