PPP HEALTHCARE

redefining / standards

# Group application form

**For office use only**

Group no:

Rate code:

Rate date:

Start date:

Please complete and sign this form and return together with an enrolment form for each employee to be covered under the group scheme, to:
AXA PPP healthcare, Beechcroft House, Ervington Court, Meridian Business Park, Leicester LE19 1WN.

## 1 Employer details

1.1 Group Secretary:

1.2 Position in business:

1.3 Business name:

1.4 Trading name (if different to business name):

1.5 Business address:

Postcode:

1.6 Telephone no:

1.7 Fax no:

1.8 Email address:

1.9 Website address:

1.10 Nature of business:

1.11 Business registration no (for plc, limited, LLP):

AXA PPP healthcare, Beechcroft House, Ervington Court, Meridian Business Park, Leicester LE19 1WN.
AXA PPP healthcare limited. Registered Office: 5 Old Broad Street, London EC2N 1AD, United Kingdom. Registered in England No. 3148119.
Authorised and regulated by the Financial Services Authority. We may record and/or monitor calls for quality assurance, training and evidential purposes.

PB39240a/08.10 (Group size 3+)

## 2 Group cover details

2.1 Quotation number you would like to proceed with:

☐

2.2 Whose cover will be paid for by the business? – (Please tick appropriate box)

☐ a. Employees only (employee to pay the premium for any family members covered).

☐ b. Employees and one family member (employee to pay for any other additional family members they wish to cover).

☐ c. The business to pay the premium for the employees and dependants.

2.3 Number of employees to be covered?:

☐

## 3 Group cover options

Please ensure you complete an enrolment form for each employee to be covered under the group scheme. The enrolment form will allow you to select the plan, level of excess and underwriting terms on which each employee will join the scheme.

The group cover options you select in the section below will apply to all employees on the group scheme where applicable.

3.1 Cover level – (Please tick appropriate box)

☐ Cover level one

☐ Cover level two

3.2 Plan upgrade options – (Please tick appropriate boxes)

☐ Psychiatric upgrade for all employees on the VIP plan

☐ Dental and Optical upgrade for all employees on the VIP plan

☐ Psychiatric upgrade for all employees on the Executive plan

3.3 Do you wish to include worldwide travel cover for all policyholders and their family members?

☐ Yes ☐ No

## 4 Payment details

Please note that payments must be made from the business bank account.

☐ Yearly Direct Debit

☐ Quarterly Direct Debit

☐ Monthly Direct Debit

If you are paying by Direct Debit please complete and enclose the separate mandate which accompanies this form.

☐ Yearly cheque

☐ Quarterly cheque

If you are paying by business cheque please make your cheque payable to AXA PPP healthcare.

## 5 Declaration

I hereby apply for membership and declare that the statements made on this application are true and correct to the best of my knowledge and belief. I agree to inform AXA PPP healthcare of any change of information on this form. I also declare that the persons covered by this application are resident in the United Kingdom. I understand that previously insured members may be transferred with continued medical exclusions, subject to the Rules and Terms of this Enrolment, upon receipt of previous insurer's Certificate. New members will be subject to the two year moratorium clause, which means the applicant does not complete a medical declaration prior to joining, but membership is on the understanding that all pre-existing medical conditions experienced during the last five years are only covered after being a member for two continuous years and after being free from all treatment relating to that condition for one year. All new conditions are covered from the date of joining. I confirm that I am acting on behalf of the listed individuals/employees and I have provided all information to them as specified in the Annual Agreement contained in the Group Secretary Guide.

Signature of Group Secretary: ✕

Date: D D M M Y Y

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## 6 Details of your present insurer

**If you are switching to us from your present insurer, please complete this section.**

Present insurer:

Date your present cover started: D D M M Y Y

Date your present cover expires: D D M M Y Y

### Declaration

We declare that to the best of our knowledge and belief, no one to be insured on this policy has been diagnosed with or has received any form of treatment/consultation for cancer in the past 12 months and no one has any medical condition likely to result in the need for an in-patient stay in hospital. For groups transferring to Directors Plan or a cover level one policy, we declare that to the best of our knowledge and belief that no one to be covered on the policy has been diagnosed with or is receiving any form of treatment/consultation for cancer in the past 12 months. We understand that AXA PPP healthcare will accept any medical underwriting terms applied by our current insurer and will not impose any additional such terms on any currently insured employees or family members also transferring. We also understand that AXA PPP healthcare will, however, apply its own rules, including its general exclusions and limitations, to all future claims. We hereby undertake to provide current registration certificates. We understand that where additional information has been used to support the application and premium generated, AXA PPP healthcare reserve the right to request documentary evidence to support this. If this evidence is not provided, it could result in a change to the premium that was originally offered or the decline of the application.

Signature of Group Secretary: ✕

Date: D D M M Y Y

## 7 Data Protection Act

**Data Protection Act – you will see this sign where we ask you to give personal information**

Please make sure that you either show this statement to anyone covered by this scheme, or inform them of its contents before you return this form.

To set up and administer this scheme AXA PPP healthcare limited will hold and use information about you, your company's employees and their family members covered by the policies under the scheme, supplied by you, your company's employees and their family members or medical providers.

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 outside the European Economic Area.

We send correspondence relating to members of the group, including claims correspondence, to the relevant policyholder unless we are advised to send it to the family member concerned.

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.

AXA PPP healthcare limited may contact the policyholder with details of other products and services. We may also share some of the policyholders details with other AXA Group companies or other carefully selected companies based within the European Economic Area to enable them to contact the policyholder with details of and, if appropriate administer, their products and services. We may contact the policyholder by post, telephone, or electronically if appropriate. By signing and returning this form you will be indicating to us that the policyholder consents to these uses to enable the policyholder to receive marketing information from AXA PPP healthcare as well as from other AXA UK Group companies and/or third party companies. If the policyholder does not consent, or you have not asked the policyholder whether the policyholder consents please tick the box to indicate this ☐.

Signature of Group Secretary: ✕ ________________  Date: D D M M 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 within three months.

**For Agent/Intermediary use only**

Intermediary name: ________________

Intermediary code: ________________