Personal Security Plan

Application Form

iphinsurance.com

Please complete the form in full and in English block letters and return it to us.

1. Applicant's Details

Title: _____ Family Name: _____

First Name: _____

Male: ☐ Female: ☐

Date of Birth: D D / M M / Y Y Y Y

Height in cm: _____

Weight in kg: _____

Occupation: _____

Nationality: _____

Country of Residence: _____

Telephone: _____

Fax: _____

Email: _____

Residential Address: _____

_____

_____

_____

_____

Postcode: _____

Correspondence Address (if different): _____

_____

_____

_____

_____

Postcode: _____

2. Dependants' Details

This includes your spouse and children who are aged not less than 6 months and not more than 18 years at the date of enrolment.
The nationality of dependants will be deemed to be the same as the main applicant.

	Family Name	First Name	Gender (M/F)	Date of Birth	Height in cm	Weight in kg	Occupation	Relationship with main Applicant
1								
2								
3								
4								
5								

3. Plan Options (please select one of each)

Plan: Bronze ☐ Silver ☐ Gold ☐

Please select **units per adult:** 1 ☐ 2 ☐

Extra Options (if required): Children's Security Plan ☐

Currency: Sterling £ ☐ US Dollar $ ☐

4. Start date

On payment of premium ☐ or specific date: D D / M M / Y Y Y Y

Please note that your application is only valid for 28 days from the date of signature and cover cannot be back dated.

5. Beneficiaries

Beneficiary of Main Applicant		
	Beneficiary 1	Beneficiary 2
Family Name		
First Name		
Male/Female		
Occupation		
Address		

Beneficiary of Spouse/Partner		
	Beneficiary 1	Beneficiary 2
Family Name		
First Name		
Male/Female		
Occupation		
Address		

In the event of Accidental Death for an Insured Person on the Children's Personal Security Plan, any applicable benefits will be payable to the Main Applicant.

6. Important notes

CONTINUING DUTY OF DISCLOSURE
If after completing, signing and dating your application form any changes occur in the facts you have given us, such as a change in your state of health, you must tell us in writing about the change, and we reserve the right to decline to accept your application or to accept your application with special terms.

DATA PROTECTION DECLARATION
We will collect certain information about you in the course of considering your application and, if we issue a policy to you, conducting our relationship with you. This information will be processed for the purposes of underwriting your insurance coverage, managing any policy issued and administering claims. We may pass your information to underwriters, medical practitioners, medical assistance companies and claims administrators for these purposes. This may involve the transfer of your information to countries that do not have data protection laws. You may have a right of access to, and correction of, information that we hold about you. Please contact International Private Healthcare if you would like to exercise either of these rights. Some of the information we collect about you may be classified as 'sensitive' - that is, information about racial or ethnic origin, and physical or mental health. Data protection laws impose specific conditions in relation to sensitive information, including in some circumstances the need to obtain your explicit consent before we process the information. By signing this proposal form you consent to the processing and transfer of information including sensitive information described in this notice. Without this consent we would not be able to consider your application.

IPH RESERVE THE RIGHT TO DECLINE ANY APPLICATION.

This insurance is not available to permanent residents of the United States of America, or Canada, of whatever nationality. Purchase of this insurance by permanent residents of the United States or Canada will render the policy void. Your application can be processed when the full premium and the completed application form is registered with International Private Healthcare Limited.

To be read in conjunction with IPH terms and conditions. Information correct at time of print.

7. Declaration

I hereby apply for cover on behalf of all the persons named in this application form for an IPH plan as specified above. I have made a full and complete disclosure about the medical history of each person included in this application and I fully understand that pre-existing conditions as defined in the IPH plan rules shall not be covered by the insurance plan. I understand that upon receipt of my IPH plan documents, if I am not entirely satisfied, I can cancel my application from inception and receive a full refund of the premium I have paid, provided I return the documents to IPH Limited within 30 days of the start of the policy, and provided I make no claim.

I agree that IPH Limited or the insurer may rescind the policy and release themselves from any liability whatsoever if it is proved that I have omitted to declare any relevant information, or have given any incorrect, incomplete or misleading information.

I also understand that I must notify IPH Limited of any changes in the facts contained in this application form, such as a change in the state of health of any person named in it. I authorise any doctor who has ever treated or advised any of the persons named in this application to provide IPH Limited with any information they may require in connection with treatment related to any claim under this plan. I declare that the information given in this application is true and complete.

I, and all those named in this application, understand that in order to assess my claim, IPH Limited may need to obtain details of my medical history. I, and all those named in this application, hereby authorise any physician, healthcare professional, hospital, clinic and other healthcare institution to disclose to IPH Limited, to the extent allowed by applicable law, any information concerning the medical history, services, supplies, or treatment provided to anyone listed on this application, including those services involving dental, substance abuse and HIV/AIDS.

I understand that IPH Limited may rely on this information to administer my policy and claims and to determine policy coverage according to applicable laws and regulations.

If I have indicated that I wish to pay by credit or debit card, I agree that IPH Limited may debit my account with the appropriate premiums on or before their due dates, and all subsequent renewal premiums due as invoiced by IPH Limited until I give written notice that I wish to terminate this agreement. I understand that my cover will terminate in accordance with the terms of the IPH Health plan agreement if IPH Limited are unable to collect my premium – for whatever reason – and I do not provide IPH Limited with an alternate method of payment immediately.

I hereby give IPH Limited authorisation to send my insurance documents in pdf format by email to the email address I have stated in this application. If I have applied through an intermediary, I hereby give IPH Limited authorisation to send my insurance documents in pdf format by email to my intermediary.

I understand that my personal data will be processed in accordance with the Data Protection Act (1998).

I understand that IPH Limited will hold and process my personal data for the purposes of processing my IPH Health plan, processing any claims submitted under my IPH Health plan and providing other related services, which may include sharing my personal data with the insurers of my plan, doctors and other medical professionals involved in my treatment or care (or the treatment or care of other persons insured under my IPH Health plan), IPH Limited's emergency assistance providers and other agents. I understand that this may include the transfer of personal data to countries outside the European Union and in signing this form I consent to such transfer and use.

I also understand that my personal data may be disclosed to any regulatory body that may require IPH Limited to disclose it and that, in the event of fraud or suspected fraud, my personal data may be disclosed to other parties, including but not limited to, the appropriate law enforcement agencies.

I consent to IPH Limited processing personal and sensitive data about me and other persons included on this application form. I understand that all personal data I supply must be accurate and confirm that I have the specific consent of all other persons included on this application to disclose their personal data.

I understand that telephone calls to IPH Limited may be recorded and monitored.

I understand that I may ask to review my personal or healthcare information and request amendments, to the extent allowed by law, and that I may revoke this authorisation at any time.

This authorisation shall remain valid for the term of my IPH plan, including any periods of cover following subsequent renewals, or for so long as allowed by law.

8. Sign and return completed form

01LLO0022907

Please return this form to us using the contact details below by post or email.

We can accept signed and scanned copies of the form attached to an email as a PDF.

We can also accept a digital version of this form, provided you have typed your name below, and your email contains the following copy: "I, [your name], have signed the form myself, and I am happy to be bound by the terms of the plan/agreement attached to this email." This needs to be sent from the same email address as stated on your form.

Signature of Applicant

Date: D D / M M / Y Y Y Y

For Official Use Only		
Ref/Quotation No	Agency No	Agency Name

Post: IPH, IPH House, Stirling Way,
Borehamwood,
WD6 2BT
United Kingdom

Email: info@iphinsurance.com

Fax: +44 (0)20 8207 2878

Tel: +44 (0)20 8905 2888

iphinsurance.com