

# Health Cover Range Application form for Competitor Switch Business



Agent No.  
Source code 3287  
Premium quoted

## For office use only

Rec'd  
Mem. No.  
w.e.f.  
Group No.

Please complete this form in block capitals

## 1 Your personal details (main policyholder)

**Full name (including title):** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
**Postcode:** \_\_\_\_\_

**Contact tel no:** \_\_\_\_\_  
**Date of birth:** \_\_\_\_\_  
**Occupation:** \_\_\_\_\_  
**\*To be enrolled from:** \_\_\_\_\_

\*This should be the day following your last day of cover with your previous insurer.

## 2 Details of all other persons to be included in the policy

Full name (including title)	Relationship to policyholder	Gender (m/f)	Date of birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## 3 Your chosen level of cover

Note: quoted prices are subject to review on 1 April and 1 October. Your quoted price may also change if you have moved or if anyone requiring cover has had a birthday since you first contacted us. The price quoted is based on a 12 month period of cover. You will receive details of how to renew your cover prior to the end of this 12 month period.

Product required (Please tick appropriate box):  
 Health Cover  Health Cover Extra  Health Cover Plus  Health Cover Plus Extra  Health Cover Deluxe   
 Psychiatric upgrade (Health Cover Deluxe only)

Option required: NCD (mandatory)  6 week (excluding Deluxe)

Level of excess required: £100 (mandatory)  £200  £500

## 4 Medical history declaration

**Important:** Please answer all questions to the best of your knowledge and belief. You must disclose all material facts. These are facts which may influence the assessment and acceptance of this application. If you are in any doubt as to whether certain fact are material, you should disclose them. Failure to do so may invalidate the policy entirely. When we ask questions about 'anyone' we mean yourself as the policyholder and any other person to be included in your application.

I undertake moderate exercise (eg walking) for a minimum of 15 minutes, 3 to 5 times a week  (tick if applicable).

**By signing the Policyholder's declaration below you are confirming that:**

1. Neither you, nor anyone else to be insured under this policy, has had treatment in hospital nor consulted a specialist in the last 12 months (this applies whether the treatment was received privately or under the National Health Service).
2. Neither you, nor anyone else to be insured under this policy, has any treatment, investigation or test planned or pending (this applies whether it is to be received privately or under the National Health Service).

Please attach a copy of your current UK medical insurance membership certificate. We will need to receive this to process your application.

### Declaration

I declare that to the best of my knowledge and belief the statements made on this form are full, true and correct. (If you are in any doubt as to whether certain facts are material, you should disclose them. Failure to do so may change the terms of your cover or invalidate the policy entirely.) I acknowledge that the acceptance of my application shall be on the basis of these statements and that I and any family members included in this policy shall be bound by the terms of the policy, which I shall read when I receive my policy details. I understand that you will send all correspondence about this application to the main policyholder unless I write to tell you otherwise. Please note: If any of the information you have given us changes before we have told you that your policy has begun, you must tell us in writing at once. We advise you to keep a record of all information you give us in connection with this application, including any letter you send us 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 feel that the applicant will not benefit properly from membership. In such circumstances, any premium we have collected will be returned in full. You and we are allowed to choose which law will govern this policy. Because we are in the United Kingdom we only sell policies when they are governed by the law of England and Wales so that is the law that applies.

Signature: X

Date: X

### Your 14 day money-back guarantee

When you receive your membership documents, you will have 14 days in which to ensure you are entirely satisfied with your cover. If, for any reason, you do not wish to proceed, 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 have paid or which we have collected will be returned to you.

### Other information

AXA PPP healthcare may decline an application if it feels that the applicant will not benefit properly from membership. In such circumstances any premiums that may have been collected will be returned in full.

**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 policy, or inform them of its contents before you return this form.

To set up and administer your policy AXA PPP healthcare limited 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 may send personal and sensitive personal information in confidence for processing by other companies and intermediaries, including those located outside the European Economic Area.

As you act on behalf of any family member covered by this policy, we send correspondence about the policy, including claims correspondence, to you unless we are advised to do otherwise.

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 may disclose information about anyone covered by your policy where there is a legal requirement for us to do so or in circumstances when it would help us prevent or investigate fraud or improper claims.

AXA PPP healthcare limited may contact you with details of its other products and services. We may also share some of your details with other AXA Group companies or other carefully selected companies based within the European Economic Area to enable them to contact you with details of and, if appropriate administer, their products and services. We may contact you by post, telephone, or electronically if appropriate. By signing and returning this form you will be consenting to these uses to enable you to receive marketing information from AXA PPP healthcare as well as from other AXA UK Group companies and/or third party companies unless you tick the box to indicate that you do not consent .

You may change your mind at any time by writing to the address on the back of the Membership Handbook.

## 5 How to pay

You can choose to pay for your cover either annually 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 annual payment box below.

**How often would you like to pay?:** Annually  Monthly

**How would you like to pay:** 1 Direct Debit (complete the mandate below ensuring that you sign and date it)  
2 Cheque (please make cheques payable to AXA PPP healthcare Ltd and enclose it with this application)

### 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, Phillips House, Crescent Road, Tunbridge Wells, Kent TN1 2PL.**

Service User Number

9 9 1 3 3 3



Name and full postal address of your Bank or Building Society

To The Manager:	Bank/Building Society
_____	
Branch address:	
_____	
Postcode:	
_____	

Reference (AXA PPP healthcare limited membership no.)

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For AXA PPP healthcare limited official use only This is not part of the instruction to your Bank or Building Society <b>Please complete this box if you are paying on behalf of the policyholder.</b> Name and address of account holder: _____ _____ _____ Telephone no: _____ Policyholder's name: _____
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Name(s) of account holder(s)

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Bank/Building Society account number

--	--	--	--	--	--	--	--	--	--

Branch Sort Code

--	--	--	--	--	--

**Banks and Building Societies may not accept Direct Debit Instructions for some types of account.**

#### 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: **X**

Date: **X**

### Checklist

*Tick the appropriate boxes in this section*

Have you:

- Checked your personal details are correct (including telephone numbers)? (section 1)
- Checked and/or completed the details of any other persons to be included? (section 2)
- Completed your chosen level of cover? (section 3)
- Completed the medical history declaration? (section 4)
- Signed and dated the policyholder declaration? (section 4)
- Chosen method of payment? (section 5)
- Signed and dated the Direct Debit form? (section 5) – if applicable
- Enclosed a cheque? – if applicable



**PPP HEALTHCARE**

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