# CHOICES APPLICATION FORM

## For Groups (including Corporate Advantage Plan)

**Please use BLOCK CAPITALS and Black Ink when completing the form.**

Please contact us on +44 (0) 1344 233950 if you have any queries. Please send your application form to us by:

- Email to info@expacare.com
- Alternatively, please send the form to your insurance broker

When selecting which benefit levels are required, please ensure that you are aware of any financial limits, cover restrictions or exclusions that may apply. Full details can be found either within the quotation that we provided, or alternatively within the Choices membership guide, copies of which are available upon request.

### 1. COMPANY DETAILS

Legal Company name: **Please provide proof of company registration**

Type of Company (eg Private limited company, Public limited company, Limited liability company, Partnership, Charity, Trust):

Trading address:

Registered address (if different from trading address):

Type of business / nature of business:

Company website address:

Company contact:

Job title:

Tel: Email:

### 2. BROKER DETAILS

Broker name:

Broker code:

### 3. PREFERRED START DATE: DD / MM / YY

### 4. AREA OF COVER

- ☐ **Area 1** – Europe only
- ☐ **Area 2** – Worldwide excluding USA, Bermuda and all islands of the Caribbean
- ☐ **Area 3** – Worldwide (not available for US Nationals residing in the US)
- ☐ **Area 4** – South East Asia (only available in USD) - including Brunei, Cambodia, Christmas island, E. Timor, Indonesia, Laos, Malaysia, Myanmar, Philippines, Thailand and Vietnam)

### 5. CHOICES CORE PLAN

| | COMPULSORY |
|---|---|
| Choices Core Plan | ☑ SELECT |

## 6. CHOICES OPTION 1 - CANCER TREATMENT AND CHRONIC CARE

Please SELECT ONE of the levels of cancer and chronic cover below. Please note that restrictions on this benefit may apply subject to the level of out-patient benefit selected (if any).

| | SELECT ONE ONLY |
|---|---|
| No cover required | ☐ SELECT |
| Treatment for in-patient and out-patient cancer and chronic conditions: restricted cover | ☐ SELECT |
| Treatment for in-patient and out-patient cancer and chronic conditions: full cover | ☐ SELECT |

## 7. CHOICES OPTION 2 - OUT-PATIENT TREATMENT

Please SELECT ONE of the levels of out-patient treatment below.

| | SELECT ONE ONLY |
|---|---|
| No cover required | ☐ SELECT |
| Basic out-patient | ☐ SELECT |
| Intermediate out-patient | ☐ SELECT |
| Extended out-patient | ☐ SELECT |
| Advanced out-patient | ☐ SELECT |

## 8. CHOICES OPTION 3 - ADDITIONAL BENEFITS

Please SELECT from the additional benefits listed below.

### Dental, Wellness and Optical Treatment

| | SELECT ONE ONLY |
|---|---|
| No cover required | ☐ SELECT |
| Dental treatment and wellness benefit | ☐ SELECT |
| Dental treatment, wellness benefit and optical | ☐ SELECT |

### Maternity Care

| | SELECT ONE ONLY |
|---|---|
| Maternity Basic | ☐ SELECT |
| Maternity care level 1 | ☐ SELECT |
| Maternity care level 2 | ☐ SELECT |

## 9. POLICY EXCESS LEVEL (OPTIONAL)

Excesses are not available for Middle East plans.

| | SELECT ONE ONLY |
|---|---|
| NIL | ☐ SELECT |
| GBP 100 / USD 170 / EUR 150 | ☐ SELECT |
| GBP 250 / USD 425 / EUR 375 | ☐ SELECT |
| GBP 500 / USD 850 / EUR 750 | ☐ SELECT |
| GBP 1,000 / USD 1,700 / EUR 1,500 | ☐ SELECT |
| GBP 2,000 / USD 3,400 / EUR 3,000 | ☐ SELECT |
| GBP 5,000 / USD 8,500 / EUR 7,500 | ☐ SELECT |

Excess applies per person, per policy period

## 10. CO-PAY (OPTIONAL) ONLY AVAILABLE FOR MIDDLE EAST PLANS

| | SELECT ONE ONLY |
|---|---|
| 20% co-pay subject to a max of AED 50 per visit<br>(applies to Consultations and diagnostic services with doctors or specialists only) | ☐ SELECT |
| 20% co-pay subject to a max of AED 100 per visit<br>(applies to Consultations and diagnostic services with doctors or specialists only) | ☐ SELECT |
| 10% co-pay applying to all outpatient services and prescription drugs | ☐ SELECT |
| 20% co-pay applying to all outpatient services and prescription drugs | ☐ SELECT |

## 11. UNDERWRITING METHOD

- ☐ Medical History Disregarded (MHD)
- ☐ Full Medical Underwriting (FMU)
- ☐ Continued Personal Medical Exclusions (CPME)
- ☐ Simplified Medical Underwriting (for ALL Corporate Advantage Plans)

## 12. DETAILS OF PREVIOUS INSURANCE

No previous medical insurance ☐ (Go straight to next section).

Name(s) of previous insurer: Previous renewal date: DD / MM / YY

Have there been any claims over GBP 50,000 for any one condition: Yes ☐ No ☐

If Yes have details been provided to Expacare Yes ☐ No ☐

Past 3 years claims information (if available) must be submitted.

## 13. PAYMENT DETAILS

Payment must be received from the Company. Plans in the Middle East are only available in USD.

Payment Currency (please note this will determine the currency of the policy): GBP ☐ USD ☐ EUR ☐

Payment method: Bank transfer ☐ Credit Card ☐

Payment Frequency: Annual ☐ Six-monthly* ☐ Quarterly* ☐

** An administration fee of 2% on six-monthly and 4% on quarterly options will be charged.*

## 14. ELIGIBILITY

a) Compulsory Membership for all employees within a defined eligibility criteria (see Section b) ☐

Or Voluntary Membership ☐

b) Defined eligibility All expatriate employees ☐ Management only ☐

Other (please state)

c) Please select whether the Policy should include cover for: Employees ☐ or Employees and Dependants ☐

- Any future people added to the scheme must be an eligible employee or a spouse/dependant of an eligible employee.
- Persons on cover: Please ensure that we have been provided with full details (First name, Last name, Gender, Nationality, Country of Residence, Date of Birth DD / MM / YY, Area of Cover) of all members to be covered on the scheme.
- Over Age Dependants: We require confirmation in writing from their place of study that any child aged 19 and over is in full time education. Children will be removed from cover on the renewal date following their 25th birthday.

Members covered by the scheme within your defined eligibility are employed by the company. All expatriate employees are included in this application and all future expatriate employees within this criteria will be included on a compulsory basis.

Discuss with your Expacare contact

## 15. DUTY OF FAIR PRESENTATION

We wish to remind clients of their duty of fair presentation. The duty on insureds and potential insureds is one of fair presentation of the risk, which requires:

- disclosure of every material circumstance which the insured knows or ought to know, or
- failing that, disclosure which gives the Insurer sufficient information to put a prudent insurer on notice that it needs to make further enquiries for the purposes of revealing those material circumstances,in a manner which would be reasonably clear and accessible to a prudent insurer. A material circumstance is one which would influence the judgment of a prudent insurer in determining whether to take the risk and, if so, on what terms.

You must satisfy yourself as to the accuracy and completeness of the information you provide to insurers. This will still apply where any amendment is made to the insurance.

If you breach your duty of fair presentation, Insurers are generally limited to "proportionate remedies", linked to what they would have done if the risk had been fairly presented. This may result in the imposition of different terms, or the proportionate reduction of claims where a higher premium would have been charged. In circumstances where Insurers would not have entered into the contract on any terms it can avoid the contract and refuse all claims, but must return the premium. If the breach is deliberate or reckless Insurers can avoid the policy, refuse all claims and keep the premium.

Please refer to our Membership Guide, in particular the Section headed 'Duty of Fair Presentation', for more information.

Are you aware of any person to be covered having any on-going serious condition, including but not limited to any type of cancer, heart condition, stroke or HIV/AIDS? Yes ☐ No ☐

Are you aware of any person to be covered having any medical condition likely to result in, or already requiring planned/pending in-patient treatment? Yes ☐ No ☐

Is any person to be covered currently pregnant? Yes ☐ No ☐

If Yes, please provide full details:

.....

If you are in any doubt as to whether information is relevant or not, or do not know the answer, or how to answer, any specific question, then please contact us for guidance.

## 16. DATA PROTECTION FAIR PROCESSING NOTICE

In your dealings with us you may provide information that includes data that is known as personal data.

The personal data we collect will include data relating to your name, address, email address, IP address, date of birth, nationality, country of residence, occupation, credit card details and medical information.

We will process your personal data to allow us to administer your health insurance policy and any associated claims and for actuarial analysis.

It will also be used to manage future communications between ourselves in relation to your policy and claims.

We will only use your data for the purpose for which it was collected. We will only grant access to or share your data where we are required or entitled to do so by law under lawful data processing. This is within our firm or other firms associated with us, our authorised partners, your broker if you have appointed one, third party service providers such as insurers, assistance companies and claims administration providers.

If you require further information on how we process your data and our lawful bases for doing so, please contact us at info@expacare.com or refer to our Privacy Policy which can be found on our website.

## 17. DECLARATION

I declare that I am authorised by the Company to enter into this Contract of Insurance with Expacare Limited. I understand that I am signing this form on behalf of a number of persons to be covered and I will make them aware of the declaration that I have signed and will inform them of how their data and medical information will be used in relation to this insurance contract. I confirm that all main members covered by the scheme are employed by the company and that it is our responsibility to inform members when cover is cancelled. I confirm that we will check and inform Expacare of any amendments that need to be made to the membership. I declare that the Company has made a fair presentation of the risk, by disclosing all material matters to Expacare which we know or ought to know or, failing that, by giving the Insurer (via Expacare) sufficient information to put a prudent Insurer on notice that it needs to make further enquiries in order to reveal material circumstances.

**By signing this application form, I authorise Expacare to deal with our broker, if one is appointed.**

Signed: .....

Position: ..... Dated: DD / MM / YY