

Worldwide Healthcare Plan - Employee Application Form

Please complete in **BLOCK** capitals ensuring all relevant fields are completed

1. To be completed by the employee

Title: Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other <input type="checkbox"/> _____	First names:
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Surname:

Date of Birth: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> D D M M Y Y 	Sex: <input type="checkbox"/> <input type="checkbox"/> M F
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Correspondence address including zip/postcode:

Telephone Number: Day Time Evening	Fax Number: Email Address:
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*Country of Residence:	*Elected Country:
*Home Country:	* See Notes below

2. Employment Details

Name of Employer:

Address of Employer, including zip/postcode:

What is your occupation?

3. Dependant Details

Surname	First names	Sex M/F	Date of Birth DD/MM/YY	*Home Country	*Country of Residence
Spouse/Partner					
Children					

Notes

- * **Home Country:** this is the country for which you hold a passport.
- * **Country of Residence:** this is the country where you are living for the most part of the year.
- * **Elected Country:** this is the country of your choice where you would wish to be treated for a major surgical intervention – please see the policy wording for further details. Please note that your Elected Country must:
 1. be within your chosen geographical area
 2. apply to all insured members of your family.

Declaration

I declare to the best of my knowledge and belief that the statements made by me on this application form, together with any supplementary information forming part of this application are full, true and correct. I understand that any changes to the information I have provided which take place between the time this form is completed and the time coverage becomes effective, must be notified in writing to the Insurer prior to the effective date of this coverage and that failure to do so may result in the rejection of a claim or cancellation of my policy.

Important Note

Please ensure that you have been provided with the terms and conditions of the policy, as agreed between the Insurer and your employer (the Policyholder), as these will apply to you and any members of your family to be covered. If you do not understand any aspect of the terms and conditions you should contact **your employer** before signing this application.

Data Protection Notice

I confirm that Europ Assistance Holdings Limited may use my personal information to administer my policy, process claims, for underwriting and pricing purposes, to maintain management for business analysis and may disclose personal information under the protection of a contract to their agents or service providers to administer my policy, to those involved with my treatment or care and to any IFA or intermediary appointed to act on my behalf. I confirm that my data may be processed by service providers in a country outside the European Economic Area. By signing this application form, I agree that Europ Assistance Holdings Limited and its agents may use the information I supply which may include health information that the Data Protection 1998 Act defines as 'sensitive data' for the purposes stated.

I confirm that for the purposes of the Act, I have the authority of any member of my family named on this application form to consent on their behalf to their personal data being processed and by signing this application form I agree that Europ Assistance Holdings Limited may use their personal data for the purposes described above.

Signature

Date / /

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For further information or for any queries, please contact: Europ Assistance, International Health Solutions S.A.S., PO Box 637, Sussex House, Perrymount Road, Haywards Heath, West Sussex RH16 1WR, United Kingdom.

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