Insured by

UNIVERSAL LIFE

Re-Insured by

AXA

MultiCare International Health Plan

Application Form

Insurance Intermediary's signature
Print name
Insurance Intermediary's Code

Please complete this form using Block Capitals and by ticking the relevant boxes. It is important that you provide the following information so that we can properly assess your application. If, therefore, 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)

Title	Surname	Full Names
Permanent residence address		
Correspondence address. (To be completed only if you wish to receive your correspondence in a different address from that of the Residence Address)		
State whether the Correspondence Address is to be applied to all policies you have with our Company or only to this policy To all policies ☐ To this policy only ☐		
Date of birth D D M M Y Y Y Y		ID number/Passport
Telephone number		Mobile number
Email		Occupation
Name of company/employer (in case of group scheme)		Nationality
Country where you are residing for most of the year		Language for correspondence Greek ☐ English ☐

2. Your choice of Plan

Cover will commence from the date shown on your membership statement provided your application has been received and accepted by us.
Choose plan type, level of cover and area that you require and tick the relevant boxes:

Plan	Premiere ☐ Value Plus ☐ *SmartStart ☐ *Student Care ☐ *(not available to corporate members)
Level of Cover	**Standard ☐ **(Please note that the Standard option is not available for SmartStart) Comprehensive ☐
Optional excess available for Standard level of cover on Premiere or Value Plus plans only	None ☐ €1,000 ☐ €2,500 ☐ €5,000 ☐
Area	1: Worldwide ☐ 2: Worldwide excluding USA, Canada & Switzerland ☐
Optional Upgrade Pack	Yes ☐ No ☐ Only available if you have chosen the Premiere plan and the Comprehensive level of cover as above.
Student Care I wish to pay:	No Excess ☐ €85 Excess ☐ €170 Excess ☐ (Excess is per year.Tick one box only)

3. Existing or any previous membership number

If you have ever been a member, or applied for membership of a Universal Life or AXA PPP healthcare scheme, you must declare it.

Universal Life ☐ AXA PPP healthcare ☐	Number

4. Paying your premium

Method of payment (not applicable for corporate members)
Please tick relevant box:

Annually ☐ Monthly ☐ Cheque/Banker's Draft ☐ (only for annual payment) Direct Debit ☐

5. Additional family members to be covered

Title	First name	Surname
Relationship to you (partner, son/daughter)		Date of birth D D M M Y Y Y Y
ID/Passport number	Nationality	Residing in
Title	First name	Surname
Relationship to you (partner, son/daughter)		Date of birth D D M M Y Y Y Y
ID/Passport number	Nationality	Residing in
Title	First name	Surname
Relationship to you (partner, son/daughter)		Date of birth D D M M Y Y Y Y
ID/Passport number	Nationality	Residing in
Title	First name	Surname
Relationship to you (partner, son/daughter)		Date of birth D D M M Y Y Y Y
ID/Passport number	Nationality	Residing in

For more family members please continue on a 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: (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 Universal Life in writing. (ii) Failure to notify Universal Life 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 anybody included in this application. This applies even if professional advice has not yet been sought. Typical examples are varicose veins, allergies, backache, foot disorders (e.g. bunions), piles, gynaecological problems (including any irregularities of menstruation), complications of pregnancy, digestive irregularities, skin problems, trouble with heart, limbs, eyes, 'nerves' etc, any ear, nose or throat problems or any pains, swellings, lumps or fever.

Part A You must declare your medical history even if you have been insured with us or anyone else before.

Please consider the following questions as they apply to each of the people named. Answer each question by clearly ticking one of the corresponding Yes/No boxes and completing the details where required.	Applicant Name	1st family member Name	2nd family member Name	3rd family member Name	4th family member Name
1. Has any in-patient stay in a hospital or nursing home taken place within the last five years?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2. Has any specialist/medical practitioner been consulted or have you undergone any health check of any kind within the last five years?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
3. Have you experienced any symptoms but not consulted a medical practitioner?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
4. Has any medical practitioner been consulted and/or provided prescriptions for any drugs or medication within the last two years?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
5. Does any chronic/long-term medical or dental condition exist or has there been any other known disability, abnormality or recurrent illness or injury?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
6. Is there any known or foreseeable need to consult any doctor or other health professional?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
7. Have you ever had a caesarean section?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
8. Has any applicant had any condition and/or surgical procedure during their lifetime which may have an impact on future health?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
9. Please give the current height in metres and weight in kilogrammes of each applicant.	..... m ..... kg	..... m ..... kg	..... m ..... kg	..... m ..... kg	..... m ..... kg

You must declare any condition you or any applicant 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 require a Medical Examiner's Report (MER) from any applicant where a previous medical condition is known to us, but has not been declared on this application and to refuse cover if such an undeclared medical condition is confirmed by the MER. We require an MER for certain other categories of applicant and will make a copy of our policy on this available if you ask us.

Part B (Please continue on a separate application form if necessary)

This part applies if you have indicated 'Yes' replies in Part A. Please disclose all medical conditions (or undiagnosed symptoms) to which these replies are intended to apply. Use section 3 to list them separately and give the further detailed information required by sections 4 to 6.

1. Name of patient	2. Question number from Part A	1. Name of patient	2. Question number from Part A
3. Nature of illness/disability and treatment received	4. When was treatment received? Month Year Duration	3. Nature of illness/disability and treatment received	4. When was treatment received? Month Year Duration
5. Need for any further treatment or consultation	6. Present state of health in this respect	5. Need for any further treatment or consultation	6. Present state of health in this respect
1. Name of patient	2. Question number from Part A	1. Name of patient	2. Question number from Part A
3. Nature of illness/disability and treatment received	4. When was treatment received? Month Year Duration	3. Nature of illness/disability and treatment received	4. When was treatment received? Month Year Duration
5. Need for any further treatment or consultation	6. Present state of health in this respect	5. Need for any further treatment or consultation	6. Present state of health in this respect
1. Name of patient	2. Question number from Part A	1. Name of patient	2. Question number from Part A
3. Nature of illness/disability and treatment received	4. When was treatment received? Month Year Duration	3. Nature of illness/disability and treatment received	4. When was treatment received? Month Year Duration
5. Need for any further treatment or consultation	6. Present state of health in this respect	5. Need for any further treatment or consultation	6. Present state of health in this respect

7. Your Signature and Declaration

DECLARATION

I declare that to the best of my knowledge and belief the statements on this application form are full, true and correct, that I shall read the Universal Life Insurance Public Company Limited MultiCare International Health Plan membership agreement when received and that I agree to be bound by it. In the event of any dispute, I agree to follow the Universal Life complaints procedure in the first instance. I agree that the acceptance of my application shall be on the basis of these statements.

Signature	Print name	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 90 days. After completing this application form and signing the Declaration, please return to:

Multicare Policy Administration Department, Universal Life, P.O Box 21270, 1505 Nicosia, Cyprus.

8. Consent for processing of personal data

Universal Life Insurance Public Co Limited (hereinafter called "Universal") with a registered office at 85 Digenis Akritas Avenue, 1070 Nicosia has prepared this consent within the provisions of the European Union Regulation 2016/679 on the protection of natural persons with regard to the processing of personal data, General Data Protection Regulation, Personal Data Processing Law (138(I)/2001 and any amendments from time to time (hereinafter called "Law").).

Universal is committed to protect the personal data of any Applicant (hereinafter called "Applicant") that will be collected and processed for predetermined purposes.

DEFINITIONS

Personal data or **data** means every information related to an Applicant as long as he/she is alive.

Special categories data or **sensitive data** means the data of an Applicant related to racial or ethnic origin, political convictions, religious or philosophical beliefs, the participation in a union, association or trade union, health, sexual life and orientation, as well as related to criminal prosecutions or convictions.

Processing or **processing of personal data** means any task or series of tasks that takes place with or without the use of automated methods and are applied to personal data and includes the collection, recording, organization, preservation, storage, alteration, extraction, use, transmission, dissemination or any other form of disposal, correlation or combination, interconnection, blocking, erasure or destruction.

PURPOSE OF PROCESSING

Universal will process the data for one or more of the following purposes:

1. Issue and management of an insurance contract ("the Contract") which includes inter alia, assessment and acceptance of risks, premium calculation, collection of premiums, interest and loan installments or any other obligations, claims processing, loan applications processing, reassurance, assignment to other organizations.
2. Research or statistical analysis

8. Consent for processing of personal data *continued*

CONFIDENTIALITY AND PROCESSING SECURITY

Universal takes all appropriate organizational and technical measures for data security and protection from accidental or unlawful destruction, accidental loss, alteration, unauthorized dissemination or access and any other form of unlawful processing.

RECIPIENTS AND TRANSMISSION OF DATA ABROAD

The recipients of data are the authorized personnel of Universal and any party that has a contractual agreement with Universal which maintains satisfactory confidentiality protection measures and levels of processing security. The recipients may also be doctors who have examined or will examine the Applicant as well as the competent staff of their clinics/private offices, the Applicant's insurance intermediary who has a contractual agreement with Universal and the competent staff of any reinsurance company that has a contractual agreement with Universal.

For the above purposes, Universal may transmit data to other countries inside and outside the E.U. These transfers will take place within the framework set by the Law and after the necessary notifications to the relevant authorities.

Your policy is underwritten and administered by Universal Life, with the support of AXA - Global Healthcare (UK) on behalf of Universal Life's re insurer, AXA PPP healthcare Limited;

I understand that the following companies may contact, if absolutely necessary, my/our medical practitioner(s) and/or any previous insurer for further details of my/our medical history and authorise such practitioner(s)/entities to release any information. In this case I will be informed beforehand.

Please tick:

Universal Life ☐ AXA PPP healthcare Limited ☐ AXA Global Healthcare (UK) ☐

If you do not consent it may impact the way we can administer your policy.

APPLICANT'S RIGHTS

In case that an Applicant wishes to have further information on data that are maintained by Universal or if he/she wishes to exercise the right of portability, and/or to access data, and/or to correct, and/or to delete, and/or to restrict processing, and/or to object to the processing, for any of his/her personal data, and/or to withdraw his/her consent at any time, he/she can write to the email address: personaldata@unilife.com.cy.

DECLARATION

I have read and been informed for the above content and I freely give my explicit consent for the processing of my personal data, sensitive or not, according to the provisions of the Law and for the purposes described in the above paragraph "Purpose of Processing".

Signature	Full Name	Date

Consent for promotion of products, schemes or services

☐ I agree and accept to receive information about the promotion of products, schemes or services of Universal.

☐ I do not agree to receive any information about the promotion of products, schemes or services of Universal.

Signature	Date

For Universal Life Only

Medical Advisors comments

Medical Advisor's signature

Underwriting

(Underwriting terms pertaining to this application)

Underwriter's signature

PB71468a/11.19