HEALTH INSURANCE PROPOSAL FORM

Notes

- PLEASE COMPLETE IN BLOCK CAPITALS.
- COMMENCEMENT OF THIS POLICY WILL BE CONFIRMED BY A POLICY CERTIFICATE. PAYMENT OF PREMIUM DOES NOT MEAN THAT THE COVER IS IN FORCE.

Section A: Policyholder Personal Details

Title	Name	Surname	
Male /Female	ID Card No./ Passport No.	Date of Birth / /	Age
Occupation	Nationality	Country of Residence	
Address		Telephone	
		Mobile	
Height	Weight	Email	

Section B: Dependant Children Under the Age of 21

Dependant	Male/Female	Name & Surname	Date of Birth	ID Card No.	Nationality
Dependant 1					
Dependant 2					
Dependant 3					
Dependant 4					

If there is insufficient space please use a separate sheet and indicate that you have done so by ticking here ☐

Section C: Other Insurances

Do you have or have you had a health insurance policy with any other insurer? Yes ☐ No ☐

If you have answered "Yes" to the above, please attach a copy of your last Certificate of Insurance.

Have you or any of your dependants to be covered under this policy had any terms imposed or been refused Health Insurance or Life Insurance Cover. Yes ☐ No ☐

Section D: Details of Residency

Do you or any of the applicants listed on this proposal form reside or intend to reside away from Malta for more than 180 days in any policy period? Yes ☐ No ☐

If you have answered "Yes" to the above, please give details: .....

Section E: Choose your Level of Cover

Level 1 ☐	Level 2 ☐	Level 3 ☐	Level 4 ☐	Level 5 ☐
Health 123	**Limited Plan**	**Hospital Plan**	**Hospital Plan Plus**	**International Plan**

Section F: Medical History Declaration

Please ensure that you disclose any known or suspected medical conditions and symptoms experienced by anyone included on this proposal form in the past seven years. This applies even if professional advice has not been sought. If there is any major condition falling outside the seven year period you must also declare it.

Failure to disclose material facts could affect your policy and make the policy invalid. If the answer to any of the following questions is yes, please complete Section G: Detailed Medical History.

	Policyholder		Dependant 1		Dependant 2		Dependant 3		Dependant 4	
Have you or any dependants to be covered under this policy ever had:	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
1. A stroke or heart problems including arterial or cardiac surgery?										
2. A malignant condition (e.g. cancer)?										
3. Surgery as a result of a bone or joint condition?										
4. Heart or cardiovascular disorders For example: chest pains, angina, high blood pressure, circulation problems, varicose veins, venous ulcers, coronary artery disease or ischaemic heart disease.										
5. Glandular disorders For example: thyroid, hormonal problems, diabetes or obesity.										
6. Breathing or respiratory disorder For example: shortness of breath, chest infections, bronchitis or asthma.										
7. Ear, nose and throat and eye problems For example: ear infections, tonsillitis, deafness or cataracts.										
8. Stomach, intestine, liver or gall bladder problems For example: repeated indigestion, irritable bowel syndrome, change in bowel habit, rectal bleeding, piles, hepatitis, ulcer or colitis.										
9. Cancer, tumours, growths or cysts.										
10. Skin problems For example: rashes, acne, psoriasis, eczema, solar keratitis, basal cell carcinomas or rodent ulcers.										
11. Brain or nervous system disorders For example: repeated headaches, migraines, nerve pain, fits, epilepsy, multiple sclerosis or stroke.										
12. Muscle, bone or joint problems For example: cartilage, ligament, tendon, back, neck, hip or knee problems, sprains, fractures, joint replacement, gout, sciatica or arthritis.										
13. Urinary problems For example: urinary infections, incontinence, urinary retention, bladder, kidney or prostate problems.										
14. Blood disorders For example: abnormal blood tests, high cholesterol, raised prosthetic specific antigen (PSA) or anaemia.										
15. Reproductive system problems For example: heavy or irregular periods, abnormal menopause, abnormal smears, infertility, fibroids, endometriosis or pregnancy problems such as pre-eclampsia or caesarean section.										
16. Dental problems For example: wisdom teeth problems or gingivitis.										
17. Allergies										
18. Psychological disorders For example: stress, anxiety, depression or eating disorders.										
19. Hernia For example: umbilical hernia, inguinal hernia or hiatus hernia										

	Policyholder		Dependant 1		Dependant 2		Dependant 3		Dependant 4	
Medical History Declaration	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
20. Is anyone to be covered taking any medication?										
21. Has anyone to be covered experienced any signs or symptoms or any medical problems in the last six months regardless of whether a healthcare professional has been consulted?										
22. Do you undergo regular check-ups such as but not limited to mammograms, bone density, pap smear, ECG, cholesterol, colonoscopies or prostate check-ups? If yes please provide us with a copy of the most recent results.										
To be completed by anyone over the age of 16										
23. Do you smoke or have you ever smoked?										
24. How tall are you? How much do you weigh? (applicable for dependants)			Height	Weight	Height	Weight	Height	Weight	Height	Weight

Section G: Detailed Medical History

If you have answered "Yes" to any questions in section F, please give full details in the space provided.

Question Number	Name	Medical condition & symptoms	Treatments received including dates	What was the outcome of the treatment?

Section H: Your General Practitioner's Details

Name and address of your General Practitioner .....

Mobile number ..... Telephone Number .....

Does your General Practitioner keep medical records? Yes ☐ No ☐

How many years have you been using your General Practitioner? .....

Section I: Payment Options

Annually by: ☐ Cash / Cheque ☐ Credit / Debit Card

Half Yearly by: ☐ direct debit

A separate direct debit mandate form in favour of Elmo Insurance will be provided for completion. A 3% premium increase charge is applicable for half yearly payments.

Section J: Underwriting Terms

With full Medical Declaration, Elmo Insurance will not pay benefit for the treatment of any symptoms, illness, injuries or conditions which were foreseeable, or that arose before the date the policy commences, unless these have been fully disclosed in this proposal form (or subsequently disclosed) and are accepted by Elmo Insurance.

Section K: Data Protection Notice

Elmo Insurance Ltd is the data controller in relation to personal data held about you or any other person whom you insure with us. By making a request for insurance with Elmo Insurance Ltd, you acknowledge that you and all persons whom you propose to insure with us accept this Data Protection Statement. You should therefore show this notice to anyone whom you propose to insure with us.

It may be necessary for us to collect sensitive personal data (such as medical conditions or injuries) relating to you or any other person insured or to be insured under the policy or who may claim under the policy. You should get their explicit consent before sharing their personal data with us. By making a request for insurance with Elmo Insurance Ltd, or making a claim under this policy, you acknowledge that you and all such persons are giving their explicit consent to such information being processed in the manner and for the purposes outlined here. Under the terms of your policy, you should give us notice about any accident which may give rise to a claim under the policy. When you give us notice about any such accident you acknowledge that you and all persons who may claim under this policy accept this Data Protection Statement. You should therefore likewise show this notice to anyone claiming under this policy.

We will use this information to manage and administer your insurance policy, to assess creditworthiness and for underwriting, claim handling and fraud prevention purposes. In order to provide you with products and services this information will be held in the data system of Elmo Insurance Ltd. We may also collect information from other sources and check the information that you provided us. We may pass this information to other insurers either directly or through persons acting on their behalf such as the Malta Insurance Association, Insurance Intermediaries or Private Investigators, Medical Consultants, the Commissioner of Police, the Malta Insurance Fraud Platform, and where we are entitled to do so under the Insurance Business Act or the Data Protection Act. Furthermore, in case you default in the payment of your premium or other dues under the policy, we may pass this information to the Malta Association of Credit Management or Credit Info and or any Credit Referencing Agency, so that such information will be recorded in the system and made available to participants.

You are entitled to know what personal data is held about you in our systems and where applicable request the rectification or erasure of such data. If you wish to receive such information, you should write to us. We may pass some or all of the information that relates or is ancillary to the claims history of persons who may claim under your policy to the Malta Insurance Fraud Platform. The aim of the Malta Insurance Fraud Platform is to prevent, detect, suppress and/or prosecute insurance fraud. Elmo Insurance Ltd jointly with other motor insurers is the data controller in relation to the Malta Insurance Fraud Platform. The platform is administered on our behalf by the Malta Insurance Association (MIA). Under the Data Protection Act, you are entitled to know what information about claims you have made is held on the Malta Insurance Platform and where applicable, request the rectification or erasure of the same. If you wish to receive this information, please write to the Malta Insurance Association at its registered address.

Section L: Declaration

I confirm that I have received, read and understood the cover provided by Elmo Insurance.

I, on behalf of any included dependants and myself apply for private health insurance cover and agree to be bound by the rules of Elmo Insurance and the policy for which I am applying.

I declare that, to the best of my knowledge and belief the answers and information I have given are true, accurate and complete and that I have not withheld any information in regard to this proposal that ought to be disclosed to Elmo Insurance. I understand that if any of the information provided by me is incorrect or incomplete, Elmo Insurance will be entitled to refuse to pay my benefits and/or cancel my policy.

I confirm that my demands and needs are met by the cover option I have selected and that I have read and understood the basis on which Elmo Insurance will underwrite my policy as detailed above in Section J: Underwriting Terms of this proposal form.

I confirm that I give explicit consent for Elmo Insurance to process my personal data and that of any included dependants in accordance with the Data Protection Notice detailed in the Data Protection Notice Section K of this form.

Section M: Signatures

Please note that all persons included in this proposal over the age of 18 must sign this declaration in the space below. In the case of persons included in this proposal under the age of 18 years then their parent/legal guardian must sign.

Policy Holder's Signature	Date
Dependant's Signature	Date
Dependant's Signature	Date
Dependant's Signature	Date
Dependant's Signature	Date