PPP HEALTHCARE

Application form

Personal Health/ Personal Health 6

For office use only			
Agent code:		Consultant name:	
Consultant no:		Membership no:	
Subscription:		Underwriting referral No:	

When to use this form

Use this form if you want to apply for our Personal Health or Personal Health 6 plans.

- Please take care to provide **accurate and complete answers** to all questions for all members who are to be covered under this plan.
- Please make sure you have permission to advise us of all the medical details for all family members you wish to add to this plan.
- Please complete this form in ink using **BLOCK CAPITALS**

Part A – Personal Health plan

Complete all sections in Part A.

1 Your details

1.1 Your title and name:

☐ Mr ☐ Mrs ☐ Ms ☐ Miss Other

First name:

1.2 Date of birth:

1.3 Gender:

☐ Male ☐ Female

Surname:

1.4 Your postal address:

Postcode:

1.5 Your daytime telephone number:

1.6 Your evening telephone number:

1.7 Your mobile telephone number:

1.8 Your email address:

1.9 Type of underwriting:

☐ Moratorium underwriting

☐ Full medical underwriting

☐ Continuing medical exclusions when switching from another insurer

2 How you receive your documents

We'll email your membership documents to you. If you want your documents to be posted, please tick this box ☐.

3 Details of family members to be covered

Children must be living at the same address as the lead member to be included on this plan.

If this plan is only for a child or children and does not include you please tick this box ☐.

3.1 Names of family members to be included (eldest first). (Please include surname if different from above)

Title: First name: Surname:

Relationship to lead member: Date of birth: Gender: ☐ Male ☐ Female

Type of underwriting:

Title: First name: Surname:

Relationship to lead member: Date of birth: Gender: ☐ Male ☐ Female

Type of underwriting:

Title: First name: Surname:

Relationship to lead member: Date of birth: Gender: ☐ Male ☐ Female

Type of underwriting:

Title: First name: Surname:

Relationship to lead member: Date of birth: Gender: ☐ Male ☐ Female

Type of underwriting:

Title: First name: Surname:

Relationship to lead member: Date of birth: Gender: ☐ Male ☐ Female

Type of underwriting:

If you need space for more family members, please use a separate sheet and tick here ☐.

4 Current health insurer

Please note: If this plan is only for a child or children, please answer these questions about the child and not yourself.

4.1 Do you currently hold healthcare insurance cover?

☐ No – please go to section 5 ☐ Yes – please give details

4.2 What is the name of your current health insurer?

4.3 What is the renewal date of your cover?

☐☐☐☐☐☐

4.4 How long have you had your current healthcare insurance cover?

☐☐ Month ☐☐ Year

4.5 If your current insurer is AXA PPP healthcare, please give your membership number:

5 Your health questions

- By treatment we mean surgical or medical services (including medication prescribed by a specialist) that are needed to diagnose, relieve or cure a disease, illness or injury.
- A specialist is any doctor who is not your GP.
- This applies whether the treatment was received privately or under the National Health Service.
- You don't need to tell us about any physiotherapy, osteopathy, chiropractic, acupuncture, homeopathy or dental treatment unless you've been referred by a specialist
- You do not need to tell us about medication prescribed by your GP (unless originally prescribed by a specialist).

☐ Please tick this box to confirm that:

- if included your family members 16 years of age or older have agreed to you acting on their behalf and giving us health information about them; and
- that on your and any family members behalf you consent to us using that health information to provide you with a quote, together with the plan, any adjustments and renewals if you choose to purchase this.

Please take care to answer the questions accurately and completely, for each person to be covered, as the answers may affect your premium or ability to claim.

5.1 In the last five years, has anyone to be insured had, or received treatment for

	You		Partner		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Heart condition or heart problem	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer (If anyone to be covered on this plan answers 'Yes' to this question, please call your intermediary to confirm your cover.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental illness, including depression, that has required referral to a specialist. (If anyone to be covered on this plan answers 'Yes' to this question, please call your intermediary to confirm your cover.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5.2 **In the last twelve months has anyone to be insured (who is age 18 or over) used any tobacco products?** (By "used any tobacco products" we mean smoking or chewing tobacco. E-cigarettes or vaporisers are not classed as tobacco products.)

You		Partner		Child 1		Child 2		Child 3	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

6 Your Personal Health plan

6.1 ☑ **Core cover** (applicable to all)

Comprehensive Cancer Cover – included

(If anyone to be covered on this plan answers 'Yes' to the Cancer question within **'Your Health Questions'**, please call your intermediary to confirm your cover.)

If you wish to reduce your Comprehensive Cancer Cover to NHS cancer support, please tick this box ☐.

6.2 **Out-Patient Options** (Tick one box only)

☐ Standard out-patient ☐ Full out-patient ☐ I don't want out-patient cover

Further Options

☐ Therapies ☐ Mental Health (If anyone to be covered on this plan answers 'Yes' to the Mental Health question within '**Your Health Questions**', please call your intermediary to confirm your cover.)

☐ Dentist and Optician Cashback ☐ Six Week Option ☐ Extended Cover ☐ Guided Option

☐ Travel Cover – European ☐ Travel Cover – European + Adventure sports

☐ Travel Cover – Worldwide ☐ Travel Cover – Worldwide + Adventure sports

Your excess – (The excess is the amount you pay towards your treatment. The higher your excess, the lower your price.)

Excess options

☐ Level 1: No excess ☐ Level 2: £100 ☐ Level 3: £250 ☐ Level 4: £500

☐ Level 5: £1,000 ☐ Level 6: £2,500 ☐ Level 7: £5,000

Note: Levels 5, 6 and 7 are not available with the Standard out-patient option.

6.3 When do you want to start your cover?

☐☐☐☐☐☐

6.4 **NCD protection** (If you are wanting to continue the terms of your cover from a previous health insurance or healthcare scheme, please call your intermediary if anyone to be covered on this plan answers 'Yes' to any of the questions in Section 10.)

☐ Do not add NCD protection ☐ Add NCD protection to all members ☐ Add NCD protection to the following members

7 Data Protection Act

Please make sure that everyone covered by this plan reads this summary and the full data privacy notice on our website axappphealthcare.co.uk/privacy-policy.

We want to reassure you we never sell personal member information to third parties. We will only use your information in ways we are allowed to by law, which includes only collecting as much information as we need. We will get your consent to process information such as your medical information when it's necessary to do so.

We get information about you and the family members who are covered by your plan from you, those family members, your healthcare providers, your employer (if you are on a company scheme), your insurance broker if you have one and third party suppliers of information, such as credit reference agencies.

We process your information mainly for managing your membership and claims, including investigating fraud. We also have a legal obligation to do things such as report suspected crime to law enforcement agencies. We also do some processing because it helps us run our business, such as research, finding out more about you, statistical analysis for example to help us decide on premiums and marketing.

We may disclose your information to other people or organisations. For example we'll do this to:

- manage your claims, e.g. to deal with your doctors;
- manage your policy with your insurance broker
- help us prevent and detect crime and medical malpractice by talking to other insurers and relevant agencies; and
- allow other AXA companies in the UK to contact you if you have agreed.

Where our using your information relies on your consent you can withdraw your consent, but if you do we may not be able to process your claims or manage your plan properly.

In some cases you have the right to ask us to stop processing your information or tell us that you don't want to receive certain information from us, such as marketing communications. You can also ask us for a copy of information we hold about you and ask us to correct information that is wrong.

If you want to ask to exercise any of your rights just call us on 0800 048 1206 or write to us.

You may contact us at any time if you change your mind. We promise to keep your details safe and AXA will never sell your details to a third party. If you wish to view our privacy policy, which explains how we use your data, please go to axappphealthcare.co.uk/privacy-policy or contact us on 0800 048 1206 if you would like a paper copy sent to you.

Part B – Types of underwriting – Covering conditions that you're already aware of

Please select one of the following options stating how you'd like the plan to be underwritten. Please then complete the relevant sections.

- ☐ Moratorium underwriting – complete section 8 and 12
- ☐ Full medical underwriting – complete section 9 and 12
- ☐ Continuing medical exclusions when switching from another insurer – complete section 10, 11 and 12

8 Moratorium underwriting

8.1 I declare that to the best of my knowledge and belief the statements made on this form are true and correct. I acknowledge that any future plan enrolments will be on the basis of these statements and that I, and my family members included on such a plan, shall be bound by the terms of that plan which I shall read when I receive my plan details. I understand that you will send most correspondence about the plan to the lead member but will, where possible, correspond with each individual member over the age of 16 about their claim. I have indicated my chosen products and method of payment I would like. I understand that the persons covered by this application will be subject to a two year rolling moratorium clause, the details of which are:

(a) Initially there is no cover at all for treatment of any medical condition which was in existence at any time during the five years immediately preceding the date on which the persons included on this application joined AXA PPP healthcare. This exclusion relates not only to those conditions for which a diagnosis has been received but also to any medical condition for which they actually had symptoms, even though no diagnosis had been attached to those symptoms. All that matters is that the person knows, or ought reasonably to have known, that something was wrong even if they had not consulted a doctor. If a claim is made, therefore, the person's doctor may be asked for confirmation that they would have had no reason to know or believe, when they joined, that they might have the condition for which they are claiming treatment.

In addition, the persons covered by this application will not be covered for treatment of specified conditions where they have been diagnosed with diabetes, are currently undergoing treatment for blood pressure (hypertension), are under investigation, having treatment or undergoing monitoring as a result of a Prostate Specific Antigen (PSA) test.

(b) Treatment of all such conditions is completely excluded from cover for two years from the date of joining.

(c) At the end of those two years the persons included in this application will be able to claim for treatment of those conditions or symptoms described in (a) above, but only if they have not had any medical treatment or any medical advice, or taken any drugs or medicines, or followed any special diets in respect of those conditions for the period of 24 consecutive months. If such treatment is received within the period of two consecutive years then they won't be able to claim for treatment of those conditions until such time as they have gone for a period of 24 consecutive months without any treatment or advice or help or drugs.

It follows that there are some medical conditions and specified conditions – those which continue or keep recurring – for which it will never be possible to make a claim for treatment. This is because the person will always need to have medical advice or take medication and therefore will not be able to go for a period of 24 consecutive months without advice or medication. Treatment of those conditions is therefore completely excluded from cover for all time.

Name of lead member:

Date:

9 Full medical underwriting

Please note: If this plan is only for a child or children, please answer these questions about the child and not yourself.

9.1 Have you or any person included in this application consulted with a specialist, been admitted to hospital or nursing home, or suffered from intermittent or recurrent illness during the last five years?

No ☐ Yes ☐ If yes, please complete the following:

Name of person(s)

Nature of illness/disability and treatment received

Period of disability/treatment – Month/Year

Duration

Present state of health in this respect (please be specific)

Name of person(s)

Nature of illness/disability and treatment received

Period of disability/treatment – Month/Year

Duration

Present state of health in this respect (please be specific)

Name of person(s)

Nature of illness/disability and treatment received

Period of disability/treatment – Month/Year

Duration

Present state of health in this respect (please be specific)

Name of person(s)

Nature of illness/disability and treatment received

Period of disability/treatment – Month/Year

Duration

Present state of health in this respect (please be specific)

Name of person(s)

Nature of illness/disability and treatment received

Period of disability/treatment – Month/Year

Duration

Present state of health in this respect (please be specific)

Name of person(s)

Nature of illness/disability and treatment received

Period of disability/treatment – Month/Year

Duration

Present state of health in this respect (please be specific)

Please give details of any medical practitioner treatment

9.2 Have you or any person included in this application seen a medical practitioner in the past year? This includes a doctor, physiotherapist, practice nurse etc.

No ☐ Yes ☐ If yes, please complete in full the following (to include full details of all minor and childhood conditions):

Name of person(s)

Nature of illness/disability and treatment received

Period of disability/treatment – Month/Year

Duration

Present state of health in this respect (please be specific)

Name of person(s)

Nature of illness/disability and treatment received

Period of disability/treatment – Month/Year

Duration

Present state of health in this respect (please be specific)

Name of person(s)

Nature of illness/disability and treatment received

Period of disability/treatment – Month/Year

Duration

Present state of health in this respect (please be specific)

Name of person(s)

Nature of illness/disability and treatment received

Period of disability/treatment – Month/Year

Duration

Present state of health in this respect (please be specific)

Name of person(s)

Nature of illness/disability and treatment received

Period of disability/treatment – Month/Year

Duration

Present state of health in this respect (please be specific)

Name of person(s)

Nature of illness/disability and treatment received

Period of disability/treatment – Month/Year

Duration

Present state of health in this respect (please be specific)

Please give details of any other condition or symptom

9.3 Have you or any person 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?

No ☐ Yes ☐ If yes, please complete the following:

Name of person(s)

Nature of illness/disability and treatment received

Period of disability/treatment – Month/Year

Duration

Present state of health in this respect (please be specific)

Name of person(s)

Nature of illness/disability and treatment received

Period of disability/treatment – Month/Year

Duration

Present state of health in this respect (please be specific)

Name of person(s)

Nature of illness/disability and treatment received

Period of disability/treatment – Month/Year

Duration

Present state of health in this respect (please be specific)

Name of person(s)

Nature of illness/disability and treatment received

Period of disability/treatment – Month/Year

Duration

Present state of health in this respect (please be specific)

Name of person(s)

Nature of illness/disability and treatment received

Period of disability/treatment – Month/Year

Duration

Present state of health in this respect (please be specific)

Name of person(s)

Nature of illness/disability and treatment received

Period of disability/treatment – Month/Year

Duration

Present state of health in this respect (please be specific)

10 Continuing medical exclusions when switching from another insurer

This option is only available to customers who have held personal cover for at least 12 months before the date you plan to begin this membership.
Please answer the questions below accurately and completely for each person to be covered, as the answers may affect your premium or ability to claim.

Please note:

- By treatment we mean surgical or medical services (including medication prescribed by a specialist) that are needed to diagnose, relieve or cure a disease, illness or injury
- A specialist is any doctor (including psychiatrist) who is not your GP.

10.1 Have you or anyone to be covered under this plan, had treatment in hospital or consulted a specialist in the last 12 months?

Please tick No ☐ Yes ☐ If yes, please complete the following:

Name of person(s)

Nature of illness/disability and treatment received

Date of first symptoms

How the person is now

Name of person(s)

Nature of illness/disability and treatment received

Date of first symptoms

How the person is now

Name of person(s)

Nature of illness/disability and treatment received

Date of first symptoms

How the person is now

10.2 Do you, or anyone else to be covered under this plan have any treatment, consultations, investigations, or diagnostic tests, planned or pending?

Please tick No ☐ Yes ☐ If yes, please complete the following:

Name of person(s)

Nature of illness/disability and treatment received

Date of first symptoms

How the person is now

Name of person(s)

Nature of illness/disability and treatment received

Date of first symptoms

How the person is now

Name of person(s)

Nature of illness/disability and treatment received

Date of first symptoms

How the person is now

Important: If you've answered 'no' to both questions above you're eligible to join with continued medical exclusions (CME). This means that you can carry over the same medical underwriting terms as you've had under your present insurer subject to the terms and conditions of the AXA PPP healthcare plan. If you've answered 'yes' to either question then we may in some cases include new medical exclusions.

Please send us a copy of your current healthcare insurance certificate as we'll need this to process your application.

11 Switching to AXA PPP healthcare

Please complete these sections if you are switching to AXA PPP healthcare from another insurer.

11.1 Please tell us the name of your present insurer:

11.2 Please tell us how long you or anyone else to be insured under this plan, has held personal private healthcare insurance.

How long private healthcare insurance has been held in years

You	Partner	Child 1	Child 2	Child 3
Y Y	Y Y	Y Y	Y Y	Y Y

11.3 When did you or anyone else to be insured under this plan, last claim on your private healthcare insurance plan?

Please tick one for each person to be insured	You	Partner	Child 1	Child 2	Child 3
Never claimed	☐	☐	☐	☐	☐
Less than 1	☐	☐	☐	☐	☐
1 to 2 years	☐	☐	☐	☐	☐
2 to 3 years	☐	☐	☐	☐	☐
3 to 4 years	☐	☐	☐	☐	☐
4 to 5 years	☐	☐	☐	☐	☐
5 or more	☐	☐	☐	☐	☐

11.4 How many claims* have you made in total on your health insurance in the last 5 years?

	You	Partner	Child 1	Child 2	Child 3
0	☐	☐	☐	☐	☐
1	☐	☐	☐	☐	☐
2	☐	☐	☐	☐	☐
3 or more	☐	☐	☐	☐	☐

***Note:** Our definition of claims for these questions is – Claims for each course of treatment or single treatment, if not a full course, which have been made on your health insurance. You don't need to tell us about:

- physiotherapy, osteopathy, chiropractic, acupuncture or homeopathy treatment unless you have been referred by a specialist
- travel insurance claims
- claims for dentist and optician care
- cash benefit received for NHS treatment.

Please read and sign the declaration below.

12 Declaration

I declare that to the best of my knowledge and belief the statements made on this form are full, true and correct.

I understand that the acceptance of my application shall be on the basis of these statements and that I and any family members included in this plan shall be bound by the terms of the plan, which I shall read when I receive my plan details. I understand that you will send most correspondence about the plan to the lead member but will, where possible, correspond with each individual member over the age of 16 about their claim.

I understand that we are allowed to choose which law will govern the policy. Unless we agree something different this policy will be governed by the Law of England and Wales.

Please note: If you don't take reasonable care and the information you give us is inaccurate or incomplete then we may take one or more of the following actions:

(i) Cancel your plan;

(ii) Declare your membership void (treating your plan as if it has never existed);

(iii) Change the terms of your plan; or

(iv) Refuse to deal with all or part of any claim or reduce the amount of any claim payments

We may ask you to provide further information and/or documentation to make sure that the information you gave us when taking out, making changes to or renewing your plan was accurate and complete.

Please do not assume that we'll carry out any searches or contact any other person to check any of the information to the answers to any of the questions on this application form or any of the information provided in response to these questions. It remains your responsibility to complete the application form and check that the information within it is accurate and complete.

We advise you to keep a record of all information you provide in connection with this application, including any letter(s) you send in connection with it.

If you would like a copy of this application, please let us know within three months. We may turn down an application if we discover that the information you provide is not sufficiently true, accurate and complete so as to present to us fairly the risk we are taking on. We reserve the right to not accept your application.

If you don't inform us of any treatment, investigation or tests that we ask about this may change the terms of your plan or invalidate it entirely in such circumstances, any subscription that has been collected will be returned in full.

Name of lead member:	Date:

Part C – Hypertension cover

13 Cover for hypertension. Please complete and sign the declaration

Healthcare insurance would usually exclude cover for pre-existing hypertension and its related conditions that might arise. However, AXA PPP healthcare Limited now offers an opportunity to cover treatment of new medical conditions associated with hypertension that arise after enrolment.

We will cover the eligible treatment of conditions associated with hypertension providing these related conditions are not pre-existing at the time you join, for example; if you have already been diagnosed with ischaemic heart disease, a condition related to hypertension, this would not be covered. To apply for this additional cover, at no additional cost, simply complete the following details and sign the declaration.

Full name	Height	Weight

This declaration applies to all persons listed above who require inclusion for hypertension related conditions.

We will cover the eligible treatment of your hypertension related conditions providing::

- you are over 40 years of age
- your body mass index is between 18 and 32
- you have not been diagnosed with, nor are you awaiting or currently having investigations into, diabetes
- your blood pressure has been controlled for at least two years by medication*.

*By "controlled" we mean that for the last two years you have been and are currently, under the supervision of your GP to monitor your hypertension.

Failure to disclose accurate information may result in future claims not being eligible for payment.

I declare that I and any others listed meet the above criteria.

Lead member's name:	Date:

Part D – How to pay

14 How to pay

You can choose to pay for your cover either yearly or monthly, it's up to you. Simply tick one of the two boxes below to indicate your choice, then decide how you would like to pay. **Important:** Please note that if you opt to pay by cheque, you cannot choose the monthly payment option and should tick the yearly payment box below.

How often would you like to pay?

☐ Yearly ☐ Monthly

How would you like to pay?

☐ 1. Direct Debit (please complete the mandate at the end of the application form ensuring that you sign and date it)

☐ 2. Cheque (please make your cheque payable to AXA PPP healthcare Limited and enclose it with this application)
Please note this payment option is not available on a monthly basis.

15 Checklist (Tick the appropriate boxes in this section)

You can use this checklist to help make sure you have completed everything before returning your form.

Have you:

1. ☐ Checked your personal details are correct (including telephone number)? (section 1)
2. ☐ Checked and/or completed the details of the additional persons to be included? (section 3)
3. ☐ Selected your chosen level of cover? (section 6)
4. ☐ Completed the appropriate underwriting section? (section 8, 9 or 10)
5. ☐ Completed the declaration? (section 12)
6. ☐ Completed the hypertension section, if applicable? (section 13)
7. ☐ Chosen method of payment? (section 14)
8. ☐ Signed and dated the Direct Debit form (on the next page)? – if applicable
9. ☐ Enclosed a cheque? – if applicable
10. ☐ Return the completed form and payment authorisation using the pre-paid envelope provided.

16 Your 14 day money-back guarantee

When you receive your membership documents, you'll have 14 days in which to ensure you are entirely satisfied with your cover. If, for any reason, you don't wish to go ahead, you may cancel your membership at any time during this period and owe nothing as long as you have not made a claim. Any money which you've paid or which has been collected will be returned to you.

PPP HEALTHCARE

DIRECT Debit

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:

Health-on-Line Ltd, 80 Holdenhurst Road, Bournemouth, Dorset BH8 8AQ

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 2 0 0 3 1

For AXA PPP healthcare Limited 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 lead member.

Name and address of account holder:

Telephone no:

Lead member's name:

Instruction to your Bank or Building Society
Please pay AXA PPP healthcare Limited 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 healthcare Limited and, if so, details will be passed electronically to my Bank/Building Society

Signature(s):

Date:

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 healthcare limited will notify you 5 working days in advance of your account being debited or as otherwise agreed. If you request AXA PPP healthcare limited 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 healthcare limited 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 healthcare 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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