Full Medical Underwriting application

Underwritten by SiriusPoint International Insurance Corporation

ALC GLOBAL HEALTH INSURANCE
AN IMG COMPANY

Full Medical Underwriting (FMU) - This is where we ask for details of your full medical history. Based on the information received we will confirm what terms we are able to offer you and any exclusions that may apply. Where special terms have been offered these will be detailed on your certificate/declaration of insurance.

Filling out this form

- Use this form to apply for one of our four Global Prima Medical Insurance plans.
- You must take care in answering all the following questions which are relevant to us in providing this insurance and setting the terms and premium. Please contact us if you do not understand the question or the nature of the information required or please seek guidance from your broker. Failure to provide information or the provision of incomplete or inaccurate information may result in the loss of cover or other remedies. Remember to sign the Declaration on page 7.
- Please write clearly using capital letters.
- If you have any questions, call us on +44 (0) 1903 817970 (UK).
- If you would like a copy of this application form, please let us know within 3 months.

What's next?

- Send your completed form back to us using **one** of these options:
  - **Email:** privateclient@alchealth.com
  - **Post:** ALC Health, 3rd Floor, Fitzalan House, Fitzalan Court, Cardiff, CF24 0EL United Kingdom
- We will write to you with your terms and requesting payment within 5 working days.
- Then, once we've received your payment, we'll send your policy documentation.

1 Choosing your level of cover

Please select **the plans** below to cover everyone on this application, then tick the boxes to choose your level of cover.
For more information on our plans, visit **www.alchealth.com** or simply scan this code with your smartphone →

☐ BRONZE PLUS	☐ SILVER	☐ GOLD	☐ PLATINUM
☑ In-patient, day-patient, and out-patient treatment ☑ Evacuation or Repatriation	☑ In-patient, day-patient, and out-patient treatment ☑ Evacuation or Repatriation	☑ In-patient, day-patient, and out-patient treatment ☑ Evacuation or Repatriation	☑ In-patient, day-patient, and out-patient treatment ☑ Evacuation or Repatriation
Routine Pregnancy & Childbirth limit: ☐ £5,000/€5,000/US$5,000 ☐ £10,000/€10,000/US$10,000 ☐ £20,000/€20,000/US$20,000	Routine Pregnancy & Childbirth limit: ☐ £5,000/€5,000/US$5,000 ☐ £10,000/€10,000/US$10,000 ☐ £20,000/€20,000/US$20,000	Routine Pregnancy & Childbirth limit: ☐ £5,000/€5,000/US$5,000 ☐ £10,000/€10,000/US$10,000 ☐ £20,000/€20,000/US$20,000	Routine Pregnancy & Childbirth limit: ☐ £5,000/€5,000/US$5,000 ☐ £10,000/€10,000/US$10,000 ☐ £20,000/€20,000/US$20,000
Dental Treatment Limit ☐ £1,000/€1,000/US$1,000 ☐ £2,000/€2,000/US$2,000	Dental Treatment Limit ☐ £1,000/€1,000/US$1,000 ☐ £2,000/€2,000/US$2,000	Dental Treatment Limit ☐ £1,000/€1,000/US$1,000 ☐ £2,000/€2,000/US$2,000	Dental Treatment Limit ☐ £1,000/€1,000/US$1,000 ☐ £2,000/€2,000/US$2,000
Area of cover:			
☐ Area 1 – Europe ☐ Area 2 – Worldwide excluding USA and any USA territories. ☐ Area 3 - Worldwide	☐ Area 1 – Europe ☐ Area 2 – Worldwide excluding USA and any USA territories. ☐ Area 3 - Worldwide	☐ Area 1 – Europe ☐ Area 2 – Worldwide excluding USA and any USA territories. ☐ Area 3 - Worldwide	☐ Area 1 – Europe ☐ Area 2 – Worldwide excluding USA and any USA territories. ☐ Area 3 - Worldwide

In which currency would you like to pay your premium? Your policy benefits will also be in this currency.

☐ GB£ ☐ Euro€ ☐ US$

How much excess would you like to pay? Excess is per person per policy year and does not apply to Routine Pregnancy & Childbirth and Dental Treatment options, Evacuation or Repatriation, Well-being, Optical and Vaccinations benefits. To reduce your premium amount, choose a higher policy excess.

☐ Nil	☐ £50/€50/US$50	☐ £150/€150/US$150	☐ £300/€300/US$300
☐ £500/€500/US$500	☐ £1,000/€1,000/US$1,000	☐ £2,500/€2,500/US$2,500	☐ £5,000/€5,000/US$5,000
☐ £7,500/€7,500/US$7,500			

How would you like to pay your premium? We'll send details following acceptance of your application.

☐ Annually →	☐ Credit/Debit Card	☐ SEPA Direct Debit	☐ Bank Transfer
☐ Quarterly →	☐ Credit/Debit Card	☐ SEPA Direct Debit	☐ Bank Transfer
☐ Monthly →	☐ Credit/Debit Card	☐ SEPA Direct Debit	☐ Bank Transfer

SEPA Direct Debit payments from EU/EEA bank accounts only.

2 Your details

Policyholder details

Title

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other:

First name(s)

Surname

Date of birth (DD-MM-YYYY)

Gender

Height (cm/ft)

Weight (kg/lbs)

Industry

Occupation (please give full details)

Nationality

Email address

Country of Residence

Is the Policyholder to be insured under this policy? ☐ Yes ☐ No

Home address

Postcode: Country

Correspondence address (if different)

Postcode: Country

Phone numbers

Home:

Work:

Mobile:

Fax:

Additional family member details

Please give details of any additional family members to be covered by this policy. This includes your spouse/partner and any children under the age of 25 years of age who are permanently living with you or in full time education.

If more than four additional family members are to be covered, please photocopy this page before you start filling in this section, and number each sheet using the boxes on the right to help us keep track.

Copy number of

1st family member

Title:

First name(s):

Surname:

Date of birth (DD-MM-YYYY)

Height (cm/ft) Weight (kg/lbs)

Relationship to policyholder:

Industry:

Occupation:

Nationality:

Country of residence:

2nd family member

Title:

First name(s):

Surname:

Date of birth (DD-MM-YYYY)

Height (cm/ft) Weight (kg/lbs)

Relationship to policyholder:

Industry:

Occupation:

Nationality:

Country of residence:

3rd family member

Title:

First name(s):

Surname:

Date of birth (DD-MM-YYYY)

Height (cm/ft) Weight (kg/lbs)

Relationship to policyholder:

Industry:

Occupation:

Nationality:

Country of residence:

4th family member

Title:

First name(s):

Surname:

Date of birth (DD-MM-YYYY)

Height (cm/ft) Weight (kg/lbs)

Relationship to policyholder:

Industry:

Occupation:

Nationality:

Country of residence:

Medical Practitioner's Details

Please provide details of your current medical practitioner or the one who is most familiar with your medical history.

Name:

Policyholder or Family Member's Name:

Email address:

Tel: Fax:

Date of last attendance (MM-YYYY)

Address:

Postcode: Country:

Reason for attendance:

Name:

Policyholder or Family Member's Name:

Email address:

Tel: Fax:

Date of last attendance (MM-YYYY)

Address:

Postcode: Country:

Reason for attendance:

Name:

Policyholder or Family Member's Name:

Email address:

Tel: Fax:

Date of last attendance (MM-YYYY)

Address:

Postcode: Country:

Reason for attendance:

Name:

Policyholder or Family Member's Name:

Email address:

Tel: Fax:

Date of last attendance (MM-YYYY)

Address:

Postcode: Country:

Reason for attendance:

Health Declaration

Please answer for each person applying for cover

Copy number ☐ of ☐

Policyholder	1st family member	2nd family member	3rd family member	4th family member
1) Are you or any other applicant presently hospitalised, or scheduled on a waiting list for or in need of hospitalisation or surgery?				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2) Are you currently receiving active treatment for any form of cancer or had a diagnosis in the last twelve months?				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3) Have you or any other applicant at any time ever tested positive for, been diagnosed with, or been treated for any Immune System Disorder, including Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV)?				
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please note if a person has answered YES to any question above, he or she does not qualify for this insurance.

Medical history

Copy number ☐ of ☐

Policyholder	1st family member	2nd family member	3rd family member	4th family member

1) In the last 5 years have you been diagnosed with, had treatment, medication or symptoms related to:
a) Cancer (whether active or if in remission) b) Heart c) Stroke d) Diabetes, hyperglycemia or hypoglycemia, e) Asthma or Allergies f) Anxiety / depression / psychiatric conditions

Policyholder	1st family member	2nd family member	3rd family member	4th family member
a) ☐ Yes ☐ No	a) ☐ Yes ☐ No	a) ☐ Yes ☐ No	a) ☐ Yes ☐ No	a) ☐ Yes ☐ No
b) ☐ Yes ☐ No	b) ☐ Yes ☐ No	b) ☐ Yes ☐ No	b) ☐ Yes ☐ No	b) ☐ Yes ☐ No
c) ☐ Yes ☐ No	c) ☐ Yes ☐ No	c) ☐ Yes ☐ No	c) ☐ Yes ☐ No	c) ☐ Yes ☐ No
d) ☐ Yes ☐ No	d) ☐ Yes ☐ No	d) ☐ Yes ☐ No	d) ☐ Yes ☐ No	d) ☐ Yes ☐ No
e) ☐ Yes ☐ No	e) ☐ Yes ☐ No	e) ☐ Yes ☐ No	e) ☐ Yes ☐ No	e) ☐ Yes ☐ No
f) ☐ Yes ☐ No	f) ☐ Yes ☐ No	f) ☐ Yes ☐ No	f) ☐ Yes ☐ No	f) ☐ Yes ☐ No

2) During the last 5 years, have you had any treatment in hospital or stayed in a nursing home, consulted a doctor, medical practitioner or specialist, or suffered from an illness which keeps returning?

Policyholder	1st family member	2nd family member	3rd family member	4th family member
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

3) Do you have any treatment, consultations, investigations, diagnostic tests or check-ups, planned, pending or awaiting results?

Policyholder	1st family member	2nd family member	3rd family member	4th family member
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

4) Have you had any medical condition, or health problem, whether or not a doctor has been consulted during the last 5 years?

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.

Policyholder	1st family member	2nd family member	3rd family member	4th family member
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

5) Are you currently on any medications (whether prescribed or not)?

Policyholder	1st family member	2nd family member	3rd family member	4th family member
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

6) Have you at any time in your life had any condition which may have an affect on your future health?

Please declare any medical investigation, consultation, advice, counselling, operation, medication or treatment that you have had or have been advised to have or are currently having, but have not previously mentioned.

Policyholder	1st family member	2nd family member	3rd family member	4th family member
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

By treatment we mean surgical or medical intervention including drugs (both organic and synthetic) prescribed by a medical practitioner/specialist, that are needed to diagnose, relieve or cure a disease, illness or injury. A specialist is any doctor, including psychiatrist who is not your usual practitioner.

Declaring illnesses

If you've answered **yes** to any of the questions above, you must give full details here.

Which question does this declaration relate to?

Full name

Date symptoms/illness first started (MM-YYYY)

Duration of illness (e.g two weeks) or is it still ongoing

Your present state of health in respect of this illness

Brief description of illness or name of condition/diagnosis (if known)

Details of treatment/medication received, current medication/types and dosages, and details of any future consultations/treatment anticipated or planned

If you have been diagnosed with Diabetes, High Blood Pressure or High Cholesterol (whether controlled by medication or not), in addition to the above please provide your last three tests results (including dates) together with confirmation of how often you have to follow up with your medical practitioner.

Which question does this declaration relate to?

Full name

Date symptoms/illness first started (MM-YYYY)

Duration of illness (e.g two weeks) or is it still ongoing

Your present state of health in respect of this illness

Brief description of illness or name of condition/diagnosis (if known)

Details of treatment/medication received, current medication/types and dosages, and details of any future consultations/treatment anticipated or planned

If you have been diagnosed with Diabetes, High Blood Pressure or High Cholesterol (whether controlled by medication or not), in addition to the above please provide your last three tests results (including dates) together with confirmation of how often you have to follow up with your medical practitioner.

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Duration of illness (e.g two weeks) or is it still ongoing

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Details of treatment/medication received, current medication/types and dosages, and details of any future consultations/treatment anticipated or planned

If you have been diagnosed with Diabetes, High Blood Pressure or High Cholesterol (whether controlled by medication or not), in addition to the above please provide your last three tests results (including dates) together with confirmation of how often you have to follow up with your medical practitioner.

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Your present state of health in respect of this illness

Brief description of illness or name of condition/diagnosis (if known)

Details of treatment/medication received, current medication/types and dosages, and details of any future consultations/treatment anticipated or planned

If you have been diagnosed with Diabetes, High Blood Pressure or High Cholesterol (whether controlled by medication or not), in addition to the above please provide your last three tests results (including dates) together with confirmation of how often you have to follow up with your medical practitioner.

If there is insufficient space on this form please provide details on a separate sheet and attach it to this declaration.

3 General Data Protection Regulation (GDPR)

This is only a summary of ALC's privacy policy and your rights under GDPR. For a complete explanation of how we gather and use your personal information and your corresponding rights, please review our complete Privacy Policy, which is available at https://www.alchealth.com/privacy.htm

ALC collects many kinds of information in order to operate effectively and provide you the best products, services and experiences we can. Regardless of the source, we believe it is important to treat that information with care and to help you maintain your privacy.

When you provide data processing consent, we will process your personal information in order to provide the services you have purchased, including to administer claims, and to receive member communications, in accordance with our Privacy Policy. If you provide marketing consent, we will send you relevant information and future marketing materials regarding products or services in which you may have interest, and for all other purposes set forth in our Privacy Policy. You may withdraw your consent at any time.

By providing marketing consent, we may gather information about you from third parties to help us identify insurance products and services in which you may have interest, and share information with third parties, such as web analytics tools, in order to send you relevant information and future marketing materials, and for all other purposes set forth in our Privacy Policy. You may withdraw your consent at any time.

We may share your information with third parties who provide services on our behalf to help with our business activities. These companies are authorized to use your personal information only as necessary to provide these services to us. When we share information with these other companies to provide services for us, they are not allowed to use it for any other purpose and must keep it confidential. These services may include:

- Adjudicating and managing the claims process
- Payment processing to healthcare providers
- Providing customer service

In certain situations, ALC may be required to disclose personal data in response to lawful requests by public authorities, including to meet national security or law enforcement requirements.

4 Fair Processing Notice

This Privacy Notice describes how SiriusPoint International Insurance Corporation (publ) (for the purpose of this notice "we", "us" or the "Insurer") collect and use the personal information of insureds, claimants and other parties (for the purpose of this notice "you") when we are providing our insurance and reinsurance services.

The information provided to the Insurer, together with medical and any other information obtained from you or from other parties about you in connection with this policy, will be used by the Insurer for the purposes of determining your application, the operation of insurance (which includes the process of underwriting, administration, claims management, analytics relevant to insurance, rehabilitation and customer concerns handling) and fraud prevention and detection. We may be required by law to collect certain personal information about you, or as a consequence of any contractual relationship we have with you. Failure to provide this information may prevent or delay the fulfilment of these obligations.

Information will be shared by the Insurer for these purposes with group companies and third party insurers, reinsurers, insurance intermediaries and service providers. Such parties may become data controllers in respect of your personal information.

Because we operate as part of a global business, we may transfer your personal information outside the European Economic Area for these purposes.

You have certain rights regarding your personal information, subject to local law. These include the rights to request access, rectification, erasure, restriction, objection and receipt of your personal information in a usable electronic format and to transmit it to a third party (right to portability).

If you have questions or concerns regarding the way in which your personal information has been used, please contact: DPOLondon@siriuspt.com

We are committed to working with you to obtain a fair resolution of any complaint or concern about privacy. If, however, you believe that we have not been able to assist with your complaint or concern, you have the right to make a complaint to the UK Information Commissioner's Office.

For more information about how we process your personal information, please see our full privacy notice at: https://www.siriuspt.com/legal/website-privacy-policy-final.pdf

5 Language

The language of this insurance contract is English and all correspondence between us will be in English.

Please tick to confirm that you accept this statement. ☐

If you do not wish the language to be English, please contact your broker or telephone us on +44 (0) 1903 817970 (UK).

6 Documentation

Would you like to receive all policy documentation and future correspondence by email? We'll use the address from page 2.

☐ Yes ☐ No

7 Top-up policy

Please tick if you have a local health insurance policy. You can use the eligible claims you make on your local health insurance policy to use up the excess on your ALC Health policy. ☐

8 Previously Insured

Have you or any family member applying for coverage ever purchased insurance through IMG, IMG Europe, or ALC?

☐ Yes ☐ No

Certificate/Policy Number:

(If yes: please provide certificate number, if any, and details. By selecting yes, you agree to the following: you acknowledge that you are applying for an entirely new certificate of coverage and not a renewal or reinstatement of any prior certificate(s) that you may have purchased through IMG, IMG Europe, or ALC in the past, and that, should IMG accept your new application, this would start a brand new coverage period under the terms, conditions and provisions of the new insurance certificate (including, but not limited to, all eligibility requirements, pre-existing condition and other exclusions, waiting periods, and benefit limits and sub-limits of the plan), and your new coverage will not qualify for any benefits of continuous coverage based upon your prior lapsed coverage.)

Have you or any family member applying for coverage ever been accepted with special terms or rates, been declined cover or had a policy cancelled under any health/medical, life or disability insurance plan?

☐ Yes ☐ No

Details:

9 Other Health Insurance

Do you hold any other insurance plan or policy that provides cover for medical costs?

☐ Yes ☐ No

Policy Certificate or ID Numbers

Private insurance or government plan name

Insurer or government entity providing the plan

Coverage Start Date (DD-MM-YYYY)

Coverage End Date (DD-MM-YYYY)

10 Your declaration

1. I have received and read the full Definitions, Benefits, Exclusions and Condition of this Policy including General Exclusion 63 relating to Pre-existing Conditions and General Condition 8 relating to Governing Law. I understand that the Application Form, Certificate of Insurance or Declaration of Insurance (if outside the EEA or UK) and the Policy Wording make up the contract between us and all form part of the policy. I am aware that cover shall be provided in accordance with the policy. General Exclusion 63 relating to Pre-existing Conditions is not applicable to full medical underwriting terms. I understand that any personal exclusions will be stated on my Certificate/ Declaration of Insurance.
2. I/we declare that the information disclosed in this proposal is, to the best of my/our knowledge and belief, both accurate and complete. I/we have taken care not to make any misrepresentation in the disclosure of this information and understand that all information provided is relevant to the acceptance and assessment of this insurance, the terms on which it is accepted and the premium charged.
3. I understand that if I am not satisfied with the content of this policy, I may cancel the insurance within 14 days of the completion of this contract as set out in the Policy Wording.
4. If I have indicated that I wish to pay by credit/debit card, I authorise à la carte healthcare limited to debit my account up to 4 days in advance of the collection/renewal date with the appropriate premium, and all subsequent renewal premiums due as notified until I give written notice that I wish to terminate this Agreement. I understand that à la carte healthcare limited cannot be liable if my policy is lapsed should the credit/debit card be declined and I do not respond to requests for alternative methods of payment within 7 days.
5. By signing this form as the policyholder, I confirm that:
   - anyone included on the plan has agreed that the policyholder has their permission to act for them to set up this plan
   - the policyholder consents on behalf of those family members and themselves to ALC Health, its underwriters and its claims handlers using personal information in the ways described above.
   - If applying for coverage with a country of residence outside of the EEA and UK or at any time move to a location outside the EEA or UK, the policyholder acknowledges and agrees to elect the Trust: the policyholder hereby applies and subscribes, for and on behalf of each individual enrolled, to the Conyers Trust Company (Bermuda) Limited, Richmond House, 12 Par-la-Ville Road Hamilton HM 08, Bermuda, or its successors, for the insurance coverage requested above and as underwritten and offered by Sirius International Insurance Corporation on the date of its receipt hereof, and as administered by ALC Health.
6. If you are arranging this insurance via a broker the policyholder understands, acknowledges and agrees that ALC Health will pay commission to the broker at inception and renewal.
7. I have read the General Data Protection Regulation (GDPR) notice as contained in this Application Form and the Privacy Policy which is available at https://www.alchealth.com/privacy.htm
8. 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 claims 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.

   No cover is in force until this proposal is accepted by the insurer and the premium is paid. The insurer reserves the right to decline any insurance proposal or to offer different premium and terms from those quoted dependent on the information you have provided.

Consent

☐ Yes ☐ No

I agree to the processing of my personal information to provide the services I have purchased, including to administer claims, and to receive member communications, in accordance with ALC Health's Privacy Policy

☐ Yes ☐ No

I agree to receive relevant information and other communications from ALC Health about insurance coverages and service options. I understand that I can withdraw my consent at any time

Policy start date

Date (DD-MM-YYYY)

Your policy cannot start until we receive and accept this form. If you'd like your cover to start at a future date, you must let us know if there are any changes to the information given in this form such a change in your state of health or the state of health of any of your dependants. If there has been a changes we reserve the right to change the terms provided – you cannot apply for cover more than 30 days in advance of completion of this form.

Confirmation

Policyholder signature

Signing this Application does not bind you to enter into this insurance.

Please PRINT name in full

Date signed (DD-MM-YYYY)

If you're completing a digital version of this form, please tick the box below to acknowledge the declaration.

☐ I confirm, as the policyholder, I have read and understood this declaration

Broker name

Broker number

CM0050A20160230302