



PPP HEALTHCARE

Confidential

Addition of family members form

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

Please complete, in ink using Block Capitals.



Policyholder's surname: (Mr/Mrs/Miss/Ms)		AXA PPP healthcare Membership no:	For office use only
Full forenames:			Rec'd:
Address:			Mem. no:
			w.e.f:
Postcode:	Telephone no. (inc STD code):		Group no:
Family members' details (now to be added to my policy)			Underwriter's authorisation:
Names (eldest first) (include surname if different from above)	Relationship to policyholder	Family members' date 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? (If the child was conceived by artificial insemination by donor, please say 'No'.) 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 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	

Please continue overleaf

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	

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 handbook and benefits table.

Member's signature: **X**

Date: **X**

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

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. We may send it in confidence for processing by other companies and intermediaries, including those located outside the European Economic Area. By signing this form you and any family members covered by your policy consent to such uses of this personal data. We may also disclose information about anyone covered by your policy when there is a legal requirement for us to do so or in circumstances when it would help us to prevent 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. If you do not wish us to do this please tick the box otherwise we will assume that, for the time being, you are happy for us to contact you .

For completion by the group secretary. The above named family member/s will be eligible for inclusion in the scheme on _____
(This is the date on which the cover will take effect.)

Signature: **X**

Group Secretary

Date: **X**

Please do not write in this space