Group Application Form

Please complete the sections relevant to your application. Please note it is vital all relevant questions on this form are answered accurately and that all relevant information is disclosed.

SECTION A - Employer Details

Employer Name			
Registered Address			
Postcode		Registered Number	
Nature of Business			
Telephone		Fax Number	
Website			

SECTION B - Employer Contact Person

Title	Mr ❑ Mrs ❑ Miss ❑ Other:		
Forename(s)			
Surname			
Job Title			
Telephone		Mobile	
E-mail			

SECTION C - Plan Selection

UNDERWRITING METHOD

1. **FMU (Full Medical Underwriting)** - All the details of your employees medical history are required in the application form with this option. By choosing this option your employee will know exactly what they are covered for. If your employees or any of their dependents have a medical condition that is likely to recur or is ongoing, that condition (and anything related to it) may not be covered. Employees must complete underwriting options 'Section E' of the Employee Application Form. Pre-existing medical conditions will not be covered unless they are declared to and accepted by us in writing.
2. **Moratorium** - No details of employee medical history are required in the application form. We will not cover any medical conditions that existed in the five years prior to application - these conditions will become eligible for cover two years after the member joins provided these conditions are eligible under the terms and conditions of the policy. This applies to all family members covered.
3. **CPME (Continued Personal Medical Exclusions)** - No details of employee medical history are required in the application form. If you or your employees have existing exclusions, these will be carried forward and continued. If no membership certificates are available from the previous insurer, employees will be underwritten as Moratorium. An additional premium may be payable and will be included in your quotation.
4. **MHD (Medical History Disregarded)** - This option is only available for employers with more than 30 employees. No medical or underwriting information is required and no pre-existing exclusions will be applied to your employees. Employees do not need to complete the underwriting options 'Section E' of the Employee Application Form. An additional premium may be payable and will be included in your quotation.

Date of Commencement	d d / m m / y y			
Programme Selected	Core ☐	Core Extra ☐	Comprehensive ☐	
Routine Healthcare	Yes ☐	No ☐		
Geographical Cover*	Area 1 ☐	Area 2 ☐	Area 3 ☐	
Excess / Deductible	Nil ☐	£75 ☐	£200 ☐	
Underwriting Method	FMU ☐	Moratorium ☐	CPME ☐	MHD ☐
Number of Employees to be Covered		Number of Dependents to be Covered		

***AREA 1** comprises the following countries: Albania, Andorra, Austria, Belarus, Belgium, Bosnia Herzegovina, Bulgaria, Channel Islands, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, Great Britain, Greece, Greenland, Hungary, Iceland, Ireland, all islands of the Mediterranean, , Isle of Man, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Macedonia, Madeira, Malta, Moldova, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Romania, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, Ukraine, Vatican State.

AREA 2 comprises all countries worldwide with the exception of the following: United States of America, Canada, Anguilla, Antigua & Barbuda, Aruba, Bahamas, Barbados, Bermuda, Cayman Islands, Cuba, Curaçao, Dominica, Dominican Republic, Dutch Antilles (including St. Maarten), Grenada, Guadeloupe, Haiti, Jamaica, Martinique, Puerto Rico, St. Kitts-Nevis, St. Lucia, St. Vincent, Trinidad & Tobago, Virgin Islands.

AREA 3 comprises all countries worldwide.

SECTION D - CPME (Continued Personal Medical Exclusions) & MHD (Medical History Disregarded) Declaration ONLY

If CPME/MHD has been selected in 'Section C', please sign the following declaration, if it is correct, on behalf of all employees.

I declare that to the best of my knowledge all applicants to be covered by this plan:

- are actively at work (in the case of employees).
- have not had any deterioration in health since being underwritten as a result of any major illness such as heart disease, stroke, cancer or mental illness.

(Please provide membership certificates from your current insurer or a fully completed employee application form - CPME applicants only).

Signed		Date	d d / m m / y y

SECTION E - Payment Details

Premium Payment	Annual ❑	Half Yearly ❑*	Quarterly ❑*	Monthly ❑*

Payment can only be made monthly if paid by Direct Debit / Recurring Credit Card or Standing Order.

* The following surcharges will be applied for the relevant payment options:- Half yearly 4% / Quarterly 6% / Monthly 8%

We accept payment in Pounds Sterling, Euros, US Dollars or in any other major local currency as agreed with us. Where the currency is other than Pounds Sterling, the exchange rate must be provided by us. Your application will be processed on receipt of payment.

Premium payment must be received by the due date for cover to be effective.
Please (✓) applicable payment method 1, 2 or 3.

1 Payment by Cheque ❑

Please make your cheque payable to LAMP Insurance Company Limited

2 Payment by Bank Transfer ❑

Please make your bank transfer payable to:

Sterling (£) Account

Beneficiary	LAMP Insurance Company Limited		
Account Number	02272997	Sort/Branch Code	40-09-19
Swift Code	MIDLGB2102G		
IBAN No.	GB35 MIDL 4009 1902 2729 97		
Address of the Bank	45 Milsom Street, Bath, BA1 1DU, United Kingdom		

Please ensure that your name is clearly stated on the bank transfer as the originator

Euro (€) Account

Beneficiary	LAMP Insurance Company Limited		
Account Number	67184697	Sort/Branch Code	40-05-15
Swift Code	MIDLGB22		
IBAN No.	GB92 MIDL 4005 1567 1846 97		
Address of the Bank	45 Milsom Street, Bath, BA1 1DU, United Kingdom		

Please ensure that your name is clearly stated on the bank transfer as the originator

US Dollar ($) Account

Beneficiary	LAMP Insurance Company Limited		
Account Number	60329686	Sort/Branch Code	40-05-15
Swift Code	MIDLGB22		
IBAN No.	GB77 MIDL 4005 1560 3296 86		
Address of the Bank	45 Milsom Street, Bath, BA1 1DU, United Kingdom		

Please ensure that your name is clearly stated on the bank transfer as the originator

3 Payment by Credit Card ❑

Card Type	VISA ❑ MASTERCARD ❑		
Card Number			
Issue Date (if applicable)	m m / y y	Expiry Date	m m / y y
Security (CVC) Code*			

* Last 3 digits in the signature field on the back of the card

Name (as appears on the card)			
Billing Address			
		Postcode	

- I authorise LAMP Insurance Company Limited to charge my credit card account with unspecified amounts in respect of my premium payments as and when these become due, until further notice. The Company will inform me in advance of any premium adjustments.

Cardholders Signature		Date	d d / m m / y y

SECTION F - Data Protection

LAMP Insurance Company Limited assures you that all your personal and medical information will be held in strictest confidence and in accordance with applicable legislation. Personal data may be passed to other companies with the LAMP Group or given to third party providers in relation to services which we provide to you, and may be transferred by electronic or other means. You have a right to know what information is held about you, and to amend or delete any data we hold which is inaccurate or out-of-date.

SECTION G - Declaration

- We, the employer (policy owner), hereby apply for membership for our employees to the LAMP International Healthcare Plan.
- We accept the benefits, terms, conditions and limits provided for in the insurance policy and we agree to be bound by such terms.
- We understand that this Application is subject to written acceptance by LAMP Insurance Company Limited. We understand that by signing this declaration we are applying on behalf of all applicants to be covered by this policy.
- We confirm the correctness of the statements and information contained in this application and confirm the correctness of all other documents submitted now or in the future by any member or intermediary of or on behalf of the employer. This clause will constitute a condition precedent to the payment of the benefits provided for in the terms of the Plan. We accept that LAMP Insurance Company Limited will be relying on such statements and information when agreeing to accept this application. LAMP Insurance Company Limited reserves the right to investigate where uncertainty exists about the validity of information provided.
- We agree to our employees and their listed dependents, subject to the employees consent, who participate in the Plan to which this proposal relates, being called upon to submit to such medical examinations and tests as LAMP Insurance Company Limited deems necessary.
- We acknowledge that LAMP Insurance Company Limited reserves the right to cancel the Plan if any amount due is not paid by or on the due date concerned.
- We agree to give LAMP Insurance Company Limited immediate written notice should any changes material to the assessment of this application occur before the date upon which LAMP Insurance Company Limited grants written acceptance. This will give LAMP Insurance Company Limited the opportunity to reconsider the terms of acceptance.
- We confirm that the signatories to this declaration are fully authorised and entitled to sign this declaration on behalf of the employer and to bind the employer to the terms of the Plan.

Signed		Date	d d / m m / y y

Name	

Please return this questionnaire to your broker/intermediary, or to:

Healthcare Underwriting Department
LAMP Insurance Company Limited
260/262 Main Street
Gibraltar

Email: healthcare@lampinsurance.com

LAMP Insurance Company Limited, 260/262 Main Street, Gibraltar
Tel: +350 200 51904

LAMP Insurance Company Limited is licensed by the Chief Executive of the
Financial Service Commission of Gibraltar under the Insurance Companies Ordinance
Registered Address: 260/262 Main Street, Gibraltar
Company Number: 93562
Email: info@lampinsurance.com
Web: www.lampinsurance.com