GLOBAL HEALTHCARE AND ASSISTANCE
expacare

Application Form - Securus

Please use BLOCK CAPITALS and Black Ink when completing the form.
Please contact us on +44 (0) 1344 381650 if you have any queries. Please send your application form to us by:

- Post to Expacare, The Columbia Centre, Station Road, Bracknell, Berkshire, RG12 1LP, United Kingdom
- Fax to +44 (0) 1344 381690
- Email to info@expacare.com
- Alternatively, please send the form to your insurance broker.

1. MAIN APPLICANT

First name: Last name:

Nationality: Country of overseas residence:

Residential address:

Telephone: Email:

Occupation:

Male ☐ Female ☐ Date of birth: DD / MM / YY

2. FAMILY MEMBERS TO BE INCLUDED ON COVER

You may include your partner/spouse and children. Child dependants aged 18-24 can join as long as we receive written confirmation from their place of study that they are in full time education.

PARTNER / SPOUSE

First Name	Last Name	Nationality	Country of Residence	Occupation	Male / Female	Date of Birth DD / MM / YY

CHILD DEPENDANTS

First Name	Last Name	Nationality	Country of Residence	Occupation	Male / Female	Date of Birth DD / MM / YY

3. YOUR DOCTOR

Please give details of your regular physician or a physician with whom you have most recently consulted and preferably in the last two years:

Name:

Address:

Telephone:

4. PLAN AND EXCESS CHOICE

	WAIVE EXCESS
Securus Essentialcare ☐	Not Applicable
Securus Extensivecare ☐	Yes ☐ No ☐
Securus Ultracare ☐	Yes ☐ No ☐

There is the option to waive the GBP 25 excess on Outpatient Services (charged on each course of treatment, per medical condition) for a payment of an additional 5% of the annual premium. This only applies to Extensivecare and Ultracare.

5. AREA OF COVER:

☐ Area 1 – Worldwide excluding USA, Canada and the Caribbean

☐ Area 2 – Worldwide

6. THE DATE YOU WANT COVER TO START: DD / MM / YY

7. PAYMENT DETAILS

a) Payment method:

I enclose a cheque: (GBP) ☐ I will be paying by bank transfer ☐ I will be paying by credit card ☐

b) Payment frequency: Annual ☐ Semi-annual* ☐ Quarterly* ☐

** An administration charge of 2% on semi-annual and 4% on quarterly options will be applied (these fees are not applicable when Individual policies are issued to policyholders in the EEA). If you do not live in the EEA and are paying for your insurance via instalments then you will not benefit from protections under the Consumer Credit Act or the Consumer Credit Sourcebook of the Financial Conduct Authority.*

8. DATA PROTECTION NOTICE

We take our responsibility for confidentiality very seriously. Any information you give us will be held securely and fairly in accordance with the Data Protection Act 1998.

How we may use your personal data or disclose it to third parties:

- To administer your plan and process your claims
- To liaise with treatment providers about treatment and costs
- To process claims that are also covered by another insurer or third party
- To help us develop services we think will be in your interest
- For statistical analysis to help us assess how the scheme you belong to is being used
- To detect fraud and improper claims

Giving you information:

- You have a right to know what information we hold about you. We may request an administration fee for supplying a copy of any personal information.

Communication:

- We may monitor any communication we have with you, including telephone conversations to ensure we have an accurate record, and have followed your instructions.
- Website: We use cookies only to track visits to our website. Visitors have the option to decline cookies.

At times, the provision of our services may necessitate the transfer of your personal data outside the European Economic Area and/or the disclosure of the same to insurers, partners, agents and professional advisers. Such employees, contractors and agents who have access to your personal data are required to keep that information confidential and are not permitted to use it for any other purposes. By signing this Application Form you consent to such transfer of data.

We will abide by the stated principles of the Data Protection Act at all times. These can be viewed on the Information Commissioners website at www.dataprotection.gov.uk. Members have the right to know what information we hold about them and can request this by writing to the:

Data Protection Officer, Expacare Limited, The Columbia Centre, Station Road, Bracknell, Berkshire, RG12 1LP

9. AUTHORISATION AND DECLARATION

Are you aware of any person to be covered having any on-going serious condition, including but not limited to any type of cancer, heart condition or stroke? Yes ☐ No ☐

Are you aware of any person to be covered having any medical condition likely to result in, or already requiring planned/pending in-patient treatment? Yes ☐ No ☐

If Yes, please provide full details:

I am applying to be covered under the Expacare plan as chosen on this application form together with the dependants listed in this application.

I declare that to the best of my knowledge and belief, the information given on this form and any additional information supplied is true and complete and that the information completed is full and accurate. I understand and accept that in the event of this application form being fraudulent in whole as or in part, the policy may be invalidated and I will be liable for prosecution.

I understand that if I provide inaccurate or incomplete information, or do not provide the information asked for in this application and make a claim, which Expacare view as being treatment for a pre-existing medical or related medical condition, my claim may be rejected.

If you are in any doubt as to whether information is relevant or not, or do not know the answer, or how to answer, any specific question, then please contact us for guidance.

I understand that Expacare will advise me of any medical conditions which they will exclude from cover based on the information I have provided to them.

I will tell Expacare about any change in the information given in this application which occurs between the date of signing and the date that cover starts.

I understand that the answers provided are necessary in order for Expacare to process my application and I consent to the processing of the personal data, including medical information.

I authorise and herewith agree that Expacare Limited may forward data obtained from the form to the Insurer or its authorised Claims Administrator or any Reinsurer for the purpose of assessing the risk and handling the reinsurance.

I authorise any doctor, physician or practitioner who has examined or observed me or any of the applicants for diagnosis, treatment, disease or ailment, to give to the Insurance Company full particulars of these, including any prior medical history and medical records.

By signing this application form, I consent to Expacare dealing with my broker, if one is appointed. I also consent that they have authority to see medical information that I have disclosed in this application and in addition any subsequent medical information that Expacare obtain in the course of dealing with my application and policy.

Signature of main applicant/policyholder:

DATE: (DD/MM/YY):

Signature of Spouse/Partner:

DATE: (DD/MM/YY):

Signature of Child Dependant 1:

DATE: (DD/MM/YY):

Signature of Child Dependant 2:

DATE: (DD/MM/YY):

Signature of Child Dependant 3:

DATE: (DD/MM/YY):

Signature of Child Dependant 4:

DATE: (DD/MM/YY):

Parents/guardians may sign the form on behalf of any dependants aged 0-17