Malta Corporate Dental Range Application Form

April 2022

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.

1. 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) | Telephone (evening) | Mobile

Occupation | Email

Name of Employer

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

2. Additional family members to be covered

	Title	Name and Surname	Gender	Date of Birth	Identity card/ passport no.
Spouse/Partner					
Child 1					
Child 2					
Child 3					

3. Details of residency and nationality

Principal country of residence (The country where you live for at least 180 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

4. 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.

5. 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 joining 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	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y
Treating dentist					
Date of last dental visit	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y
Treating dentist					
Treatment carried out					
Planned treatment					

6. Other

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

• any previous private health or dental insurance? Y N

If yes, please give the name of the company

• 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 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 Handbook and Membership Agreement and be bound by the conditions of the said agreement.

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

Atlas Insurance PCC Limited and/or any other subsidiaries of Atlas Holdings Limited or any of its daughter companies (hereinafter '**Atlas Insurance**', '**us**', '**our**', '**we**') are the data controllers, as defined by relevant data protection laws and regulations, of personal data held about **you** or relating to **you** and/or to any other person/s (**family member/s**) whom **you** insure with **Atlas**.

In completing all the forms related to **your policy** or claims, **you** confirm **your** understanding and acceptance of the terms in **our** Data Protection and Privacy Statement. **You** hereby warrant that **you** have informed **your family member/s** why **we** asked for this information and what **we** will use it for and have obtained the necessary explicit verbal consent to process such data for the purposes mentioned below.

Atlas collects and processes information about **you** and **your family member/s** for purposes which include preparing requested quotations, underwriting and administering the insurance proposal and **policy**, carrying out its contractual obligations including handling and settling of claims, and preventing or detecting crime (including fraud). **Atlas** may monitor calls to and from customers for training, quality and regulatory purposes.

Atlas may collect and disclose **your** and **your family members'** information from/to other entities in order to conduct **our** business including:

- managing claims, which may require **us** to obtain data including medical information from healthcare providers (including any dentist, medical practitioner, any public or private hospital, clinic, laboratory or other medical facility), and/or **your** employers (for company schemes) and which **you** hereby authorise to provide the information;
- administering policies with:
  - **our** associated companies
  - introducers, intermediaries, agents or brokers when these are appointed by **you**,
  - the policyholder (in the case of corporate policies),
  - insurance principals, reinsurers and co-insurers

including third parties providing services to these;

- helping **us** prevent or detect crime by sharing **your** information with regulatory and public bodies in **Malta** or, if applicable, overseas, including the Police, as well as with other insurance companies (directly or via shared databases such as the Malta Insurance Fraud Platform), or other agencies or appointed experts to undertake credit reference or fraud searches or investigations;
- **our** third party suppliers or service providers to whom **we** outsource certain business operations.

We will retain data for the period necessary to fulfil the above-mentioned purposes unless a longer retention period is required or permitted by law.

You can withdraw **your** consent to **Atlas** processing **your** personal information which is processed with **your** consent, e.g. direct marketing, at any time. **You** have the right to access **your** personal data and ask **Atlas** to update or correct the information held or delete such personal data from our records if it is no longer needed for the purposes indicated above. **You** may exercise these and other rights held in **Atlas's** Data Protection and Privacy Statement, by contacting our Data Protection Officer at The Data Protection Officer, Atlas Insurance PCC Limited, 419 Ta' Xbiex Seafront, Ta' Xbiex XBX 1021 Malta or email dpo@atlas.com.mt. Please note, however, that certain personal information may be exempt from such access, correction or erasure requests pursuant to applicable data protection laws or other laws and regulations.

If **you** and **your family member/s** consider that the processing of personal data by **Atlas** is not in compliance with data protection laws and regulations, **you** and **your family member/s** may lodge a complaint with **us** and/or the Office of the Information and Data Protection Commissioner by following this link https://idpc.org.mt/en/Pages/contact/complaints.aspx.

If **you** wish to view the full **Atlas's** Data Protection and Privacy Statement, for a better understanding of how we use this data please visit https://www.atlas.com.mt/legal/data-protection/. Kindly note that this is subject to occasional changes including to comply with changing data protection laws, regulations and guidance.

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 ☐

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

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.

Extra space if needed:

Contact us:

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

+(356) 2132 2600
dental@atlas.com.mt
atlas.com.mt/dental

Calls may be recorded and/or monitored for quality assurance, training and as a record of our conversation

Atlas Healthcare

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