AXA Health

Registration or amendment form

Fully underwritten

Completing this form

- Use this form when adding new employees and/or family members to a group plan.
- 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.
- We won't be able to finalise your membership or confirm any benefit until we receive your completed application form. So, to avoid delays, please send us your information as soon as possible.

Please complete this form in black ink using **BLOCK CAPITALS**.

After completing this application, including the medical declaration, please return it to:
The Medical Underwriting Department, AXA Health, Phillips House, Crescent Road, Tunbridge Wells, Kent, TN1 2PL
or email it to largecorporateadmin.health@axahealth.co.uk. Please include your group number and, if you have one, your new membership number in the subject title of your email.

For office use only	
Membership number	
Group number	
Received	
With effect from	
Underwriter's authorisation	

1 To be completed by the Group Secretary

To be completed by the Group Secretary when the company is to pay the employee's part of the subscription.

The below employee (and their family members) is or will be included in the group arrangement on

› This is the date on which the cover will begin

D D / M M / Y Y Y Y

Signature of Group Secretary

✕

Date

D D / M M / Y Y Y Y

2 Lead member details

Company name

Group number

› if joining an existing plan

Membership number if already a subscriber to AXA Health or other medical insurance policy

Your title

☐ Mr ☐ Mrs ☐ Ms ☐ Miss

☐ Other

First name

Last name

Your home address

Postcode

Your phone number

› including the area code

Your email address

Your date of birth

D D / M M / Y Y Y Y

Occupation

3 Family members' details (to be included on your plan) – if applicable

Family member's first name

Family member's last name

Relationship to lead member

Date of birth

D D / M M / Y Y Y Y

Gender

☐ Male ☐ Female

Family member's first name

Family member's last name

Relationship to lead member

Date of birth

D D / M M / Y Y Y Y

Gender

☐ Male ☐ Female

Family member's first name

Family member's last name

Relationship to lead member

Date of birth

D D / M M / Y Y Y Y

Gender

☐ Male ☐ Female

Family member's first name

Family member's last name

Relationship to lead member

Date of birth

D D / M M / Y Y Y Y

Gender

☐ Male ☐ Female

Family member's first name

Family member's last name

Relationship to lead member

Date of birth

D D / M M / Y Y Y Y

Gender

☐ Male ☐ Female

Family member's first name

Family member's last name

Relationship to lead member

Date of birth

D D / M M / Y Y Y Y

Gender

☐ Male ☐ Female

4 Medical declaration

☐ 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.

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 plan may be invalid entirely if you fail to let us know about any material facts. If for any reason you do not answer a question, we shall take that as meaning you have nothing to inform us about. You don't 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 they're being treated and any previous medical condition(s) which recurs of which you should reasonably have known about even if you had not spoken to a doctor about this.

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

Hospital or specialist treatment

Have you or any of the people you want to include 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 patient(s)

Nature of illness/disability and treatment received

Period of disability/treatment

Month Year Duration

M M / Y Y

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

Name of patient(s)

Nature of illness/disability and treatment received

Period of disability/treatment

Month Year Duration

M M / Y Y

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

Name of patient(s)

Nature of illness/disability and treatment received

Period of disability/treatment

Month Year Duration

M M / Y Y

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

Name of patient(s)

Nature of illness/disability and treatment received

Period of disability/treatment

Month Year Duration

M M / Y Y

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

4 Medical declaration continued

Medical practitioner treatment

Have you or any of the people you want to include 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 patient(s)

Nature of illness/disability and treatment received

Period of disability/treatment

Month Year Duration

M M / Y Y

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

Name of patient(s)

Nature of illness/disability and treatment received

Period of disability/treatment

Month Year Duration

M M / Y Y

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

Name of patient(s)

Nature of illness/disability and treatment received

Period of disability/treatment

Month Year Duration

M M / Y Y

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

Name of patient(s)

Nature of illness/disability and treatment received

Period of disability/treatment

Month Year Duration

M M / Y Y

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

4 Medical declaration continued

Other treatment

Have you or any of the people you want to include 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?

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

Name of patient(s)

Nature of illness/disability and treatment received

Period of disability/treatment

Month Year Duration

M M / Y Y

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

Name of patient(s)

Nature of illness/disability and treatment received

Period of disability/treatment

Month Year Duration

M M / Y Y

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

Name of patient(s)

Nature of illness/disability and treatment received

Period of disability/treatment

Month Year Duration

M M / Y Y

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

Name of patient(s)

Nature of illness/disability and treatment received

Period of disability/treatment

Month Year Duration

M M / Y Y

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

Additional medical information

› If you need more space please use a separate piece of paper. Please then sign it, date it and attach it to the form.

5 Data Protection Act

Please make sure that everyone covered by this plan reads this summary and the full data privacy notice on our website axahealth.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 family members who are covered by your plan. This information can be provided by you, those family members, your healthcare providers, your employer, your employer's intermediary if they have one and third party suppliers of information.

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, or any reinsurers; and
- 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 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 axahealth.co.uk/privacy-policy or call us if you would like a paper copy sent to you.

6 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 the acceptance of my application shall be on the basis of these statements and that I and my 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 all correspondence about this application to the lead member unless I write to tell you otherwise. If you break any terms of the plan that we reasonably consider to be fundamental, we may do one or more of the following:

(i) refuse to pay any of your claims;

(ii) recover from you any loss caused by the break;

(iii) refuse to renew your membership to the plan;

(iv) impose different terms to your cover on the plan;

(v) end your membership of the plan and all cover immediately.

If you (or anyone acting on your behalf) claim knowing that the claim is false or fraudulent, we can refuse to pay that claim and may declare your plan void, as if it never existed. If we have already paid the claim we can recover what we have paid from you.

If we pay a claim and the claim is later found to be wholly or partly false or fraudulent, we will be able to recover what we have paid from you.

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.

If any of the information you have given us changes before we have told you that your plan 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 enable us fairly to assess the risk we are taking on.

Lead member's signature	✘
Date	D D / M M / Y Y Y Y

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