Irish Life health

Health Insurance Application Form

1 Health Scheme Details

Group Name/Employer (if applicable)

Intermediary Name (if applicable) Quote Number (if applicable)

2 Personal Details

Title First Names Surname

PPS Number Gender Date of birth D M Y

Address

Telephone Numbers Home Mobile Email

Date you wish to commence cover D M Y

You must include your PPS number and your dependants PPS numbers in the section below in order to avail of tax relief at source on your premiums

3 Previous Health Insurance Details

Please complete this section where applicable. This information is used to ensure continuity of cover and prompt claim settlement for you and your dependants

Previous Health Insurer Previous Level of Cover

Last Renewal Date D M Y Previous Policy Number

Have you, or any of your dependants had a break in health insurance cover of more than 13 weeks in the last 10 years?

If yes, please include details on a separate sheet of paper

Please note that if this is the first time you are buying health insurance, if you are increasing the level of your cover, or you have a pre-existing condition, certain exclusion periods may apply before you can make a claim.

4 Plan and Level of Cover Required

5 Dependants

1 First Name Surname Date of Birth D M Y

Relationship (e.g. Spouse/Child) Gender PPS Number

Tick if full time student between age 18 and 20 ☐ Last Renewal Date D M Y Previous Insurer

Previous Plan Previous Policy Number

2 First Name Surname Date of Birth D M Y

Relationship (e.g. Spouse/Child) Gender PPS Number

Tick if full time student between age 18 and 20 ☐ Last Renewal Date D M Y Previous Insurer

Previous Plan Previous Policy Number

3 First Name Surname Date of Birth D M Y

Relationship (e.g. Spouse/Child) Gender PPS Number

Tick if full time student between age 18 and 20 ☐ Last Renewal Date D M Y Previous Insurer

Previous Plan Previous Policy Number

4 First Name Surname Date of Birth D M Y

Relationship (e.g. Spouse/Child) ☐ Gender PPS Number

Tick if full time student between age 18 and 20 Last Renewal Date D M Y Previous Insurer

Previous Plan Previous Policy Number

Please turn over

Irish Life health

Health Insurance Application Form

6 Lifetime Community Rating

Lifetime Community Rating Legislation came into effect on May 1st 2015, affecting those who are 35 years of age or older. **If you are 35 years of age or older, you will need to answer the following questions.** The questions relate to health insurance cover that you held in Ireland only.

	Policyholder	Dependant 1	Dependant 2	Dependant 3	Dependant 4
Q1. Have you had continuous health insurance cover since April 30th 2015?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Q2. Were you insured during the period between 1st May 2009 and 30th April 2015 continuously?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Q3. How long have you held health insurance for?	☐ Yrs ☐ Mths	☐ Yrs ☐ Mths	☐ Yrs ☐ Mths	☐ Yrs ☐ Mths	☐ Yrs ☐ Mths
Q4. Were you resident in Ireland on May 1st 2015?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Q5. On what date did you become a resident in Ireland?					
Q6. From 1st January 2008 were you in receipt of social welfare or financially dependent on someone who was?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Q7. For how long were you dependent on a social welfare payment?	☐ Yrs ☐ Mths	☐ Yrs ☐ Mths	☐ Yrs ☐ Mths	☐ Yrs ☐ Mths	☐ Yrs ☐ Mths

7 Method of Payment (Please tick one box only)

Bank Cheque annually ☐ Credit Card annually ☐ Debit Card annually ☐ Direct Debit monthly ☐

To pay by credit card or laser card, please call 1890 717 717

Irish Life health

Health Insurance Application Form

8 SEPA Direct Debit Mandate SEPA (Single Euro Payment Area)

For Office Use only	
Unique Mandate Reference (UMR)	

To be completed by Irish Life Health

By signing this mandate form, you authorise (A) Irish Life Health to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instructions from Irish Life Health. As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited. Your rights regarding the below mandate are explained in a statement that you can obtain from your bank.

Please complete all the fields marked* and return the form to Irish Life, P.O. Box 764, Cork

* Your Name Name of the Debtor(s)	
* City/Postcode	
* Country	
* Account Number - BAN	

Creditor's Name	Irish Life Health
Creditor Identifier	303988
Creditor Address	Irish Life Centre, Lower Abbey Street
City/Postcode	Dublin 1
Country	Ireland

Type of Payment ☑ Recurrent Payment ☐ One-off payment Note: Irish Life Health does not offer this service

*Signature 1 ..... *Date .....

*Signature 2 ..... *Date .....

For Information only	
*Date that you would like money to be debited from your account	____ ____ You can choose any date between 1st and 28th of the month

9 For Office Use Only

Health Membership number

Please turn over

Irish Life health

Health Insurance Application Form

10 To be signed by the Customer

I agree to be bound by the terms of the policy including those set out in the relevant handbook**

**will be sent on registration, but may be obtained on request or may be viewed by logging onto www.irishlifehealth.ie

Irish Life Health dac is registered with the Office of the Data Protection Commissioner to act as a data controller and data processor in relation to the personal information held about you and any other member named on your policy.

The personal information that you have provided to us or that we otherwise obtain in connection with your policy will be used to administer your policy and other insurance products provided by us, other companies in the Irish Life Group or other commercial partners, in accordance with data protection and other applicable legislation and the Office of the Data Protection Commissioner-approved Code of Practice on Data Protection for the Insurance Sector. Please do not send us any genetic test results.

We will share this information with our third party administrators and any other commercial entity for the purposes above and as required to provide our services and in order to comply with legal obligations imposed on us. We may share and use this information both inside and outside of the European Economic Area, in confidence, for these purposes. We may in certain circumstances either directly or indirectly share your personal information with other insurers for the purposes of verifying information and determining waiting periods and with insurance bodies to the extent permitted by law. If you give us false information or fail to disclose information, we will record this.

To help improve the level of service we provide, we may on occasions contact you for participation in consumer satisfaction or research surveys. Your details may be used for these purposes for 12 months after your policy has ceased.

Important: In certain instances, we may need to collect personal information, including medical or other sensitive personal information, from third parties about you and any other member named on your policy. This information will remain strictly confidential and will only be sought and used in order to provide the services set out in your contract with us and for administration of this policy. By entering into a new policy with us, or renewing or amending an existing policy with us, you are also confirming that where relevant, each member of the policy has reviewed this notice and given their consent for the disclosure to us and the use of their personal information (including information collected from third parties) in the manner and for the purposes set out in this notice.

ONLY SIGN THE DECLARATION OVERLEAF IF YOU FULLY UNDERSTAND AND HAVE MET ALL OF THE ABOVE REQUIREMENTS.

Declaration

I confirm that all the details, answers and information given in this form are true, accurate and complete. I acknowledge that this registration will form the basis of my contract with Irish Life Health. I confirm that I am giving my permission to you to use the information I have given on this form for the purposes set out in the Data Protection section above.

Print name in block capitals: .....

Your signature: ..... Date: .....