Supported by

Health Insurance Application Form – Budget Plus Hospital Plan

Please keep a record of all the information you have supplied. Copies of this application are available on request as are copies of the policy terms. To join a group scheme, pass this application back to your group secretary in a sealed envelope if you prefer. **Please complete in BLOCK CAPITALS throughout**. Use extra space on reverse if needed.

1. Your choice of plan (please leave unanswered if you are joining a group scheme)

Is cover required for work visa purposes? Yes ☐ No ☐

Malta Budget Hospital Plan ☐

Preventive Care ☐ Preventive Care Plus ☐

International Emergency Medical Assistance ☐

Declaration and Needs Statement

On the basis of the information provided by you, your demands and needs are those of someone:
1. who is resident in Malta (the country where you live for 180 days or more in a policy year)
2. wishing to insure against the cost of medical treatment for new medical conditions that arise after the start date of the policy. The level of cover and any optional benefits are as stated above in section 1 'Your choice of plan' and reflect your choice of levels of reimbursement.

2. Your Personal Details

Title: Name: Surname:

Gender: Date of birth: ID/Passport number:

Place of issue: Occupation:

Nationality:

Address in Malta:

Name of employer (if group scheme):

Contact Number: Email:

Name and address of family doctor: For how many years have you been using this family doctor:

If you have used another family doctor or other medical practitioner in the last five years, please give names and addresses

Does any member of your family use a different family doctor? Yes ☐ No ☐
If you have answered Yes, please give name/s and address/es of family doctor/s

Preferred start date of your Policy: No insurance is in force until we accept this application in writing.

3. Additional family members to be covered

	Title:	Name and surname:	Gender:	Date of birth:	Occupation:	Contact telephone number for adult family member/s if different from your own:	Passport Number
Spouse/ Partner:							
Child 1:							
Child 2:							
Child 3:							
Child 4:							
Child 5:							

4. Details of Residency and Nationality

Principal country of residence (The country where you live for at least 180 days in any year): Nationality:

Is anyone listed in this application away from the principal country of residence listed above for more than 120 days in one year? Yes No

If yes, please give details:

5. Your method of payment (please leave unanswered if you are joining a group scheme)

Variable direct debit on bank account which is within the Single Euro Payments Area (SEPA)

Cash/Cheque/Credit or Debit card issued by Malta bank/internet banking

Please ask for a separate form if paying by direct debit or credit card.

6. Medical History Declaration

Please note (i) 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 Atlas. (ii) Failure to notify Atlas Healthcare of a medical condition may result in your policy being invalidated. If you are in any doubt you must disclose the medical condition. Full and complete details must be given in respect of each person to be covered.

	You (Y/N)	Spouse/ partner (Y/N)	Child 1 (Y/N)	Child 2 (Y/N)	Child 3 (Y/N)	Child 4 (Y/N)	Child 5 (Y/N)
a. Present physical defects or medical conditions							
b. Consultations with specialists or hospital admittance/s in the last 5 years							
c. Consultations with a family doctor in the last 2 years							
d. Routine checks within the last 5 years (e.g. mammograms, smear tests, etc).							
e. Are you or any applicant aware that you are or may be pregnant at the time of making this application?							

If you have answered yes to any of the above, please give full details including names of medical conditions, relevant dates, treatment received including drugs, present state of health and foreseeable need for further treatment.

If there is any major condition falling outside the five year period mentioned above that we should know about in good faith you must declare it.

Declaration

I/We declare that I/we have read this application and to the best of my/our knowledge and belief all statements are true and correct whether they relate to me/us or my dependants, and that no material fact that can influence the acceptance or assessment of this insurance has been withheld. If you are in any doubt as to whether a fact is material you must disclose it. This declaration and the information given on this application shall be the basis of the contract between me/us and Atlas Healthcare. If this form has been completed by another person on my/our behalf this person shall be my/our agent and not the agent of Atlas Healthcare. I/We agree to read my/our Membership Handbook and be bound by the conditions of the said agreement unless I/we cancel my/our enrolment within 15 days of acceptance.

Data Protection Statement – you will see this sign where we ask you to give personal or sensitive information.

Atlas Insurance PCC Limited and/or any other subsidiaries of Atlas Holdings Limited or any of its daughter companies (hereinafter '**Atlas Insurance**', '**us**', '**our**', '**we**') are the data controllers, as defined by relevant data protection laws and regulations, of personal data held about **you** or relating to **you** and/or to any other person/s (**family member/s**) whom **you** insure with **Atlas**.

In completing all the forms related to **your policy** or claims, **you** confirm **your** understanding and acceptance of the terms in **our** Data Protection and Privacy Statement. **You** hereby warrant that **you** have informed **your family member/s** why **we** asked for this information and what **we** will use it for and have obtained the necessary explicit verbal consent to process such data for the purposes mentioned below.

Atlas collects and processes information about **you** and **your family member/s** for purposes which include preparing requested quotations, underwriting and administering the insurance proposal and **policy**, carrying out its contractual obligations including handling and settling of claims, and preventing or detecting crime (including fraud). **Atlas** may monitor calls to and from customers for training, quality and regulatory purposes.

Atlas may collect and disclose **your** and **your family members'** information from/to other entities in order to conduct **our** business including:

- managing claims, which may require **us** to obtain data including medical information from healthcare providers (including any medical practitioner, any public or private hospital, clinic, laboratory or other medical facility), and/or **your** employers (for company schemes) and which **you** hereby authorise to provide the information;
- administering policies with:
  - **our** associated companies

- introducers, intermediaries, agents or brokers when these are appointed by **you**,
- the policyholder (in the case of corporate policies),
- insurance principals, reinsurers and co-insurers

including third parties providing services to these;

- helping **us** prevent or detect crime by sharing **your** information with regulatory and public bodies in **Malta** or, if applicable, overseas, including the police, as well as with other insurance companies (directly or via shared databases such as the Malta Insurance Fraud Platform), or other agencies or appointed experts to undertake credit reference or fraud searches or investigations;
- **our** third party suppliers or service providers to whom **we** may outsource certain business operations.

We will retain data for the period necessary to fulfil the above-mentioned purposes unless a longer retention period is required or permitted by law.

You can withdraw **your** consent to **Atlas** processing **your** personal information which is processed with **your** consent, e.g. direct marketing, at any time. **You** have the right to access **your** personal data and ask **Atlas** to update or correct the information held or delete such personal data from our records if it is no longer needed for the purposes indicated above. **You** may exercise these and other rights held in **Atlas** Data Protection and Privacy Statement, by contacting our Data Protection Officer at The Data Protection Officer, Atlas Insurance PCC Limited, 48-50 Ta' Xbiex Seafront, Ta' Xbiex XBX 1021 Malta or email dpo@atlas.com.mt. Please note, however, that certain personal information may be exempt from such access, correction or erasure requests pursuant to applicable data protection laws or other laws and regulations.

If **you** and **your family member/s** consider that the processing of personal data by **Atlas** is not in compliance with data protection laws and regulations, **you** and **your family member/s** may lodge a complaint with **us** and/or the Office of the Information and Data Protection Commissioner by following this link https://idpc.org.mt/en/Pages/contact/complaints.aspx.

If **you** wish to view the full **Atlas** Data Protection and Privacy Statement, for a better understanding of how we use this data please visit https://www.atlas.com.mt/legal/data-protection/. Kindly note that this is subject to occasional changes including to comply with changing data protection laws, regulations and guidance.

Please tick the boxes below to choose how you would like to receive updates about our products and services, promotions, special offers and news from Atlas Healthcare Insurance Agency Limited and/or any other subsidiary companies of Atlas Holdings Limited:

Email ☐ Telephone ☐ Post ☐ SMS ☐

Signature of Subscriber: Date:

Please note that all persons aged 18 or over must sign and date this form.

Signature: Date:

Signature: Date:

Signature: Date:

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 form please let us know. Calls may be recorded for quality and assurance purposes. The completed application form is to be sent to our offices immediately or if you are looking to join a group scheme, pass this application back to your group secretary in a sealed envelope if you prefer. If received more than three weeks after completion a new form will be required. Should there be any material change in answers given in this application before you receive notice of cover, we must be advised immediately.

Additional notes

For office use only

Basis of underwriting:

Intermediary:

Contact us:

Atlas Healthcare Insurance Agency Limited
Abate Rigord Street
Ta' Xbiex XBX 1121
Malta
Tel: +(356) 2132 2600
Fax: +(356) 2326 5601
email: health@atlas.com.mt
www.atlas.com.mt

Calls may be recorded and/or monitored for quality assurance, training and as a record of our conversation

Atlas Healthcare

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