AXA PPP INTERNATIONAL
redefining / standards

International Health Plan Individual application form

This section to be completed by AXA PPP International

Quote number

Q

Effective date

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 to mean that you have nothing to disclose. Please note we will not be able to process your application if this form is incomplete.

1 Your personal details

1.1 Title and name:

☐ Mr ☐ Mrs ☐ Ms ☐ Miss Other:

Full forenames:

Surname/last name:

1.2 Address:

Country: Postcode:

1.3 Telephone no: (include country and area code)

This is the number that is most appropriate to contact you on, Monday to Friday between 9am and 5pm (GMT).

1.4 E-mail address:

1.5 Fax no: (include country and area code)

1.6 Occupation:

1.7 Date of birth:

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BSI ISO14001 UKAS ENVIRONMENTAL MANAGEMENT

PB44782b/08.12

1 Your personal details – continued

1.8 Principal country of residence:

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 ☐ No ☐

1.9 Nationality:

1.10 Customer number if already a member of AXA PPP International/AXA PPP healthcare (shown as membership number):

2 Additional family members to be included in the plan

2.1 Title: First name: Last name:

Date of birth: D D M M Y Y Relationship to policyholder: Nationality:

Title: First name: Last name:

Date of birth: D D M M Y Y Relationship to policyholder: Nationality:

Title: First name: Last name:

Date of birth: D D M M Y Y Relationship to policyholder: Nationality:

Title: First name: Last name:

Date of birth: D D M M Y Y Relationship to policyholder: Nationality:

Title: First name: Last name:

Date of birth: D D M M Y Y Relationship to policyholder: Nationality:

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 USA

(b) Choose the level of cover you require and tick the relevant box:

☐ Prestige Plus
(Inc. Travel Insurance)

☐ Prestige
(Inc. Travel Insurance)

☐ Prestige with dental add-on
(Inc. Travel Insurance)

☐ Comprehensive

☐ Comprehensive with dental add-on

☐ Standard

☐ Standard with outpatient add-on

☐ Please include Travel Insurance cover for all persons covered in this application form (please tick).
Note: Travel Insurance is included in the Prestige and Prestige Plus options. It can be added to the Comprehensive and Standard options for an extra cost and must cover all persons in this application form.

☐ Please include IHP Marine Cover for all persons included in this application form (please tick)
Note: IHP Marine Cover is available at extra cost and must cover all persons on this application form.

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

£0 ☐	Option 1 – £100 ☐	Option 2 – £250 ☐	Option 3 – £500 ☐	Option 4 – £1,000 ☐	Option 5 – £2,000 ☐
$0 ☐	Option 1 – $160 ☐	Option 2 – $400 ☐	Option 3 – $800 ☐	Option 4 – $1,600 ☐	Option 5 – $3,200 ☐
€0 ☐	Option 1 – €125 ☐	Option 2 – €320 ☐	Option 3 – €640 ☐	Option 4 – €1,275 ☐	Option 5 – €2,550 ☐

5 Preferred start date

Date:

D D M M Y Y

6 Paying your premium

(a) I would like to pay my premium: ☐ Annually ☐ Quarterly ☐ Monthly

(b) I would like to pay my premium by:

☐ Direct Debit
(GBP Sterling Policy and UK Banks only)
(Refer to section 10)

☐ Credit card
(Refer to section 9)

☐ Cheque/Direct Debit transfer
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
7.1 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?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
7.2 Have you or any members of your family (if included in this application) consulted with a medical practitioner in the past 12 months?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
7.3 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?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

If you have chosen Prestige Plus as your level of cover please answer the question below:

7.4 Do you or anyone else covered on your policy suffer from AIDS or HIV or are currently awaiting treatment, investigations, check ups or the results of investigations for AIDS or HIV?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

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

7.5 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.

Question no. | Name of patient | Nature of illness

Period of illness Month Year | Duration | Present state of health in this respect

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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

I 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 you and your family member(s) has or have been added to your policy, you must tell us in writing immediately.

Signature: ✕ Date: D D M M Y Y

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 International 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 in countries outside the European Economic Area (EEA) including to countries where the laws protecting personal information may not be as strong as in the EEA. We take steps to ensure that any sub-contractors give at least the same protections as we do.

As the legal holder of the insurance policy we send correspondence about the policy, including claims correspondence to the policyholder. If any person over 18 that you intend to insure under the policy does not want us to do this they should apply for their own policy.

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.

By signing and returning this form you agree that we, and other members of the AXA UK Group, may use the information you have provided to inform you by letter, telephone, email or mobile message of products and services, such as special offers and healthcare information unless you tick this box to indicate otherwise ☐.

You may change your mind at any time by writing to the address below.

After completing this application form and signing the declaration, please return to:
AXA PPP International, Forest Road, Tunbridge Wells, Kent, TN2 5FE, 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: D D M M Y Y

9 Credit card authorisation

Credit card authorisation form

To: AXA PPP International. I authorise you, until further notice in writing, to charge to my Mastercard/Visa account unspecified amounts in respect of my AXA PPP International premiums as and when they become due, until this instruction is countermanded by my giving notice in writing to AXA PPP International. You will be given at least 7 days notice of any premium increase.

Credit card number

Please insert your appropriate credit card number.

MasterCard ☐ Please tick VISA ☐ Please tick

Expiry date | | | | |

Quote no: | | | | | | | | | | |

Please use block capitals

Surname Mr/Mrs/Miss: (as on credit card) _____

Forenames: (as on credit card) _____

Address of cardholder: _____

_____ Postcode: _____

Telephone number: _____

Signature: _____ Date: _____

10 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, International House, Forest Road, Tunbridge Wells, Kent, TN2 5FE, UK

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: 4 3 5 1 1 0

DIRECT Debit

FOR AXA PPP INTERNATIONAL OFFICIAL USE ONLY.

This is not part of the instruction to your bank or building society.

Please complete this box if you are paying on behalf of the policy holder.

Name and address of account holder: _____

_____

_____

Telephone number: _____

Policyholder's name: _____

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: D D M M Y Y

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

DIRECT Debit

- 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 International will notify you 7 working days in advance of your account being debited or as otherwise agreed. If you request AXA PPP International 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 International 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 International 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.

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