INSURED BY

FULL MEDICAL UNDERWRITING (FMU) APPLICATION FORM

PLEASE COMPLETE THIS FORM USING **BLOCK CAPITALS** THROUGHOUT AND BY TICKING THE RELEVANT BOXES. IT IS IMPORTANT THAT YOU PROVIDE THE FOLLOWING INFORMATION SO THAT WE CAN PROPERLY ASSESS YOUR APPLICATION. **IF, YOU DO NOT ANSWER THE QUESTIONS WE SHALL TAKE THAT FAILURE TO ANSWER TO MEAN THAT YOU HAVE NOTHING TO DISCLOSE. THIS APPLICATION MUST BE COMPLETED BY YOU IN YOUR OWN HANDWRITING. IF YOU NEED TO MAKE A CORRECTION, PLEASE INITIAL THE CHANGE.**

1. YOUR PERSONAL DETAILS (PLEASE KEEP US INFORMED OF ANY CHANGE OF YOUR ADDRESS) ABOUT THE MAIN APPLICANT (POLICYHOLDER)

TITLE

FAMILY AND FIRST NAME

RESIDENCE ADDRESS

PERMANENT RESIDENCE ADDRESS (To be completed only if you wish to receive your correspondence in a different address from that of the Residence Address)

NAME OF COMPANY/EMPLOYER

DATE OF BIRTH (DD/MM/YYYY)

ID/PASSPORT NO

NATIONALITY (If you have dual citizenship, please state the countries)

COUNTRY WHERE YOU ARE RESIDING FOR MOST OF THE YEAR

OCCUPATION

EMAIL

MOBILE NUMBER

2. YOUR CHOICE OF PLAN & DEDUCTIBLE

Cover will commence from the date shown on your Insurance Certificate/Membership Certificate provided your application has been received and accepted by us. Choose **ONE** level of cover, deductible and area of cover that you require and tick (√) the relevant boxes. Your choice applies to your dependents insured under the policy.

CHOICE OF LEVEL OF COVER: YELLOW ☐ SUNRISE ☐ HONEY ☐ MARIGOLD ☐ SAFFRON ☐

DEDUCTIBLE OPTION: YELLOW & SUNRISE / Annual deductible on all benefits, per person, per policy year:

NIL ☐ €75 ☐ €150 ☐ €250 ☐ €500 ☐ €1000 ☐ €2500 ☐ €4500 ☐

DEDUCTIBLE OPTION: HONEY, MARIGOLD, SAFFRON / Annual deductible on all In-patient benefits, per person, per policy year:

NIL ☐ €150 ☐ €300 ☐ €625 ☐ €1250 ☐ €2500 ☐ €6250 ☐

AREA OF COVER

EU ☐ WORLDWIDE EXCLUDING USA & CANADA ☐ WORLDWIDE ☐

3. EXISTING OR ANY PREVIOUS INSURANCE MEMBERSHIP

HAVE YOU EVER BEEN INSURED OR APPLIED FOR MEMBERSHIP UNDER ANY HEALTH INSURANCE? IF YES, PLEASE PROVIDE US WITH THE DETAILS BELOW.

YES ☐ NO ☐

NAME OF INSURER(S) AND PLAN(S):

DATE OF POLICY EXPIRY:

4. CURRENCY & PAYING YOUR PREMIUM

CURRENCY: €

CHOOSE ONE PAYMENT MODE:

ANNUALLY ☐ SEMI-ANNUAL ☐ QUARTERLY ☐

PREFERRED DATE OF ENTRY (DD/MM/YYYY)

5. MEMBERS TO BE COVERED*

TITLE

FAMILY AND FIRST NAME

RELATIONSHIP TO YOU (spouse, partner, son/daughter)

DATE OF BIRTH (DD/MM/YYYY)

ID/PASSPORT NO

NATIONALITY

OCCUPATION

RESIDING IN

TITLE

FAMILY AND FIRST NAME

RELATIONSHIP TO YOU (spouse, partner, son/daughter)

DATE OF BIRTH (DD/MM/YYYY)

ID/PASSPORT NO

NATIONALITY

OCCUPATION

RESIDING IN

TITLE

FAMILY AND FIRST NAME

RELATIONSHIP TO YOU (spouse, partner, son/daughter)

DATE OF BIRTH (DD/MM/YYYY)

ID/PASSPORT NO

NATIONALITY

OCCUPATION

RESIDING IN

TITLE

FAMILY AND FIRST NAME

RELATIONSHIP TO YOU (spouse, partner, son/daughter)

DATE OF BIRTH (DD/MM/YYYY)

ID/PASSPORT NO

NATIONALITY

OCCUPATION

RESIDING IN

*For more family members please continue and use another separate Application Form, if necessary.

6. CONFIDENTIAL MEDICAL HISTORY (DECLARATIONS MUST BE MADE IN WRITING ON THIS APPLICATION. VERBAL DECLARATIONS WILL NOT BE ACCEPTED)

Please Note:

1. You must declare your/applicants' medical history even if you have been insured with us or anywhere else before.
2. NO LIABILITY WILL BE ACCEPTED FOR ANY MEDICAL CONDITION WHICH ORIGINATED BEFORE THE DATE OF ENROLMENT OR WHICH WAS FORESEEABLE AT THE TIME OF APPLICATION, unless such medical condition has been declared to and accepted by us in writing before the cover commence.
3. Any failure to notify us in writing of a medical condition may result in claims for benefit being refused or cover withdrawn. If you are in any doubt, you should disclose the medical condition. Please ensure that you fully disclose any known or suspected conditions and symptoms experienced by any applicants included in this form. This applies even if professional advice has not yet been sought.

6.1. PERSONAL STATEMENT: BODY BUILD AND HABIT

Please consider the following questions as they apply to each of the people named in this form. Answer each question by clearly ticking (√) one of the corresponding Yes/No boxes and completing the details where required if answer is Yes.

6.1a. Please give the current height and weight. Has anyone lost more than 5kg in the last 6 (six) months?

NAME OF APPLICANTS	YES	NO	WEIGHT (KG)	HEIGHT (CM)	IF YES, REASON FOR LOSS OF WEIGHT IN LAST 6 (SIX) MONTHS	INVESTIGATION/TREATMENT		DOCTOR/CLINIC/HOSPITAL NAME
						DATE (MM/YYYY)	DETAILS	

6.1b. Have you smoked or used any tobacco or smokeless tobacco products (including but not limited to cigarettes, cigars, pipes and chewing tobacco)?

NAME OF APPLICANTS	YES	NO	AVERAGE DAILY CONSUMPTION (PCS/DAY)	NUMBER OF YEARS	DATE CEASED SMOKING		REASON FOR CEASING SMOKING
					DATE (MM/YYYY)	DETAILS	

6.1c. Have you ever taken habit forming drugs or narcotics, or been treated or counselled for a drug or alcohol problem?

NAME OF APPLICANTS	YES	NO	DATE OF ONSET (YYYY/MM)	LAST SYMPTOM DATE (YYYY/MM)	DEGREE OF RECOVERY	INVESTIGATION/TREATMENT		DOCTOR/CLINIC/HOSPITAL NAME
						DATE (MM/YYYY)	DETAILS	

6.2. PERSONAL STATEMENT: HEALTH INFORMATION – PLEASE ANSWER ALL QUESTIONS

Has anyone ever had history of or are currently suffering from or received medical advice or had treatment for any of the following (whether diagnosed or not). If any of the answers to questions 6.2a. to 6.2m. in this Section is Yes, GO TO SECTION 6.3. and provide details.	MAIN APPLICANT NAME	1ST FAMILY MEMBER NAME	2ND FAMILY MEMBER NAME	3RD FAMILY MEMBER NAME	4TH FAMILY MEMBER NAME
6.2a. Chest pain, high blood pressure, heart attack, murmur, palpitation, stroke, high cholesterol, congenital conditions, anaemia, or any heart /blood / vascular diseases?	YES NO	YES NO	YES NO	YES NO	YES NO
6.2b. Cancer (including melanoma), lump / polyp / cyst / growth of any kind or potential cancer diagnosis?	YES NO	YES NO	YES NO	YES NO	YES NO
6.2c. Diabetes, thyroid diseases, metabolic diseases or endocrine diseases?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
6.2d. Hepatitis B, Hepatitis C, (including any other Hepatitis or being Hepatitis carrier), HIV infection / AIDS, liver diseases, gallbladder diseases, or any gastrointestinal diseases (including gastric /duodenal ulcer, ulcerative colitis)?	YES NO	YES NO	YES NO	YES NO	YES NO
6.2e. Kidney or bladder problems, recurrent urinary infections, incontinence, kidney diseases, stones, nephritis, or diseases of the genitourinary system (including the bladder, prostate), breast diseases, or any reproductive organ diseases (including the ovaries, uterus and cervix, fibroid, endometriosis, heavy or irregular periods), testicular disorders?	YES NO	YES NO	YES NO	YES NO	YES NO
6.2f. Any musculoskeletal diseases (including joint / bone diseases, arthritis, spinal disorders, back pain, neck / shoulder problems, cartilage or ligament problems, fractures, osteoporosis, gout or other inflammatory conditions) or any auto-immune diseases (including lupus)?	YES NO	YES NO	YES NO	YES NO	YES NO
6.2g. Eyes / ears / nose / throat diseases, or any respiratory diseases (including asthma, pneumonia, tuberculosis, emphysema, Chronic Obstructive Airways Disorder, COVID-19)?	YES NO	YES NO	YES NO	YES NO	YES NO
6.2h. Epilepsy, head / brain injury, paralysis, alcohol / drug dependency, psychiatric diseases (including depression or anxiety disorders) or other neurological diseases?	YES NO	YES NO	YES NO	YES NO	YES NO
6.2i. Dentistry? E.g. Specialized dentistry, maxillo-facial treatment (currently undergoing or anticipating)	YES NO	YES NO	YES NO	YES NO	YES NO
6.2j. In the last 5 years, has anyone received medical treatment or been prescribed medication for any condition which has lasted longer than 7 days (other than for minor conditions such as cold or flu)?	YES NO	YES NO	YES NO	YES NO	YES NO
6.2k. Has anyone been advised by a registered physician, or do any of the applicants plan to attend, or have attended or are currently attending, in the last 5 years any hospital, clinic or registered physician for: 6.2k.I. Diagnostic tests such as X-ray, ultrasonogram, blood tests, Computerized Tomography (CT) scan, biopsy, Electrocardiogram (ECG), urine or other investigations, etc. (other than for routine employment purpose with normal results)? 6.2k.II. Illness, operation, signs and symptoms, physical disability, injury or other medical advice or treatment not stated under any previous questions?	YES NO	YES NO	YES NO	YES NO	YES NO
6.2l. Is anyone waiting for the results of tests or investigations into an undiagnosed medical condition or have symptoms for which you have not had a diagnosis? If Yes, please provide details.	YES NO	YES NO	YES NO	YES NO	YES NO
6.2m. Pregnancy 6.2m.I. Are you or any of the applicants pregnant (please state the number of months)? 6.2m.II. Are you undergoing or had any form of fertility treatment? 6.2m.III. Do you have any previous or current complications associated with conception, pregnancy or caesarean-section?	YES NO	YES NO	YES NO	YES NO	YES NO

6.3.	THIS PART APPLIES IF YOU HAVE INDICATED 'YES' REPLIES TO ANY QUESTION UNDER SECTION 6.2. QUESTIONS 6.2A. TO 6.2M. PLEASE DISCLOSE ALL MEDICAL CONDITIONS (OR UNDIAGNOSED SYMPTOMS) TO WHICH THESE REPLIES ARE INTENDED TO APPLY. YOU MUST DECLARE ANY CONDITION YOU OR ANY DEPENDENT HAS HAD DURING YOUR/THEIR LIFETIME WHICH MAY HAVE AN IMPACT ON YOUR/THEIR FUTURE HEALTH. IF YOU ARE IN ANY DOUBT AS TO WHETHER A CONDITION MAY BE RELEVANT TO THIS APPLICATION, YOU MUST DECLARE IT IN GOOD FAITH. WE RESERVE THE RIGHT TO REQUEST FOR A MEDICAL EXAMINER'S REPORT (MER) AT YOUR OWN EXPENSE. (IF YOU REQUIRE ADDITIONAL SPACE FOR YOUR DECLARATION, PLEASE GO TO SECTION 6.4. – ADDITIONAL INFORMATION).

QUESTION NO.: NAME OF PATIENT:

NATURE OF ILLNESS AND FINAL DIAGNOSIS:

WHEN DID IT START? (MM/YYYY) WHEN DID IT STOP? (MM/YYYY) NUMBER OF EPISODE(S) BETWEEN THE START DATE AND THE END DATE:

TREATMENT PRESCRIBED: NAME OF HOSPITAL AND ATTENDING DOCTOR:

PRESENT STATE OF HEALTH IN THIS RESPECT:

QUESTION NO.: NAME OF PATIENT:

NATURE OF ILLNESS AND FINAL DIAGNOSIS:

WHEN DID IT START? (MM/YYYY) WHEN DID IT STOP? (MM/YYYY) NUMBER OF EPISODE(S) BETWEEN THE START DATE AND THE END DATE:

TREATMENT PRESCRIBED: NAME OF HOSPITAL AND ATTENDING DOCTOR:

PRESENT STATE OF HEALTH IN THIS RESPECT:

QUESTION NO.: NAME OF PATIENT:

NATURE OF ILLNESS AND FINAL DIAGNOSIS:

WHEN DID IT START? (MM/YYYY) WHEN DID IT STOP? (MM/YYYY) NUMBER OF EPISODE(S) BETWEEN THE START DATE AND THE END DATE:

TREATMENT PRESCRIBED: NAME OF HOSPITAL AND ATTENDING DOCTOR:

PRESENT STATE OF HEALTH IN THIS RESPECT:

QUESTION NO.:

NAME OF PATIENT:

NATURE OF ILLNESS AND FINAL DIAGNOSIS:

WHEN DID IT START? (MM/YYYY)

WHEN DID IT STOP? (MM/YYYY)

NUMBER OF EPISODE(S) BETWEEN THE START DATE AND THE END DATE:

TREATMENT PRESCRIBED:

NAME OF HOSPITAL AND ATTENDING DOCTOR:

PRESENT STATE OF HEALTH IN THIS RESPECT:

QUESTION NO.:

NAME OF PATIENT:

NATURE OF ILLNESS AND FINAL DIAGNOSIS:

WHEN DID IT START? (MM/YYYY)

WHEN DID IT STOP? (MM/YYYY)

NUMBER OF EPISODE(S) BETWEEN THE START DATE AND THE END DATE:

TREATMENT PRESCRIBED:

NAME OF HOSPITAL AND ATTENDING DOCTOR:

PRESENT STATE OF HEALTH IN THIS RESPECT:

Please provide the name and address of your/applicants personal registered physician.

NAME OF APPLICANTS	NAME OF REGISTERED PHYSICIAN & SPECIALIZATION	ADDRESS OF REGISTERED PHYSICIAN

6.4. ADDITIONAL INFORMATION

Please use this section if you need more space to answer any questions. If you don't need more space, Now GO TO SECTIONS, 7 Consent for processing of personal data and 8 Declaration and Signature. In your answers, please include:

- Question number,
- Member name.

7. CONSENT FOR PROCESSING OF PERSONAL DATA

Your application and policy membership are through MediSky International, insured by Inter Partner Assistance S.A. Oddział w Polsce and reinsured by AXA PPP healthcare Limited. Some aspects of the administration of your policy is undertaken by AXA Global Healthcare (UK) Limited or AXA Global Healthcare (Singapore) Pte. Limited, jointly AXA – Global Healthcare. The AXA - Global Healthcare Privacy Policies can be found at: **www.axaglobalhealthcare.com/globalassets/shared/documents/agh-privacy-policy.pdf**.

Please make sure that everyone covered by this policy reads this summary and the full data privacy policies on our website. We want to reassure you that we will never sell personal member information to third parties. We will only use your information in ways we are allowed by law, which includes only collecting as much information as we need. We will obtain your consent to process information such as your medical information when it's necessary to do so.

We collect information about you and the family members who are covered by your plan from you, those family members, your healthcare providers, your employer (if you are on a company scheme), your insurance broker if you have one and third-party suppliers of information.

We process your information mainly for managing your membership and claims, including investigating fraud. We also have a legal obligation to do things such as report suspected crime to law enforcement agencies. We also do some processing because it helps us run our business, such as research, finding out more about you, statistical analysis for example to help us decide on premiums and marketing.

We may disclose your information to other people or organizations. For example, we'll do this to:

- Manage your claims, e.g. to deal with your doctors;
- Facilitate the provision of benefits or otherwise manage your policy; and
- Help us prevent and detect crime and medical malpractice by talking to other insurers and relevant agencies; and
- Allow other AXA companies to contact you if you have agreed.

In order, to be able to manage your policy, we may transfer and access your information from countries anywhere in the world including India and the USA where some administration is undertaken and Switzerland where AXA has a European data centre. Before doing so we will ensure that your data is protected and disclosed only to authorised individuals solely for servicing your policy or claim. Any internal transfer of your data will be undertaken only in accordance with the relevant data protection laws and regulations. Where our using your information relies on your consent you can withdraw your consent, but if you do we may not be able to process claims or manage your plan properly.

We will inform you if a data breach occurs and your personal and medical information are disclosed to unauthorized parties. The notification will be provided within 72 hours of the confirmation of the incident. In some cases, you have the right to ask us to stop processing your information or tell us that you don't want to receive certain information from us, such as marketing communications. You can also ask us for a copy of information we hold about you and ask us to correct information that is wrong.

If you want to ask to exercise any of your rights just **call us** on **(+48) 22 826 11 46** or write to us.

1. I expressly give my consent for the Insurer and MediSky to process MY PERSONAL DATA REGARDING MY HEALTH, data which is absolutely necessary for the provision of the insurance service corresponding to the insurance policy I concluded or, as applicable, whose effects apply to me.

I agree to empower the Insurer to perform any investigations, to request documents to treating physicians, which can help with the complete assessment of my health. I authorize any physician, hospital, policlinic or any other health facility that holds data or information and/or documents regarding my health to provide, upon the Insurer's written request, complete information regarding any disease, accident, treatment, examination, consultation or hospitalization I have undertaken.

In the event an insured Event/Risk occurs, I empower the Insurer to undertake all actions for obtaining the documents necessary for establishing the extension of the obligation to pay the Insurance Benefit, exempting from the professional secrecy obligation both the physicians who have examined / treated me, as well as any public or private institution holding information regarding my health and my health history, both during my lifetime and subsequently, in case of death, regardless of the causes.

I have understood that, should I refuse to expressly give my consent on health data processing, the Insurer will not be able to execute the insurance contract to which I am a part of or whose effects apply to me, including, but not limited to, the payment of compensation.

YES	NO	NAME AND SURNAME	SIGNATURE
☐	☐		

2. I expressly give my consent for the Insurer and MediSky to send me newsletters about their products and services, including for the improvement of these, benefits that I could access, promotional offers or insurance opportunities (MARKETING PURPOSE).

YES	NO	NAME AND SURNAME	SIGNATURE
☐	☐		

3. I expressly give my consent to receive electronic correspondence using my contact data given in this form, for the closing of the contract and/or by running it, reminders of due invoices, this type of correspondence producing the same effects as the correspondence on paper.

YES	NO	NAME AND SURNAME	SIGNATURE
☐	☐		

8. DECLARATION AND SIGNATURE

a. I declare that:

- to the best of my knowledge and belief the statements on this application form are full, true and correct;
- I shall read the General Terms, Conditions and Agreement when received and that I agree to be bound by it unless I cancel the enrolment within 14 days of acceptance of my application.

b. I agree that the acceptance of my application shall be on the basis of these statements.

c. I understand that if there are changes in the information I have given before the start date of my/our policy, I must inform you in writing immediately.

d. I understand that once the policy has started, you will not pay for treatment of any medical condition (or related medical condition) which the member(s) already had when they joined unless fully disclosed on this application and accepted by you. This includes any such medical condition(s) or symptoms, whether or not being treated and any previous medical condition(s) which recurs, or which I should reasonably have known about even if I/We had not consulted a doctor.

e. I understand that as the legal holder of this insurance policy, all correspondence about this application, including claims correspondence, will be sent to me unless I write to tell you otherwise. I also understand that policy documents, written communications and membership details will be issued in English unless you and I have specifically agreed, in writing, to communicate in a different language.

f. I understand that some countries require residents, whether expatriates or otherwise, to take out health cover through a local provider or to hold cover which meets certain compulsory requirements and that the cover provided by you may not meet these country specific requirements and therefore additional cover may be necessary. I further understand that in some situations there may be consequences in the form of tax penalties or otherwise where a resident does not hold the required local cover in addition to their international medical insurance policy. If I have any concerns about any additional cover requirements in my principal country of residence (as defined in 1 About the Policyholder), I understand that it will be my responsibility to check with the local authorities to determine whether there are any further healthcare requirements with which I am expected to comply.

g. By signing and returning this form I confirm that the declarations set out in this application are correct and that I have the authority to enter this policy on behalf of any family members.

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 90 (ninety) days. After completing this application form and signing the Declaration, please return to: **customer-care@medisky.pl**. The declaration is valid for 30 (thirty) days from the date of the signature. **I shall disclose to the Company any change in health and/or medical consultation and/or material facts of all applicants that occur after signing this application form but before the policy is issued.**

I acknowledge and confirm that:

a. I have received a copy of the General Terms and Conditions,
b. I had the opportunity to review the General terms and Conditions, to formulate questions and request for clarifications in relation to such General Terms and Conditions (all of which have been answered by the Insurer in a satisfactory manner),
c. I understand the General Terms and Conditions and
d. I agree to them.

NAME OF POLICYHOLDER

DATE

SIGNATURE OF POLICYHOLDER