Supported by

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 BLOCK CAPITALS throughout.**
Use extra space on reverse if needed.

1. Your Personal Details

Title: Name: Surname:

Gender: Date of birth: DDMMYYYY ID/Passport No:

Date passport issued: DDMMYYYY Place of issue:

Address:

Telephone (daytime): Telephone (evening): Mobile:

Occupation: Email:

Name of employer (if group scheme):

Name and address of family doctor: For how many years have you been using this family doctor:

If you have used another family doctor or other medical practitioner in the last five years, please give names and address

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

2. Additional family members to be covered

	Title:	Name and surname:	Gender:	Date of birth:	Occupation:	Contact telephone number for adult family member/s if different from your own:	ID Number
Spouse/ Partner:			M/F	DDMMYYYY			
Child 1:			M/F	DDMMYYYY			
Child 2:			M/F	DDMMYYYY			
Child 3:			M/F	DDMMYYYY			
Child 4:			M/F	DDMMYYYY			
Child 5:			M/F	DDMMYYYY			

3. Details of Residency and Nationality

Principal country of residence Nationality:
(The country where you live for at least 180 days in any year):

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

International Plan: Full cover Value option
Private Hospital Plan: Full cover Value option
Private Clinic Plan: Full cover Value option

Optional extra benefits available:
Routine maternity for groups*: Preventive Care: Preventive Care Plus:
Personal Case Management and Wellbeing Cover:
*only available for company paid groups of ten or more employees.

5. Preferred start date of your policy

DDMMYYYY

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)

Variable direct debit on bank account which is within the Single Euro Payments Area (SEPA). If you wish to pay by this method, please ask us for a SEPA Direct Debit Mandate form.

Annually ☐ Half Yearly ☐ Quarterly ☐ Monthly (Only available for International Plan) ☐

Cash/Cheque/Credit or Debit card issued by Malta bank/internet banking (please ask for separate credit card application)

Annually ☐

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 Atlas. (ii) **Failure to notify Atlas 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 e.g. 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 and please specify which family member (if applicable) this refers to. This section needs to be completed even if you have been insured with us or another insurance provider before.

	You	Spouse/ partner	Child 1	Child 2	Child 3	Child 4	Child 5
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.*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *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.*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*
3) Consultations with specialists or any other practitioner (e.g. 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.*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*
4) Consultations with any family doctor 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.*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*
5) Have you ever given birth by caesarean section? (if applicable)	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*
6) Routine checks within the last five years, e.g. routine cervical cancer screening, colonoscopies, bone densitometry, mammography, electrocardiogram (ECG), prostate, cholesterol etc. *Give (i) type of check (ii) dates (iii) results in each case (iv) reason for the check.*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*
7) Do you smoke or have you ever smoked? *If Yes give details i.e. dates and how many per day.*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*	Yes ☐ No ☐ *Details if Yes*
8) Height (cm) Weight (kg)	Height ☐ Weight ☐	Height ☐ Weight ☐	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 in the extra space provided overleaf.

8. Other

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

1. any previous private health insurance — Yes ☐ No ☐

If yes please give the name of the company

and/or

2. any private health insurance or any life, accident or sickness insurance declined — Yes ☐ No ☐

and/or

3. had any special terms imposed — Yes ☐ No ☐

and/or

4. been asked to pay a higher than standard rate of premium? — Yes ☐ No ☐

and/or

5. Are you or any applicant aware that you are or may be pregnant at the time of making this application? — Yes ☐ No ☐

(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 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 Atlas Healthcare. 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 Atlas Healthcare. I/We agree to read my/our Membership Handbook and be bound by the conditions of the said agreement unless I/we cancel my/our enrolment within 15 days of acceptance.

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 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** may 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** Data Protection and Privacy Statement, by contacting

our Data Protection Officer at The Data Protection Officer, Atlas Insurance PCC Limited, 48-50 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** 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.

Additional notes

For office use only

Basis of underwriting:

Intermediary:

Contact us:

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

Tel: +(356) 21 322600
Fax: +(356) 23 265601
email: health@atlas.com.mt
www.atlas.com.mt

SEPA Direct Debit Mandate

Creditor: Atlas Healthcare Insurance Agency Limited
Creditor Identifier: MT98ZZZ000507983T

Mandate Reference number: (to be completed by us)

By signing this mandate form you authorise (a) Atlas Healthcare Insurance Agency Limited to send instructions to your bank to debit your account for the repayment of your health insurance and (b) your bank to debit your account in accordance with the instructions from Atlas Healthcare Insurance Agency Limited.

As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited.

Name and Surname

Address

IBAN (International Bank Account Number)

Debtor account number

SWIFT/BIC

Type of Payment: Recurrent payment ☐ Single payment ☐

Place of signature	Date of signature
Signature	Time of signature

Your rights are explained in a statement that you can obtain from your bank.

Details regarding the underlying relationship between the Creditor and the Debtor - for information purposes only

Name of Policy holder/s

Name of the person on whose behalf payment is made
(if you are making a payment in respect of an arrangement between Atlas Healthcare Insurance Agency Limited and another person)

Policy Number

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 amounts 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.

If the policy is renewable between the 1st and 15th of the month, my/our account will be debited on or around the 28th of the previous month. If the policy is renewable between the 16th and the end of the month, my/our bank account will be debited mid-month.

Please return form to: Atlas Healthcare Insurance Agency Limited, Abate Rigord Street, Ta' Xbiex XBX 1121 Malta

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Request for claim payments to be credited directly to bank account

PLEASE FILL IN ALL DETAILS AND USE **BLOCK** CAPITALS THROUGHOUT

This form is to be sent to: Atlas Healthcare Insurance Agency Limited, Abate Rigord Street, Ta' Xbiex XBX1121, Malta

Policy Details

Policy No.	Group (if applicable)
Member name and surname	
ID Card/Passport No.	Mobile No.
Email Address*	Telephone No.

*This is required for payment notification purposes

Bank Details

Note: Claim settlement by direct credit transfer is only possible for bank accounts which are within the Single Euro Payments Area (SEPA)

Bank Name	Branch
Name of Bank Account Holder	

IBAN (International Bank Account Number)

BIC/SWIFT (Bank Identifier Code, foreign bank accounts only)

Member's Signature	Date

In future, if you are the subscriber, claims for all members aged under 18 will be credited to this account unless notified otherwise.
If dependents aged 18 and over would like their claims to be settled to this account, please complete the section below.

Dependants (For completion ONLY for family members aged 18 and over)

Dependant 1 name and surname	
Dependant's signature	Date
Dependant 2 name and surname	
Dependant's signature	Date
Dependant 3 name and surname	
Dependant's signature	Date