

Application Form

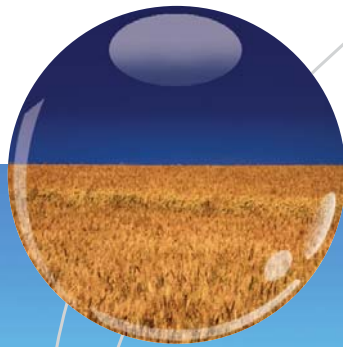
Prima Premier

Prima Classic

your health

your choice

your plan



...peace of mind for whatever is beyond your horizon

Details of policyholder

Please print clearly in capital letters

| | | | |
|---|----------------------|------------|----------------------|
| Title (Mr/Mrs/Ms/Miss/Other) | <input type="text"/> | First Name | <input type="text"/> |
| Other Initials | <input type="text"/> | Surname | <input type="text"/> |
| Residential Address | <input type="text"/> | | |
| | <input type="text"/> | Postcode | <input type="text"/> |
| Country | <input type="text"/> | | |
| Correspondence/Postal Address (if different from above) | <input type="text"/> | | |
| | <input type="text"/> | Postcode | <input type="text"/> |
| Email address | <input type="text"/> | | |
| Telephone Number Home | <input type="text"/> | Office | <input type="text"/> |
| Mobile | <input type="text"/> | Fax | <input type="text"/> |

Medical Underwriting Terms

Please tick to indicate the underwriting terms applicable to you.

Moratorium (standard) Applying to transfer from another insurer or from an ALC Health group policy

Please note that the transfer option is subject to the following terms:

- 1 There must be no break in cover from previous insurer
- 2 A copy of your previous Certificate of Insurance is required
- 3 A completed Health Declaration which is subject to acceptance by underwriters

Details of all persons to be covered

Please enter the details of **all** persons to be covered under this policy, including the policyholder if applicable. (This can include your spouse/partner and any children up to the age of 21 years of age who are permanently living with you or in full time education.)

| | 1st Person | 2nd Person |
|------------------------------|----------------------|----------------------|
| Title (Mr/Mrs/Ms/Miss/Other) | <input type="text"/> | <input type="text"/> |
| First Name | <input type="text"/> | <input type="text"/> |
| Other Initials | <input type="text"/> | <input type="text"/> |
| Surname | <input type="text"/> | <input type="text"/> |
| Gender | <input type="text"/> | <input type="text"/> |
| Date of Birth dd/mm/yy | <input type="text"/> | <input type="text"/> |
| Relationship to Policyholder | <input type="text"/> | <input type="text"/> |
| Occupation | <input type="text"/> | <input type="text"/> |
| Nationality | <input type="text"/> | <input type="text"/> |
| Country of Residence | <input type="text"/> | <input type="text"/> |
| | 3rd Person | 4th Person |
| Title (Mr/Mrs/Ms/Miss/Other) | <input type="text"/> | <input type="text"/> |
| First Name | <input type="text"/> | <input type="text"/> |
| Other Initials | <input type="text"/> | <input type="text"/> |
| Surname | <input type="text"/> | <input type="text"/> |
| Gender | <input type="text"/> | <input type="text"/> |
| Date of Birth dd/mm/yy | <input type="text"/> | <input type="text"/> |
| Relationship to Policyholder | <input type="text"/> | <input type="text"/> |
| Occupation | <input type="text"/> | <input type="text"/> |
| Nationality | <input type="text"/> | <input type="text"/> |
| Country of Residence | <input type="text"/> | <input type="text"/> |

If there is insufficient space on this form, please supply details on a separate sheet and attach it to this Application.

Cover required

Please tick to indicate your preferred plan:

Prima Premier Prima Classic

Please tick to indicate the level of cover you require:

Prima Premier

Prima Classic

In-patient/Day-patient Treatment

In-patient/Day-patient/Out-patient Treatment

Out-patient Treatment

Pregnancy & Childbirth

Pregnancy & Childbirth

Dental Treatment

Dental Treatment

Evacuation & Repatriation

Evacuation & Repatriation

The level of cover selected can be amended at any renewal date.

Please tick to indicate the area of cover you require:

Prima Premier and Prima Classic

Area 1 Europe

Area 2 Worldwide excluding USA

Area 3 Worldwide

Please tick to indicate the currency in which you wish to receive your benefits:

Prima Premier and Prima Classic

Sterling (£) Euro (€) Dollars (US\$)

Policy excess

The Prima Premier and Prima Classic carry a standard £150: €180: US\$225 policy excess per person per policy year which applies to both In-patient & Out-patient expenses. You can amend this by applying for an increased/decreased policy excess (which will also be applied to both In-patient & Out-patient expenses). Please tick to indicate which excess level you require. If no box is ticked, then the policy will be issued with the standard policy excess of £150: €180: US\$225.

Nil £50 £300 £500 £1,000 £5,000 £7,500
 Nil €60 €360 €600 €1,200 €6,000 €9,000
 Nil US\$75 US\$450 US\$750 US\$1,500 US\$7,500 US\$11,250

Method of payment

Premiums are payable annually or quarterly. Please tick which method you wish to use.

Annually By Cheque, Bank Transfer (Details to be provided upon acceptance)

Quarterly By Credit / Debit Card

All cheque payments must be in favour of à la carte healthcare limited. à la carte healthcare limited do not accept liability for any payments made by other methods or for any payment which does not clearly identify the policyholder.

If you have chosen to pay by credit /debit card please supply the following information:

Card Type AMEX MasterCard Delta Switch VISA ELECTRON

Card Number Name on Card

Address#

Postcode

Issue Date (mm/yy) Expiry Date (mm/yy)

Switch Issue Number* Card Security Value Number**

Address to which card registered (if different from Residential Address)

* This is the number on the front of SWITCH cards

** This is the 3 or 4 digit number on the back of the card, or a 4 digit number on the front of an Amex card

Commencement date

Date on which you wish this policy to commence.

Day Month Year

Our policies are required to renew on the first of the month. If commencement of cover is required on a date other than the first, a pro-rata premium will apply in the first policy year.

Cover under this policy cannot commence until such time as we receive and accept this Application Form.

If you wish your cover to commence at a future date, you must notify us of any material change to the information provided in this Application Form. You cannot apply for cover to commence more than 60 days in advance of completion of this Application Form.

If you pay your premiums by credit or debit card, annually or quarterly, at your policy renewal date we will automatically collect your premium from the card details already notified to us, unless you instruct us to the contrary.

Data Protection Act 1998

We will collect certain information about you in the course of considering your application and, if we issue a policy to you, conducting our relationship with you. This information will be processed for the purposes of underwriting your insurance coverage, managing any policy issued and administering claims. We may pass your information to Underwriters, Medical Practitioners, Medical Assistance Companies and Claims Administrators for these purposes. This may involve the transfer of your information to countries that do not have data protection laws. You may have a right of access to, and correction of, information that we hold about you. Please contact us if you would like to exercise either of these rights. Some of the information we collect about you may be classified as 'sensitive' – that is information about racial or ethnic origin and physical or mental health. Data protection laws impose specific conditions in relation to sensitive information, including in some circumstances the need to obtain your explicit consent before we process the information. By signing this proposal form you consent to the processing and transfer of information (including sensitive information) described in this notice. Without this consent we would not be able to consider your application.

Declaration by Policyholder

- 1 I have received, read and understood the full Definitions, Benefits, Exclusions and Conditions of this Policy including General Exclusion 1 relating to Pre-existing Conditions and General Condition 7 relating to Governing Law. General Exclusion 1 relating to Pre-existing Conditions is not applicable to medical underwriting transfers.
- 2 I declare that the information given in this Application is true and complete in respect of all persons to be covered under the policy, including all answers given which are not in my own handwriting.
- 3 I understand that if I am not satisfied with the content of this policy, I may cancel the insurance within 14 days from the commencement date and, provided I have not submitted a claim, I am entitled to a full refund of premium.
- 4 If I have indicated that I wish to pay by credit/debit card, I authorise à la carte healthcare limited to debit my account up to 4 days in advance of the collection/renewal date with the appropriate premium, and all subsequent renewal premiums due as notified until I give written notice that I wish to terminate this Agreement. I understand that à la carte healthcare limited cannot be liable if my policy is lapsed should the credit/debit card be declined/expired and I do not respond to requests for alternative methods of payment within 7 days.
- 5 I have read and understood the Data Protection Act 1998 as contained in this Application Form.

Signature

Date

Agency Name

Agency Number

HEAD OFFICE

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