Flexible health insurance plans that work around you

Application form

Atlas Healthcare

AXA PPP healthcare

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 BLOCKS. Use extra space on reverse if more space needed.

For office use only.
Date received by Atlas Healthcare Insurance Agency
Basis of underwriting

Intermediary

1. Your personal details

Title ( ) Name ( ) Surname ( )

Sex 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 and address of employer (if group scheme) ( )

Name and address of GP ( )

For how many years have you been using this GP? ( )

If you have used another GP or other medical practitioner in the last five years, please give name and address

( )

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

( )

Do all the GPs listed on this application keep medical records? Yes ☐ No ☐ If No, which GPs do not ( )

2. Additional family members to be covered

	Title	Name and Surname	Sex (M/F)	Date of Birth	Occupation	Identity Card Number
Spouse/Partner				D D M M Y Y		
Child 1				D D M M Y Y		
Child 2				D D M M Y Y		
Child 3				D D M M Y Y		

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 and/or optional benefits *(please leave unanswered if you are joining a group scheme)*

1. AXA PPP healthcare International Plan — ☐ Full Cover ☐ Value option
2. AXA PPP healthcare Private Hospital Plan — ☐ Full Cover ☐ Value option
3. AXA PPP healthcare Private Clinic Plan — ☐ Full Cover ☐ Value option

Optional extra benefits available:
Routine maternity for groups* ☐ Preventive Care ☐ Preventive Care Plus ☐

*only available for company paid groups of ten or more subscribers

5. Preferred start date of your policy ( )

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.)*

	Annually	Half Yearly	Quarterly	Monthly (Only available for International Plan)
Variable direct debit on Malta bank (please complete application on next page)	☐	☐	☐	☐
Cash/Cheque/Credit or Debit card issued by Malta bank/internet banking (*please ask for separate credit card application*)	☐	n/a	n/a	n/a

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 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 eg 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
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.*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *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.*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*
3) Consultations with specialists or any other practitioner (eg 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.*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*
4) Consultations with any GP 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.*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*
5) Have you ever given birth by caesarean section? (if applicable)	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
6) Routine checks within the last five years, e.g. routine cervical cancer screening, colonoscopies, bone densitometry, mammography, ECG, prostate, cholesterol etc. *Give (i) type of check (ii) dates (iii) results in each case.*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*	Y ☐ N ☐ *Details if Yes*
7) Do you smoke or have you ever smoked? *If Yes give details ie dates and how many per day*	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
8) Height (cm) Weight (kg)	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.

Instruction to your Bank to pay by Direct Debit

(please leave unanswered if you are joining a group scheme)

Note: If your policy is renewable between the 1st and the 15th of the month, your account will be debited at the end of the previous month. If your policy is renewable between the 16th and the end of the month, your bank account will be debited mid month.

Please complete:

Name of Account Holder(s)

Bank account number

Branch

Bank: ☐ APS Bank ☐ Lombard Bank ☐ Banif Bank Malta plc ☐ Bank of Valletta ☐ HSBC Bank Malta plc

International Banking Account Number (IBAN)

Office Use Only

Membership Number

Branch Sort Code

DIRECT Debit

Instruction to your Bank to pay by Direct Debit.

Please pay by Direct Debit, from the account detailed below, at the request of Atlas Healthcare Insurance Agency Limited the repayment of my/our Health Insurance policy. I/We understand that Atlas Healthcare Insurance Agency Limited will inform me/us 14 days prior to each annual renewal payment and prior to any change in payment amount or dates. The bank will not be bound to verify whether such notice has been given. I/We understand that the Bank is at liberty to refuse to effect payment if my/our bank account does not have sufficient funds to meet such requests. I/We also note that the bank is entitled to terminate such Direct Debit arrangements at its sole discretion by advising me/us and Atlas Healthcare Insurance Agency Limited in writing. I/We will inform the Bank in writing if I/we wish to cancel this mandate.

Signature of bank account holder/s ✗ Date ✗

Name in block letters

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) Y ☐ N ☐
   and/or
2. any private health insurance or any life, accident or sickness insurance declined Y ☐ N ☐
   and/or
3. had any special terms imposed Y ☐ N ☐
   and/or
4. been asked to pay a higher than standard rate of premium? Y ☐ N ☐

5. Are you or any applicant aware that you are or may be pregnant at the time of making this application? 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. 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/our 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 agreement and be bound by the conditions of the said agreement unless I/we cancel my/our enrolment within 30 days of acceptance.

Data Protection Declaration – you will see this sign where we ask you to give personal or sensitive information.
I/We consent to the processing of my/our personal data by AXA PPP healthcare limited, Atlas Healthcare Insurance Agency Limited, any other member of the AXA Group and any other companies acting under AXA PPP healthcare's instructions (any of which may be located outside the European Economic Area) as long as this processing relates to the administration of my health insurance policy, its underwriting, the handling and settling of claims, the detection, prevention and/or suppression of fraud and the recording of statistics.
I/We authorise the Company to seek any medical information relating to me/us or my/our minor dependants. I/We also authorise any doctor, hospital, laboratory, other medical facility, insurance provider or any other practitioner to provide full medical information concerning me/us or my/our minor dependants.
I/We understand that the Company may, in addition, exchange information with others (including but not limited to my/our intermediary, medical advisers, the Malta Insurance Association or other insurance companies) for the purposes shown in the Data Protection Declaration. I/We also understand that I/we have the right to request access to my/our personal data by contacting the Company in writing.

Signature of subscriber _____ Date D D M M Y Y Y Y

Please note that, all persons aged 18 or 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

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. 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

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Atlas Healthcare Insurance Agency Limited
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