FMU personal application form



	For office use only: FMU P1				
I	Enquiry date:				
Your personal reference number:					
-	·				

Please quote this if you call or write to us

Please complete this form in BLOCK CAPITALS

1 Your per	rsonal details (m	nain policyholder)			
Full name: (including title) Address:			Date of birth Gender		
Contact tel no:					
Email address:					
2 Details	of all other person	ons to be included	l in the policy		
Please ensure all t	the details below are corr				
Full name (including title)		Relationship to	policyholder	Date of birth	th Gender (M / F)
				1 1	
				1 1	
3 Your ch	osen level of co	ver			
Note: Prices are revi change if you have n is based on a 12 mod	iewed 1 April and 1 October noved, if anyone requiring co	If your quotation changes outsi over has had a birthday since yo receive details of how to renew	u first contacted us or due to	your medical histo	ry declaration. The price
Plan name	Excess	Premium	Payment frequence	cy (Please	tick)
		·			

This quote has been based upon the information that you have provided us with. Please check all these details are correct and amend if necessary. Please note that any amendments made to this information may be reflected in your final quote eligibility.

Medical history declaration

Important: Please answer all the questions in full and to the best of your knowledge and belief. If you have any doubts whether something may influence how we deal with your application (we call these material facts), you should include it as your policy may be invalid entirely if you fail to disclose any material facts. If for any reason you do not answer a question, we shall take that as meaning you have nothing to disclose. You do not answer a question we shall take that as meaning you have nothing to disclose. You do not answer as question we shall take that as meaning you have nothing to disclose.

nee tre wh	ed to tell us about a atment of any me lich you should ha cluded it. This incl	any genetic test results. Please	note, once you have or associated with so tell us at all or did n ition(s) or symptom	e joined we do uch a medical ot tell us ever s, whether or i	not pay conditior ything un not being	for treatment of h) which you alrealess you have d treated and any	eady had when you joined and leclared it and we have not previous medical		
Please tell us the medical history of everyone you want the policy A Name of the person affected. B Their medical conditions, illness, disabilities, injuries or symptoms. C When they were affected: the month and year it started and ended.				to cover, including yourself: D The treatment that was carried out. E How the person is now (eg do they still need medication or further check-ups: are they better or are they still experiencing problems).					
	nursing home, o	rears, have you or any persor suffered from intermitted			nsulted a	a specialist, be	en admitted to hospital or a		
YES A	Name of person	B Brief description of illness/disability/s		Date (mm/yy)	D -	Freatment received	E How the person is now		
YES	received a pres	y person included in this e cription for medication in t s, colds, flu, health checks Brief description of illness/disability/s	the last 12 months s, vaccinations, con condition/	(or are plann	ning to se r hormo	eek treatment o			
4.3 YES	Medical conditio complications of pain, allergies, a wisdom teeth)	y person included in this alth problem (like those liens, disabilities, illness and horegnancy, varicose veins, nxiety, depression, alcohol	sted below) which nealth problems inc back trouble, joint	in good fait luding, for exa replacement,	n you sh ample: gy bunions,	ould disclose? naecological of indigestion, bo	? r menstrual problems, wel problems, abdominal		
Α	Name of person	B Brief description of illness/disability/s		Date (mm/yy)		Treatment received	E How the person is now		

}	Additional medical information (If you need more space please use a separate piece of paper. Sign, date it and attach it to the form)
	I declare that to the best of my knowledge and belief the statements made on this form are true and correct. I acknowledge that the acceptance of my
	application shall be on the basis of these statements and that I and my family members included in this policy shall be bound by the terms of the policy which I shall read when I receive my policy details. I understand that you will send all correspondence about this policy to the main policyholder unless I write to tel you otherwise. I have indicated the policy and method of payment I would like.
	Please note: If any of the information you have given us changes before we have told you that your policy has begun, you must tell us in writing at once 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 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. We reserve the right to decline your application.
	You and we are allowed to choose which law will govern this policy. Because we are in the United Kingdom we only sell policies that are governed by the Law of England and Wales, so that is the law that applies.
}	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 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 are required by law, in certain circumstances, to disclose information to law enforcement agencies about suspicions of fraudulent claims and other crime. We will disclose information to third parties including other insurers for the purposes of prevention or investigation of crime including reasonable suspicion about fraud or otherwise improper claims. This may involve adding non-medical information to a database that will be accessible by other insurers and law enforcement agencies. We are obliged to notify the General Medical Council or other relevant regulatory body about any issue where we have reason to believe a medical provider's fitness to practice may be impaired.
	AXA PPP healthcare, SecureHealth and Denplan ("we") are members of the AXA UK Group of companies. We would like to use the contact details obtained as a result of this application, to inform you by letter, telephone or email of other products and services. AXA PPP healthcare would also like to share these contact details with further members of the AXA UK Group and carefully selected third parties based within the European Economic Area so that they can let you know about their products and services by letter or telephone and, if appropriate, to administer them. By signing and returning this form you will be consenting to these uses to enable you to receive marketing information from AXA PPP healthcare, SecureHealth and Denplan as well a form other AXA UK Group companies unless you tick the box to indicate you do not consent
	You may change your mind at any time by writing to the address on the back of the Membership Handbook.
	Signature: X

Your 14 day money-back guarantee

When you receive your documents, you will have 14 days in which to ensure you are entirely satisfied with your cover before your contract with us is concluded. You then have a further 14 days when, if you do not wish to proceed for any reason, you may cancel the membership and owe nothing as long as a claim has not been made. Any money which you have paid or which we have collected will be returned to you.

5 How to pay				
You can choose to pay for your cover either annually, quarterly or month then decide how you would like to pay. Important : Please note that if should tick either the annual or quarterly payment box below.				
How often would you like to pay?: Annually Quarterly	Monthly			
How would you like to pay: 1 Direct Debit (complete the mandate b 2 Cheque (please make cheques payab				
Instruction to your Bank or Building Soc Please fill in the whole form (including the official use box if approp AXA PPP healthcare, Phillips House, Crescent Road, Tunbridge W Name and full postal address of your Bank or Building Society	riate) and send to: ells, Kent TN1 2PL.	rect Debit		
To The Manager: Bank/Building Society	Service User Number 9 9 1 3 3 3	DIRECT		
Branch address:	This is not part of the instruc	healthcare limited official use only tion to your Bank or Building Society f you are paying on behalf of the Policyholder.		
Postcode:	Name and address of accou	nt holder:		
Name(s) of Account Holder(s)				
	Telephone no:			
Bank/Building Society account number	Policyholder's name:			
Branch Sort Code	Instruction to your Bank or Building Society Please pay AXA PPP healthcare limited Direct Debits from the account detailed in this Instruction, subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with AXA PPP healthcare limited and, if so, details will be passed electronically to my Bank/Building Society.			
Reference	Signature: X	Date: 🗡		
Banks and Building Societies may not accep	ot Direct Debit Instructions fo	or some types of account.		
Checklist Tick the appropriate boxes in this section				
Have you:				
1. Checked your personal details are correct (including	5. Signed and dated the policyholder declaration? (section 4)			
telephone number)? (section 1)	6. ☐ Chosen method of payment? (section 5)			
 Checked and/or completed the details of the addition persons to be included? (section 2) 	7. ☐ Signed and dated the Direct Debit form?(section 5) – if applicable			
3. Selected your chosen level of cover? (section 3)	8. Enclosed a cheque? – if applicable			
4. Completed the medical history declaration? (section 4)		т арриссию		
Now send the form to: New Business Administration, AXA PPP healthcare, Phillips Or use the envelope provided.	House, Crescent Road, Tu	nbridge Wells, Kent TN1 2PL		
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