AXA Health

Employee enrolment form

Business Health and Business Protect

Completing this form

- Use this form when enrolling on to a new 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 ensure you have permission to advise us of all the medical details for all family members you wish to add to this plan.
- We advise you to keep a record of all information you supply in connection with your application, including any letters you send us. If you would like a copy of this application form, please ask us within three months.

Please send your completed form to your Group Administrator in a sealed envelope. Alternatively, it can be returned to us directly by email to sme.admin@axahealth.co.uk or by post to AXA Health, Beechcroft House, Ervington Court, Meridian Business Park, Leicester, LE19 1WN.

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

1 For completion by the Group Administrator

The below employee is/will be eligible for inclusion in the group plan on > This is the date on which the cover will begin	D D / M M / Y Y Y Y
Group Administrator signature	×
Date	D D / M M / Y Y Y Y

BSI ISO14001 UKAS ENVIRONMENTAL MANAGEMENT

PB114076a/04.24

2 Your personal details (Lead member)

Business name

Your title

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other

First name

Last name

Your postal address

Postcode

Your telephone number

> including the area code

Your mobile telephone number

Your date of birth

D D / M M / Y Y Y Y

Email address

Your current medical insurer

> if applicable

Your current medical insurance plan number

> if applicable

3 Details of all family members to be included under your name on your plan

Family members to be included (eldest first)

Family member's title

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 title

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

3 Details of all family members to be included under your name on your plan continued

Family members to be included (eldest first)

Family member's title

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 title

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 title

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 title

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 Full medical declaration

Complete this section if you want to make a full medical declaration.

Please answer all of the questions in full and to the best of your knowledge and belief.

If you don't answer a question, we'll take that to mean you have nothing to tell us about.

Genetic test results

You don't need to tell us about any genetic test results.

Medical conditions you already have

Please note: once you've joined, there is no cover for treatment of any medical condition that you already had when you joined, and that you should have told us about but didn't, or which you didn't tell us everything about, unless you've declared it and it hasn't been excluded. This includes:

- any medical condition or symptoms, whether or not these are being treated;
- medical conditions that arose from or were associated with that condition;
- any previous medical condition that recurs and that you should within reason have known about, even if you hadn't talked to a doctor.

☐ 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; and
- that on your and any family members behalf you consent to us using that health information to provide you with a quote, together with the plan, any adjustments and renewals if you choose to purchase this.

Hospital and specialist treatment

In the past five years, have you or anyone you want to include in your plan: • consulted a specialist;

• been admitted to a hospital or nursing home; • suffered from intermittent or recurrent illness?

☐ No ☐ Yes – If yes please give details

Name of person(s)

Condition

Date condition started

Month Year Duration

M M / Y Y

Treatment

Current state of health related to this illness

Name of person(s)

Condition

Date condition started

Month Year Duration

M M / Y Y

Treatment

Current state of health related to this illness

4 Full medical declaration continued

Name of person(s)

Condition

Date condition started

Month M M / Year Y Y

Duration

Treatment

Current state of health related to this illness

Name of person(s)

Condition

Date condition started

Month M M / Year Y Y

Duration

Treatment

Current state of health related to this illness

Name of person(s)

Condition

Date condition started

Month M M / Year Y Y

Duration

Treatment

Current state of health related to this illness

Name of person(s)

Condition

Date condition started

Month M M / Year Y Y

Duration

Treatment

Current state of health related to this illness

4 Full medical declaration continued

General practitioner treatment

Have you or anyone you want to include in your plan been to see a medical practitioner in the past year? (this includes doctor, physiotherapist, practice nurse etc)

☐ No ☐ Yes – If yes please give details

Name of person(s)

Condition

Date condition started

Month M M / Year Y Y Duration

Treatment

Current state of health related to this illness

Name of person(s)

Condition

Date condition started

Month M M / Year Y Y Duration

Treatment

Current state of health related to this illness

Name of person(s)

Condition

Date condition started

Month M M / Year Y Y Duration

Treatment

Current state of health related to this illness

Name of person(s)

Condition

Date condition started

Month M M / Year Y Y Duration

Treatment

Current state of health related to this illness

4 Full medical declaration continued

Name of person(s)

Condition

Date condition started

Month M M / Year Y Y

Duration

Treatment

Current state of health related to this illness

Name of person(s)

Condition

Date condition started

Month M M / Year Y Y

Duration

Treatment

Current state of health related to this illness

Other medical conditions and symptoms

Have you or anyone you want to include in your plan had any other medical conditions, disabilities, health problems or symptoms that you haven't mentioned on the previous page?

Answer yes whether or not a doctor has been consulted.

If you're not sure whether we need to know about something, please give details anyway.

Examples of the kind of conditions we need to know about include: gynaecological or menstrual problems, complications of pregnancy, signs or symptoms of varicose veins, back trouble, joint disorders, joint replacements, foot problems (such as bunions), indigestion or bowel problems, abdominal pain, skin problems, allergies, anxiety, depression or other psychiatric problems, heart problems, limb problems, ear problems, eye problems or urination problems.

☐ No ☐ Yes – If yes please give details

Name of person(s)

Condition

Date condition started

Month M M / Year Y Y

Duration

Treatment

Current state of health related to this illness

Name of person(s)

Condition

Date condition started

Month M M / Year Y Y

Duration

Treatment

Current state of health related to this illness

4 Full medical declaration continued

Name of person(s)

Condition

Date condition started

Month Year Duration

M M / Y Y

Treatment

Current state of health related to this illness

Name of person(s)

Condition

Date condition started

Month Year Duration

M M / Y Y

Treatment

Current state of health related to this illness

Name of person(s)

Condition

Date condition started

Month Year Duration

M M / Y Y

Treatment

Current state of health related to this illness

Name of person(s)

Condition

Date condition started

Month Year Duration

M M / Y Y

Treatment

Current state of health related to this illness

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, your employees and family members who are covered by your plan. This information can be provided by you, those family members, your healthcare providers, you as an employer or your employer (if you are on a company scheme), your insurance broker if you have one and third party suppliers of information, such as credit reference agencies.

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;
- manage your plan with your insurance broker;
- 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 on 0800 587 0955 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 contact us on 0800 587 0955 if you would like a paper copy sent to you.

6 Declaration

I understand that if any of the information given on this form changes before my plan starts, I must tell AXA Health in writing at once.

I declare that to the best of my knowledge and belief the statements made on this form are full, true and correct.

I understand that we are allowed to choose which law will govern the plan. Unless we agree something different this plan will be governed by the Law of England and Wales.

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 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 most correspondence about the plan to the lead member but will, where possible, correspond with each individual member over the age of 16 about their claim.

Please note: If you don't take reasonable care and the information you give us is inaccurate or incomplete then we may take one or more of the following actions:

(i) Cancel your plan;

(ii) Declare your membership void (treating your plan as if it had never existed);

(iii) Change the terms of your plan; or

(iv) Refuse to deal with all or part of any claim or reduce the amount of any claim payments.

We may ask you to provide further information and/or documentation to make sure that the information you gave us when taking out, making changes to or renewing your plan was accurate and complete.

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. 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.

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

Now please return the form to your Group Administrator in a sealed envelope.