



ISLANDS CHOICES APPLICATION FORM For Groups

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:

- Post to Expacare, 11 Bracknell Beeches, Old Bracknell Lane West, Bracknell, Berkshire, RG12 7BW, United Kingdom
- 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 Islands Choices membership guide, copies of which are available upon request.

1. COMPANY DETAILS

Legal Company name: *Proof of Company registration is required.*

Trading address:

Registered address (if different from trading address):

Type of business:

Company website address:

Company contact:

Job title:

Tel: Fax: Email:

2. BROKER DETAILS

Broker name:

Broker code:

3. PREFERRED START DATE: DD / MM / YY

4. AREA OF COVER

Area 1 – Europe only

5. ISLANDS CHOICES CORE PLAN

| | COMPULSORY |
|---------------------------|--|
| Islands Choices Core Plan | <input checked="" type="checkbox"/> SELECT |

6. ISLANDS CHOICES OPTIONAL MODULE 1 - GP FEES

Please SELECT ONE of the options below.

| | SELECT ONE ONLY |
|------------------------------|---------------------------------|
| No additional cover required | <input type="checkbox"/> SELECT |
| GP Fee - Full Refund | <input type="checkbox"/> SELECT |

7. ISLANDS CHOICES OPTIONAL MODULE 2 - DENTAL, WELLNESS AND OPTICAL

Please SELECT ONE of the options below.

| | SELECT ONE ONLY |
|--|---------------------------------|
| No cover required | <input type="checkbox"/> SELECT |
| Dental treatment, wellness benefit and optical | <input type="checkbox"/> SELECT |

8. POLICY EXCESS LEVEL (OPTIONAL)

| | SELECT ONE ONLY |
|-----------|---------------------------------|
| NIL | <input type="checkbox"/> SELECT |
| GBP 100 | <input type="checkbox"/> SELECT |
| GBP 250 | <input type="checkbox"/> SELECT |
| GBP 500 | <input type="checkbox"/> SELECT |
| GBP 1,000 | <input type="checkbox"/> SELECT |
| GBP 2,000 | <input type="checkbox"/> SELECT |
| GBP 5,000 | <input type="checkbox"/> SELECT |

Excess applies per person, per policy period

9. UNDERWRITING METHOD

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

10. 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.

11. PAYMENT DETAILS

Payment must be received from the Company.

Payment Currency: GBP

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.

12. ELIGIBILITY

a) Compulsory Membership for all employees residing on the Channel Islands applies
All main members covered by the scheme are employed by the company. All employees residing on the Channel Islands are included in this application and all future employees residing on the Channel Islands will be included on a compulsory basis.

Or
Voluntary Membership for expatriate employees

b) 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.
- If there are 5 or more employees with different eligibility, please contact us to discuss and agree the eligibility criteria
- 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.

Or

c) Defined eligibility (eg Management only)

Discuss with your Expacare contact

13. 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 or stroke? 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.

14. 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.

15. 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