

Addition of family members form



Confidential
EA Member Services
S4

PPP HEALTHCARE

I apply to add to my policy the family members shown below.

Please complete, in ink using block capitals.

<input type="checkbox"/> Policyholder's surname: (Mr/Mrs/Miss/Ms)		AXA PPP healthcare membership no:	For office use only
Other names:		Rec'd	
Address:		Mem. no.	
		w.e.f.	
Postcode:	Telephone no:	Group no.	
Email address:		Underwriter's authorisation:	
<input type="checkbox"/> Family members' details (now to be added to my policy)			
Names (eldest first) (include surname if different from above)		Relationship to policyholder	Family members' dates of birth
1. Adult			
2. Children			
3.			
4.			
5.			

Medical history

Please Note:

- (i) You will not be able to claim benefits for any medical condition which was already existing or foreseeable at the date of joining unless such medical condition has been declared to and accepted by AXA PPP healthcare.
- (ii) Failure to notify AXA PPP healthcare of a medical condition may result in claims for benefit being refused. If you are in any doubt you should disclose the medical condition. (If you do not have any medical conditions to disclose please ensure that you tick the relevant boxes.)
- (iii) If a newborn child is being added within three months of birth, we have to consider the rule relating to this, would you therefore please tell us: was the child adopted or was the child conceived through assisted conception? Tick Yes or No . If your answer is 'Yes', please complete the medical declaration below. (No medical history is required if your answer is 'No'.) If your answer is 'No', the child will be added to your policy from his/her date of birth.
- (iv) If for any reason you do not answer a question we shall take that as meaning that you have nothing to disclose or that the answer is 'No'.

Please note: You are advised to keep a record of all information supplied in connection with this application, including any letters you send to us in connection with it. If you would like a copy of this application form please let us know within three months.

1. Have any of your family members included in this application, during the past five years consulted a specialist, been admitted to hospital or nursing home, or suffered from an intermittent or recurring illness?

Please tick Yes or No . If 'Yes' please complete the following:

Name of patient	Nature of illness/disability and treatment received	Period of disability/treatment			Present state of health in this respect
		Month	Year	Duration	

2. Is there any medical condition, disability or health problem in any of your family members included in this application, 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, abnormal dental conditions, foot disorders (eg bunions), digestive irregularities, skin problems or trouble with heart, limbs, eyes, "nerves" etc; and any other information which you should in good faith disclose?

Please tick Yes or No . If 'Yes' please complete the following:

Name of patient	Nature of illness/disability and treatment received	Period of disability/treatment			Present state of health in this respect
		Month	Year	Duration	

Please continue overleaf

3. Have any of your family members included in this application, consulted a general practitioner in the past year?

Please tick Yes or No . If 'Yes' please complete the following:

Name of patient	Nature of illness/disability and treatment received	Month of visit(s)	Present state of health in this respect

Name and address of general practitioner _____

Declaration: I declare that to the best of my knowledge and belief the statements 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 any family members included in my policy shall be bound by the terms of the policy which I shall read when I receive my policy details. I also understand that you will send all correspondence about this application to the main policyholder unless I write to tell you otherwise. **Please remember:** If there are changes in the information you have given before we have told you that your family member(s) has or have been added to your policy, you must tell us in writing immediately.

Member's signature **X**

Date **X**

Data Protection Act – you will see this sign where we ask you to give personal information.

Please make sure that you either show this statement to anyone covered by this policy, or inform them of its contents before you return this form.

To set up and administer your policy AXA PPP healthcare limited will hold and use information about you and any family members covered by your policy, supplied by you, those family members, medical providers or your employer. Please ensure that you only provide us with sensitive personal information, such as health information, about other people with their agreement. When you give us this information we will take this as confirmation that you have consent to do so.

We may send personal and sensitive personal information in confidence for processing by other companies and intermediaries, including those located outside the European Economic Area.

As you act on behalf of any family member covered by this policy, we send correspondence about the policy, including claims correspondence, to you unless we are advised to do otherwise.

By signing and returning this form you indicate that you have authority to give consent on behalf of any family members covered by your policy and on your own and their behalf you consent to the use of personal information in the ways described above.

We may disclose information about anyone covered by your policy where there is a legal requirement for us to do so or in circumstances when it would help us prevent or investigate fraud or improper claims.

AXA PPP healthcare limited may contact you with details of its other products and services. We may also share some of your details with other AXA Group companies or other carefully selected companies based within the European Economic Area to enable them to contact you with details of and, if appropriate administer, their products and services. We may contact you by post, telephone, or electronically if appropriate. By signing and returning this form you will be consenting to these uses to enable you to receive marketing information from AXA PPP healthcare as well as from other AXA UK Group companies and/or third party companies unless you tick the box to indicate that you do not consent .

You may change your mind at any time by writing to the address on the back of the membership handbook.

Checklist

 Tick the appropriate boxes in this section

-Have you:

- 1 Checked your personal details are correct (including telephone numbers)?
- 2 Checked and/or completed the details of the additional persons to be included?
- 3 Completed the medical history declaration? (section 3)

Now send the form to: **AXA PPP healthcare**
Phillips House
Crescent Road
Tunbridge Wells
KENT TN1 2BR

Or use the envelope provided.



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