Insured by

UNIVERSAL LIFE

Supported by

AXA

MultiCare Essential Health Plan

Application form

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.**
You and/or any dependants must be between the age of 90 days to 60 years (both inclusive) to be eligible to apply for this plan.

Insurance Intermediary's signature
Print name
Insurance Intermediary's Code
For production purposes, referred by

1. Main Subscriber (Policyholder) 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 benefit options

Cover will commence from the date shown on your Membership Statement provided your application has been received and accepted by us.
Choose the area that you require and tick the relevant box:

Area	1: Worldwide *(excluding all sanction countries)* ☐ 2: Worldwide excluding U.S.A, Canada & Switzerland *(excluding all sanction countries)* ☐

3. Existing or any previous membership number

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

Universal Life ☐ AXA Health / 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

Please complete the below on behalf of all dependants that you wish to be covered by the plan.

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

5. Additional family members to be covered *continued*

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 to be covered 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 and/or my cover under this policy may be amended or terminated. 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 section 5 of this application. This applies regardless of whether you or your dependents sought professional advice or treatment, and irrespective of whether any diagnosis was made. You must declare any condition you or any subscriber included in section 5 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 would deem any such condition as Pre-existing.

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

Please complete parts A & B on behalf of yourself and all dependants.

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.	Subscriber Name	1st family member Name	2nd family member Name	3rd family member Name	4th family member Name
1. Has any surgery, in-patient stay in a hospital or nursing home taken place?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2. Has any specialist/medical practitioner been consulted or have you ever undergone any health check-up or ever experienced symptoms or received medical advice (whether diagnosed or not) for cancer, myocardial infarction, chest pain, structural heart abnormalities, diabetes, hyperlipidaemia, high blood pressure, cerebral aneurysm/stroke or major organ failure?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
3. In the last 5 years, have you been advised by any doctor to take any medications for a continuous period of more than 2 weeks?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
4. Do you intend seeking or have been advised by a registered physician or medical professional to seek medical treatment for any health condition or are you currently waiting for the results of any medical tests/investigations?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
5. For dependant child (aged 3 years and below), please answer the following questions: (a) Was the child a premature baby (i.e. less than 37 weeks of gestation)? (b) Were there any significant events of the child including but not limited to difficulties during or at birth, any cardiac or heart problems, any respiratory disorders, prolonged neonatal jaundice, or congenital issues?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
6. Other than for the health conditions you have already told us about, have you been advised: (a) Of any abnormal diagnostic tests results or any diagnostic tests (includes self-administered) which have not been completed? (b) To undergo any treatment, surgery, hospitalisation, or consultation which has not been completed? (c) To refer to a specialist and have not yet done so?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
7. Have you been smoking more than thirty (30) cigarettes per day?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
8. Has your biological mother, father, or any sister or brother been diagnosed prior to age 60 with any of these conditions: Cancer (examples: colon, breast, ovarian or other site), heart disease/problem (example heart attack), stroke, diabetes, polycystic kidney disease, familial adenomatous polyposis, or any other inherited or familial medical conditions? If yes, please provide details with exact nature of the illness e.g. breast cancer, colon cancer or heart attack etc and age of occurrence.	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
9. Has any of your proposal for or reinstatement of Life, Health, Critical Illness, or Disability Insurance ever been declined, postponed or accepted on special terms?	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
10. Please give the current height in metres and weight in kilograms of each Subscriber included within section 5.	..... m .....kg	..... m .....kg	..... m .....kg	..... m .....kg	..... m .....kg

We reserve the right to require a Medical Examiner's Report (MER) from any subscriber 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 subscriber 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?			3. Nature of illness/disability and treatment received	4. When was treatment received?		
	Month	Year	Duration		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?			3. Nature of illness/disability and treatment received	4. When was treatment received?		
	Month	Year	Duration		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?			3. Nature of illness/disability and treatment received	4. When was treatment received?		
	Month	Year	Duration		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		

Family Medical History: If you answered 'Yes' to question 8 of Part A, please complete the following table with exact nature of illness, e.g. diabetes, heart condition, cancer - specific type of cancer, etc:

Name of Subscriber	Specify affected family member-relationship to the subscriber (e.g. father, mother, brother, sister, etc.)	Diagnosis / Condition (e.g. diabetes, cardiovascular, etc) (if cancer, please specify type)	Age of the affected family member	
			Age of onset / diagnosis	Current Age (if alive)

7. Signature and Declaration of Main Subscriber and Adult Dependants

With the signing of the below the Main Subscriber agrees to the below declarations on his/her behalf and for any minor and adult dependants for which he/she has applied for cover. Each adult dependant for which cover has been applied for must also sign to indicate their agreement to the below declarations.

DECLARATION

I declare that to the best of my knowledge and belief the statements on this application form are true, accurate and complete. I understand that if I do not provide the information requested in this application form, any claim for benefits may be refused and/or my cover under this policy may be amended or terminated.

I confirm that I shall read the Universal Life Insurance Public Company Limited Multicare Essential Health Plan membership agreement when received and that I agree to be bound by it.

I understand that my personal information will be processed in accordance with the privacy notice set out herein below. I confirm that I have read such Privacy Notice, and acknowledge that the processing of my personal information is necessary for the administration and execution of this Policy.

I agree that the acceptance of this application shall be on the basis of these statements.

Main Subscriber Signature	Full Name	Date
Adult Dependants Signature	Full Name	

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. Privacy Notice and Consent for Processing of Special Categories of Data

Universal Life Insurance Public Co Limited (hereinafter referred to as "we", "us" or "our" accordingly), is a licensed insurance company with registration number HE2895 and with registered office at 85 Digenis Akritas Avenue, 1070 Nicosia. Our privacy notice set out herein below, is provided in accordance with the provisions of the EU General Data Protection Regulation 2016/679 (hereinafter referred to as "GDPR"), and the Protection of Natural Persons with regard to the Processing of Personal Data and for the Free Movement of such Data Law (125(I)/2018) and any amendments from time to time (hereinafter jointly referred to as the "Law").

Our privacy notice applies to any natural person whose information is provided in this application form for the purpose of provision of insurance cover, and our reference to "you" or "your" includes a reference to the main subscriber and the minor and/or adult dependents for which cover is requested. Below is a brief overview of how your personal data is collected and processed. Further detailed information on the processing of your personal data can be found in our full privacy notice available on our website at *www.universallife.com.cy*.

8. Privacy Notice and Consent for Processing of Special Categories of Data *continued*

We can assure you that your personal information is of paramount importance to us, and we are committed to protecting your privacy.

Definitions

«personal data» or **«personal information»** means any information related to you whilst you are alive.

«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 is 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.

Categories of Personal Data

We process the following categories of personal data: standard personal data such as your contact details and identification data, and special categories of data, specifically data concerning your health.

How we Collect your Personal Data

We collect your personal data from you, and from certain third parties that you have authorized to provide us with information (e.g. you insurance intermediary, healthcare providers).

Legal Basis and Purpose of Processing

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

1. Performance of an insurance policy ("the policy") which includes, the issue and management of the policy, and the execution of requests from the policyholder.
2. Our compliance with a legal obligation, where the processing of your personal data is undertaken for the purposes of compliance with obligations that arise from the legal framework that we are governed by (e.g. compliance with sanctions regulations).
3. If processing is necessary to safeguard our legitimate interests or those of a third party where this does not compromise your rights (e.g. research and statistical analysis, measures to ensure the security of our systems and property or for the prevention of criminal or malicious acts or infringements).
4. If you have given your specific consent for such processing, e.g. for the processing of data concerning your health or for the purposes of promoting our products, policies or services.

Confidentiality and Processing Security

We assure you that we take all appropriate organizational and technical measures for personal data security and protection from accidental or unlawful destruction, accidental loss, alteration, unauthorized dissemination or access and any other form of unlawful processing.

Personal Data Retention

We process your personal data for as long as the Policy remains in force. Once the policy is terminated, we will retain your personal information for a further time period as set out in our full privacy notice available from our website *www.universallife.com.cy*

Recipients and Transmission of Personal Data Abroad

The recipients of your personal data are our authorized personnel and/or any party that has a contractual agreement with us and that maintains satisfactory levels of privacy protection and processing security. Recipients may also be doctors who have examined or will examine you for the purposes of this application, your insurance intermediary who has a contractual agreement with us, and the competent staff of any reinsurance company that has a contractual agreement with us. For adult dependents for whom the main subscriber has applied for cover, recipient to your personal information is also the main subscriber.

For the provision and administration of this policy, we cooperate and are supported by AXA Global Healthcare Group. Recipients of your personal data are also therefore competent staff of the AXA Global Healthcare Group, which is comprised of AXA Global Healthcare (UK) Limited and its subsidiaries globally (hereinafter referred to as "AXA Group"). Any data transmitted within the AXA Group is done so in accordance with GDPR requirements.

Any further transfer of your personal information outside the EU, is done so in accordance with the Law, and special safeguards are put into place to ensure that protection afforded by the Law, travels with this data.

Automated Decision-Making Process and Profiling

At present and for the purposes of performance of the policy, we do not use automated means for decision making or for profiling.

Your Rights

You have the right at any time, to request further information on the personal data that we maintain, and to request that we correct, erase or restrict the processing (in certain circumstances as set out by the Law) of your personal data. You may also object to the use of your personal information, request that we electronically transfer information you have made available to us (the right of portability), and/or withdraw your consent for the processing of your personal data. We note however that should you choose to withdraw consent for the processing of special categories of data, this will impact our ability to administer the Policy. To exercise any of these rights, or to lodge a complaint about the use of your personal data, please contact us in writing at the email address: *personaldata@unilife.com.cy*. You also have the right to submit a complaint about the use of your personal information by us to our Data Protection Officer at the above email address and to the Office of the Commissioner for Personal Data Protection.

Consent for the Processing of Special Categories of Data

I hereby declare that I have read the above Privacy Notice and understand and accept its contents.

With my signature below I hereby provide my express consent to the processing of data concerning my health (special categories of personal data) by the recipients outlined above, for the purposes of execution and administration of the Policy under which I will be provided insurance cover.

I acknowledge that should this consent be withdrawn, my insurance cover under this Policy may be terminated, and/or a claim/request made according to this Policy may be rejected.

Main Subscriber Signature	Full Name	Date
Adult Dependants Signature	Full Name	

Consent by Main Subscriber: Please tick if you consent to the processing of your personal data for the purposes of receiving information about our products, schemes or services by post, telephone, email and text.

☐ I agree and accept

☐ I do not agree

Signature	Date

For Universal Life Only

Underwriting

(Underwriting terms pertaining to this application)

Underwriter's signature