expacare

TOKIO MARINE NICHIDO

APPLICATION FORM SMU
Employee Declaration

COMPANY NAME: .....

1. EMPLOYEE

First name: ..... Last name: .....

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

Occupation and Industry/nature of business: .....

Nationality: ..... Country of residence: .....

Start date: DD / MM / YY

2. PARTNER / SPOUSE – ONLY COMPLETE IF THEY ARE TO BE COVERED

First name: ..... Last name: .....

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

Occupation and Industry/nature of business: .....

Nationality: ..... Country of residence: .....

3. CHILD DEPENDANTS – ONLY COMPLETE IF THEY ARE TO BE COVERED

	First Name	Last Name	Nationality	Country of Residence	Male / Female	Date of Birth DD / MM / YY
Child Dependant 1						
Child Dependant 2						
Child Dependant 3						
Child Dependant 4						

4. MEDICAL DECLARATION

Please confirm if any of the persons on this application:

1. Have suffered any symptoms or have had any consultations in the two years prior to the enrolment date or are receiving any on-going medical treatment? Yes ☐ No ☐
2. Have, or have had any form of disease or disorder of the heart? Yes ☐ No ☐
3. Have, or have had any form of cancer? Yes ☐ No ☐
4. Are aware of any pending treatment? Yes ☐ No ☐
5. Are currently pregnant or undergoing any form of fertility treatment? Yes ☐ No ☐
6. Are you opting for cover that includes dental treatment? Yes ☐ No ☐

If yes, please provide details of the last time you and anyone else to be covered went for a dental check-up.

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Was all necessary work concluded? Yes ☐ No ☐

Please provide full details for any questions where you have answered 'Yes' (and continue on a separate sheet if necessary):

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5. INFORMATION YOU PROVIDE TO US

In addition to providing all basic information to enable us to place the risk, you must take reasonable care not to make a misrepresentation to the Insurer and to disclose all material matters relating to the risk. In this respect, you must provide all information relating to the risk, whether favourable or not, which would influence the judgement of a prudent insurer in determining whether he will accept the risk and, if so, on what terms.

Please take reasonable care to answer all the questions asked by the Insurer and us, whether by way of this declaration form or otherwise, honestly, to the best of your knowledge, and provide complete, accurate and relevant details. If you do not answer the questions honestly or to the best of your knowledge, it may be seen as a deliberate or reckless misrepresentation by the Insurer and your cover may be cancelled or your claim rejected or not fully paid by the insurer. You should note that failure to comply with your insurers' request at renewal to confirm or amend particulars you have previously given may amount to misrepresentation which could prejudice your insurance cover in whole or in part. You must tell Expacare about any change in the information given in this application form which occurs between the date of signing and the date that cover starts.

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.

6. DATA PROTECTION FAIR PROCESSING NOTICE

In your dealings with us you may provide information that includes data that is known as personal data.

The personal data we collect will include data relating to your name, address, email address, IP address, date of birth, nationality, country of residence, occupation, credit card details and medical information.

We will process your personal data to allow us to administer your health insurance policy and any associated claims and for actuarial analysis.

It will also be used to manage future communications between ourselves in relation to your policy and claims.

We will only use your data for the purpose for which it was collected. We will only grant access to or share your data where we are required or entitled to do so by law under lawful data processing. This is within our firm or other firms associated wit us, our authorised partners, your broker if you have appointed one, third party service providers such as insurers, assistance companies and claims administration providers.

If you require further information on how we process your data and our lawful bases for doing so, please contact us.

7. AUTHORISATION AND DECLARATION

I am applying to be covered under the Expacare Choices plan as chosen on the group 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 (including pregnancy), 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 understand that Expacare will process my personal data, including medical data in relation to my insurance policy.

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.

Please sign on back page.

By signing this application form, I authorise Expacare to deal with my broker, if one is appointed. I also agree 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