



# Group application form

AXA PPP healthcare

Please complete this form and return to: AXA PPP healthcare, PPP House, Meridian East, Meridian Business Park, Leicester LE19 1UR.

## Employer details

	Group Secretary	Position in company	<b>FOR OFFICE USE ONLY</b> Group no Rate code Rate date Start date
	Company name		
	Business address		
	Postcode		
	Telephone no.	Fax no.	
	E-mail address		
	Nature of business		

## Cover details

	Quotation number if previously quoted by AXA PPP healthcare.	
	Total number of employees to be covered at inception	Total number of employees in the company
	Category of employees eg All directors/all staff etc.	
	For whom will the company actually be paying the premiums? (please tick box)	
	a) Employees only (employee to pay the premium for any family members covered).	<input type="checkbox"/>
	b) Employees and one family member (employee to pay for any family members).	<input type="checkbox"/>
	c) The company to pay the premium for the whole group.	<input type="checkbox"/>
	Do you wish to include worldwide travel cover for all members and their family members? Yes <input type="checkbox"/> No <input type="checkbox"/>	

## Subscription details

	Please tick box
	Yearly cheque <input type="checkbox"/> Yearly direct debit* <input type="checkbox"/> Quarterly cheque <input type="checkbox"/> Quarterly direct debit* <input type="checkbox"/> Monthly direct debit* <input type="checkbox"/>
	If you are paying by direct debit please complete and enclose the separate mandate which accompanies this form. If you are paying by cheque please make your cheque payable to AXA PPP healthcare.

Please complete the section overleaf and sign the declaration.

If the application is not completed fully, this may delay the processing of your membership.

## Declaration



I hereby apply for membership and declare that the statements made on this application are true and correct to the best of my knowledge and belief. I agree to inform AXA PPP healthcare of any change of information on this form. I also declare that the persons covered by this application are resident in the United Kingdom. I understand that previously insured members may be transferred on no worse medical underwriting terms, subject to the Rules and terms of this Enrolment, upon receipt of previous insurer's Certificates. New members will be subject to the two year moratorium clause, which means the applicant does not complete a medical declaration prior to joining, but membership is on the understanding that all pre-existing medical conditions experienced during the last five years are only covered after being a member for two continuous years and after being free from all treatment relating to that condition for one year. All new conditions are covered from the date of joining. I confirm that I am acting on behalf of the listed individuals/employees and I have provided all information to them as specified in the Annual Agreement contained in the Group Secretary Guide.

**Data Protection Act** – you will see this sign where we ask you to give personal information  
AXA PPP healthcare is a member of the AXA Group. To set up and administer this group policy we will hold and use information about employees and family members covered by the policy, supplied by you, employees or those family members and by medical providers. We may send it in confidence for processing to other companies in the AXA Group (or companies acting on our instruction) including those located outside the European Economic Area. By submitting this form you confirm that employees and their family members covered by the policy consent to such use of their personal data. AXA PPP healthcare may send employees details of our other products and services . To enable them to send details of their services we may also share names and addresses with other AXA Group Companies based within the European Economic Area  and with other carefully selected companies outside the AXA Group . If the employee does not wish to receive such details please tick the appropriate box(es). The employee may be contacted by telephone, fax or e-mail if appropriate. I confirm that I have provided all information to the listed employee/family members as specified in the Annual Agreement contained in the Group Secretary Guide.

Signed   
By Group Secretary

Date

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.

## Section for previously insured groups only



Present insurer

Date cover originally effected

Date present cover expires

### Declaration

We declare that to the best of our knowledge and belief none of our employees and their dependants whom we wish to insure currently have any medical conditions likely to result in the need for an in-patient stay in hospital. We understand that AXA PPP healthcare will accept any medical underwriting terms applied by our current insurer and will not impose any additional such terms on any currently insured employees or dependants also transferring. We also understand that AXA PPP healthcare will, however, apply its own rules, including its general exclusions and limitations, to all future claims. We hereby undertake to provide current registration certificates.

Signed

Dated

Position

## For Agent/Intermediary use only

Intermediary name

Intermediary code



For further information:

AXA PPP healthcare, Phillips House, Meridian East, Meridian Business Park, Leicester LE19 1UR.

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