

SecureHealth Care Options Application form

Please complete details here

Policyholder's surname: _____ Title (Mr/Mrs/Miss/Ms): _____

Forename(s): _____ Date of birth: _____

Occupation: _____

Home address: _____

Postcode: _____ Daytime tel no: _____

Email: _____ Evening tel no: _____

Intermediary code
Agent code
Source code

For office use only

Rec'd
Mem no
Group no

	Policyholder	Partner	Child	Child	Child
1. Forename (eldest first, include surname if different from above)					
2. Sex M/F					
3. Date of Birth					
4. Premium					
5. In the past five years, have you suffered from any form of heart condition or problem, stroke, cancer, diabetes or mental illness (including depression)? (Please delete as applicable)	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Start date: / /					Total premium

If any person has answered 'Yes' to question 5 above, this application must be completed on a fully medically underwritten basis. If 'No', you can also choose to apply on a moratorium basis.

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 facts are material, you should disclose them. Failure to do so may change the terms of your cover or invalidate the policy entirely.

Please confirm the options you require

Option 1 (Standard cover) Option 6 (Additional Benefits)

Option 2 (Limited out-patient) Option 7 (No Claims Discount)

Option 3 (Full out-patient) Option 8 (Cancer Upgrade – only available with Option 3)

Option 4 (Therapy treatment)

Option 5 (Psychiatric treatment – only available with Option 2 or 3) 6 Week Option

Level of excess required: £100 (mandatory) £250 £500 £1000

Type of underwriting: Moratorium **(please complete sections 4, 10 plus 11 or 12)**
 Full medical **(please complete sections 6, 7, 8, 9, 10 plus 11 or 12)**

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 policy enrolments will be on the basis of these statements and that I, and my family members included on such a policy, shall be bound by the terms of that policy which I shall read when I receive my policy details. I understand that you will send all correspondence about this policy to the main policyholder unless I or my family members write to tell you otherwise. I have indicated my chosen options 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) There is initially 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 includes treatment for any medical condition for which they actually had symptoms, even though no diagnosis had been attached to those symptoms. All that matters is that they know or ought reasonably to have known, that something was wrong even if they had not consulted a doctor. If they make a claim in the early years of the policy, therefore, we will ask for the doctor's 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. In addition, they will get no cover for treatment of a related condition to any pre-existing medical condition excluded under this moratorium.
- (b) Treatment of all such conditions is completely excluded from the cover for two years from the date of joining.
- (c) At the end of those two years they will be able to claim for treatment of those pre-existing conditions and any related conditions, 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 that pre-existing condition for the period of two consecutive years (immediately before the treatment starts).

If they have had such treatment within the period of two years then they won't be able to claim for those pre-existing conditions or related conditions until such time as they have gone for a period of two consecutive years without any treatment or advice or help or drugs.

It follows that there are some medical conditions and related 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 two consecutive years without advice or medication. Treatment of those conditions and their related conditions is therefore completely excluded from cover for all time.

Signature: (main policyholder) **X** Date: **X**

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(s) you send us in connection with it. If you would like a copy of this application, please let us know within three months. We reserve the Right to decline your application. You and we are allowed to choose which law will govern this policy. Because we are in the United Kingdom we only sell policies that are governed by the law of England and Wales, so that is the law that applies.

1
Please complete details here

2
Please complete details of family members to be included

3
Please confirm the cover you require

4
Moratorium declaration

5 Please read carefully

Please read carefully

Important: 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 of which you should reasonably have known about even if you had not consulted a doctor.

6 Please give details of any hospital/specialist treatment

Please complete this section for all individuals. If you need to declare further information please use an additional sheet of paper.

Hospital/Specialist Treatment – 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?

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

Name of Patient(s)	Nature of illness/disability and treatment received	Period of disability/treatment			Present state of health in this respect (please be specific)
		Month	Year	Duration	
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

7 Please give details of any General Practitioner treatment

Medical Practitioner Treatment – 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.

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

Name of Patient(s)	Nature of illness/disability and treatment received	Period of disability/treatment			Present state of health in this respect (please be specific)
		Month	Year	Duration	
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

8 Please give details of any other condition or symptom

Other Treatment – 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 and is there any other information which you should, in good faith, disclose?

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

Name of Patient(s)	Nature of illness/disability and treatment received	Period of disability/treatment			Present state of health in this respect (please be specific)
		Month	Year	Duration	
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

9 Full medical declaration

Please read and sign the declaration

Policyholder's declaration: I declare that to the best of my knowledge and belief the statements made on this form are full, true and correct. I acknowledge that any future policy enrolments will 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 or family members write to tell you otherwise.

I have shown the options and method of payment I would like on this form.

■ Signature (main Policyholder)

Date

X

/ /

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(s) 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 discover that the information you give us is not sufficiently true, accurate and complete so as to present to us fairly the risk we are taking on.

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.

10
Choose your
payment
method

11
Credit card

12
Direct Debit

How do I 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 opposite.

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 Credit card (please complete section 11).
- 3 Please make annual cheque payable to AXA PPP healthcare Ltd (and enclose with this application).

By credit card Please use block capitals

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

Forenames
(as on credit card)

Address

Postcode

Signature ✕

Date ✕

To AXA PPP healthcare,

Phillips House, Crescent Road, Tunbridge Wells, Kent TN1 2PL.
I authorise you, until further notice to you, to charge to my Access/Visa account unspecified amounts in respect of premiums as and when these become due, until this instruction is countermanded by my giving notice in writing to AXA PPP healthcare at the address above.
AXA PPP healthcare will give at least one month's notice of any premium increase.

Access/Visa Account Number

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

Expiry Date

--	--	--	--



Please tick



Please tick

By 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:
AXA PPP healthcare, Phillips House, Crescent Road, Tunbridge Wells, Kent TN1 2PL

To The Manager:

Bank/Building Society

Branch Address:

Postcode

Name(s) of Account Holder(s)

Bank/Building Society account number

Branch Sort Code

Reference Number (AXA PPP healthcare membership no.)

Banks and building societies may not accept Direct Debits for some type of accounts

Originator's Identification Number

9 9 1 3 3 3



For AXA PPP healthcare 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 Policyholder.

Name and address of account holder: _____

Policyholder's name: _____

Telephone no: _____

Instruction to your Bank or Building Society

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

Signature ✕ _____ Date ✕ _____



This guarantee should be detached and retained by the Payer

The Direct Debit Guarantee



- The Guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by your own Bank or Building Society.
- If the amounts to be paid or the payment dates change AXA PPP healthcare will notify you 10 working days in advance of your account being debited or as otherwise agreed.
- If an error is made by AXA PPP healthcare or your Bank or Building Society, you are guaranteed a full and immediate refund from your branch of the amount paid.
- You can cancel a Direct Debit at any time by writing to your Bank or Building Society. Please also send a copy of your letter to us.

Other information

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.

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

To set up and administer your policy SecureHealth and 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. We may send it in confidence for processing by other companies and intermediaries, including those located outside the European Economic Area. By signing this form you and any family members covered by your policy consent to such uses of this personal data. We may also disclose information about anyone covered by your policy when there is a legal requirement for us to do so or in circumstances when it would help us to prevent fraud or improper claims.

SecureHealth may contact you with details of its other products and services. We may also share some of your details with other SecureHealth 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. If you do not wish us to do this please tick the box otherwise we will assume that, for the time being, you are happy for us to contact you.

Checklist

Tick the appropriate boxes in this section

Have you:

- 1 **Checked your personal details are correct (including telephone numbers)? (section 1)**
- 2 **Checked and/or completed the details of any other persons, if they are to be included? (section 2)**
- 3 **Chosen your Options required (section 3)**
- 4 **Signed and dated the policyholder declaration? (section 4 or 9, depending on underwriting available)**
- 5 **Chosen method of payment? (section 10)**
- 6 **Signed and dated the credit card authorisation? (section 11) – if applicable**
- 7 **Signed and dated the Direct Debit form? (section 12) – if applicable**
- 8 **Enclosed a cheque? – if applicable**

For office use only

Return to:

SecureHealth Limited, Link House, 62 High Street, Billericay, Essex CM12 9BS

SecureHealth is an intermediary which acts as your general agent and accepts responsibility for the advice provided and arrangement of your insurance.

SecureHealth Limited, Link House, 62 High Street, Billericay, Essex CM12 9BS

Tel: 08450 60 80 60 Fax: 08450 60 90 60 www.securehealth.co.uk email:info@securehealth.co.uk

Authorised and regulated by the Financial Services Authority

Underwritten and administered by AXA PPP healthcare limited.

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