

OPALE

With attractive benefits and a comprehensive level of cover, OPALE is a contract designed for expatriates living in France.

- Application for membership Amendment to existing policy

This product meets the demands and needs of those who wish to ensure that their health insurance needs are met now and in the future



For further information, please contact:

AMARIZ LIMITED

Freephone from France: 0800 900 258

Email: info@amariz.co.uk

www.amariz.co.uk

4 OPTIONS:

Please tick the option(s) of your choice:

- OPTION 1:** PRIVATE HEALTH INSURANCE COVER (100%) *
- OPTION 1A:** ECONOMY PRIVATE HEALTH INSURANCE COVER (CONSULTATIONS EXCLUDED)
- OPTION 2:** HOSPITALISATION COVER *
- OPTION 3:** TOP-UP COVER: **LEVEL 1** no medical questionnaire
 LEVEL 2 *

* Including personal accident cover for persons aged under 65 on membership.

THE MAIN MEMBER

Surname: First name:

Address:

Post code: Town:

Country: Tel: Work:

Email: Mob: Fax:

Occupation: (please attach proof if you are a student)

Marital status: Single Married Divorced Separated Widow(er) Other

For all options except Top-Up Level 1, please tick here if you are left-handed (for the 'Minerva' personal accident cover)

For Top-Up cover (Option 3) only:

French Social Security Number: Administrating 'Caisse':

Please attach a copy of the 'Attestation' you received with your 'Carte Vitale'

MEMBERSHIP OF ASSOCIATION SCHETLAND

The OPALE plan is a group insurance contract which has been subscribed by Association Schetland for its members. You must therefore become a member of the Association in order to benefit from health cover hereunder:

➤ I hereby agree to become a member of Association Schetland and confirm that I have read the rules of the Association enclosed with my application form.

I enclose a cheque in the sum of € 15.24 (or equivalent in Sterling) payable to **AMARIZ LIMITED** in respect of my annual membership fee to Schetland*

I would prefer the membership fee to Schetland to be collected by direct debit at the same time as my insurance premium*

*The annual membership fee will be transferred to Association Schetland by Amariz Limited

Date and signature

preceded by the text
'read and approved'

PREMIUMS

Monthly premium per person to be covered (age on membership)

	SURNAME / FIRST NAME	DATE OF BIRTH	SEX	MONTHLY PREMIUM
Main Member				
2 nd Person				
3 rd Person				
4 th Person				
5 th Person				
<i>No premiums are payable from the 3rd child onwards</i>				TOTAL MONTHLY PREMIUM (€)

DATE OF INCEPTION / SIGNATURE

Date of inception required : / / or **IMMEDIATE** (the date of receipt of your completed application form at the earliest)

Waiting period : **YES** **NO** If you reply NO, you confirm that all the persons to be covered had equivalent health cover up to three months or less before the date of membership to the OPALE plan (a detailed certificate of cancellation or a similar supporting document, and details of the previous cover should be provided). **If no evidence of previous medical cover is attached to this application form, the waiting period will be applied** (see Article 3 of the summary of the general conditions).

Cover commences at the date requested by the Member and on the date his/her application form is received at the earliest, subject to medical acceptance (Options 1, 1A & 2 and Option 3 Level 2). In the event of an application form being submitted to the Insurer for acceptance due to the medical declarations made for one or more the persons thereon, accident cover only is granted for two months from the date of inception while the application form is being considered by the Insurer. The Insurer reserves the right to decline any application.

Any information provided to Amariz Limited will be dealt with in accordance with the requirements of the Data Protection Act 1998. Our Data Protection Statement is published on our website. The information collected on this application form will be used by the Insurer for underwriting purposes and by Amariz Limited to set up and administer your insurance cover. In the event that further medical investigation is considered necessary in order to process your application, personal and medical information you have provided may be given to the Insurer's Consulting Doctor and you shall receive written confirmation of this, including details of who the information has been sent to.

My membership is based on the information which I have provided. Any non-disclosure or inaccurate declaration on my part can lead to the cancellation of my membership or the non-payment of a claim. I should therefore ensure that I have disclosed all material facts on this application form, ie. any facts that an Insurer would regard as likely to influence the assessment and acceptance of my proposal. If I am in any doubt about whether certain facts are material, I should disclose them. Until commencement of the, policy I must advise the Insurer of any changes to my personal health. I confirm that I have familiarised myself with the conditions and exclusions indicated in the general conditions and that I have read the policy summary. I confirm that I give my explicit consent for my personal data to be processed in order to set up and administer my cover.

Date and signature
preceded by the text
'read and approved'

PERSONS TO BE COVERED

SURNAME					
FIRST NAME					
Sex	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>	M <input type="checkbox"/> F <input type="checkbox"/>

MEDICAL QUESTIONNAIRE – ALL QUESTIONS TO BE ANSWERED FULLY (OPTIONS 1, 1A & 2 / OPTION 3 LEVEL 2)

Sensitive medical information will need to be processed in order to provide cover. Please obtain the consent of any other people named before disclosing this. If you consider that information relating to your state of health should remain confidential, please send it in a sealed envelope for the attention of the Consulting Doctor.

1.	Height Weight	.....M.....Kg	.....M.....Kg	.....M.....Kg	.....M.....Kg	.....M.....Kg
2.	<u>Blood pressure</u> Systolic / Diastolic	..... / ..... mmHg	..... / ..... mmHg	..... / ..... mmHg	..... / ..... mmHg	..... / ..... mmHg
3.	Have you ever been hospitalised or had surgery? If so, please provide date and reason for hospitalisation	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
4.	Do you need to be hospitalised or have surgery? If so, please provide date and reason for hospitalisation	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
5.	Have you received or are you currently receiving regular medical treatment? If so, please provide details	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
6.	Do you suffer from a chronic or long-term illness? If so, please provide details	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
7.	Do you have any aftereffects from an accident, illness or disability? If so, please provide details	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
8.	Have you been or are you currently unable to work for medical reasons? If so, please provide details	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
9.	Do you have any dentures or orthodontic work planned within the next 12 months? If so, please attach a quote. (Options 1, 1A & 3 only)	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

WARNING: You are advised to complete this proposal form yourself. Where this is not possible, you are advised not to sign the proposal form until you have read and agreed that the answers given to the questions are accurate and complete. You should also state who completed the form on your behalf:

LANGUAGE

I wish to receive my Membership Certificate and the Summary of the General Conditions:

in French in English

Signed in

on the

SIGNATURE preceded by the text '**read and approved**'

METHOD OF PAYMENT

Premiums are payable in advance:

- monthly, quarterly, six-monthly or annually (5% discount for annual payment)
 by direct debit on the 8th of the month (**please complete the direct debit mandate below**) or
 by cheque or bank transfer

DIRECT DEBIT MANDATE

Nom du Créancier : AMARIZ LTD

N° National d'Emetteur : 476535

J'autorise l'Etablissement teneur de mon compte à prélever sur ce dernier, si la situation le permet, tous les prélèvements ordonnés par le créancier désigné ci-dessus. En cas de litige sur un prélèvement, je pourrai en faire suspendre l'exécution par simple demande à l'Etablissement teneur de mon compte. Je réglerai le différend directement avec le créancier.

Titulaire du Compte

Etablissement Bancaire

Nom / Prénom

Nom de la Banque

Adresse

Adresse de la Banque

Code Postal Ville

Code Postal Ville

Date / /

Le compte à débiter (Joindre un RIB ou RIP)

Signature

Code Banque Code Guichet Numéro de compte Clé

I authorise Amariz Ltd to collect my annual membership fee to Association Schetland by direct debit.

I would like my claims payments to be made by bank transfer into this account.

NOTES: Direct debits are carried out on the 8th day of the month. In the event of an unpaid direct debit, costs (bank charges and related charges) will be payable by the Member. If your bank account details change, you must inform us at least 15 days before the date of the next direct debit. The cost of paying by direct debit is borne by the Administrator.

THE DIFFERENT PARTIES / GOVERNING LAW

This group insurance contract has been concluded between Association Schetland for its members and certain underwriters at Lloyd's of London.

Amariz Limited, Imperial House, 1 Harley Place, Bristol, BS8 3JT, UK has been appointed as Administrator. The latter shall have the authority to review and process proposals of insurance, prepare and issue certificates of insurance and settle claims approved by the Insurer. All communications, enquiries and claims shall be addressed to the Administrator.

It is possible to choose the Law applicable to a contract of insurance covering a risk situated within the European Economic Area or Switzerland. The Insurer has chosen English Law to apply. Payment of a premium by a Member is evidence of acceptance of the Insurer's choice. If any other law is to apply, it must be agreed by both parties and evidenced in writing.

The 'Minerva' personal accident contract is subject to the laws of the French Republic.

It is moreover advised that the Subscribers of Lloyd's of London are regulated by the Financial Services Authority, 25 The North Colonnade, Canary Wharf, London E14 5HS, UK.

WHERE TO SEND YOUR APPLICATION FORM

Please send your completed application form to the following address:

Amariz Limited
Imperial House
1 Harley Place
BRISTOL BS8 3JT
UNITED KINGDOM

Freephone from France: 0800 900 258

Email: info@amariz.co.uk

Fax: +44 (0)117 974 5780

Before posting your application, please check that you have:

SIGNED:

- The box for Association Schetland
 The box in the Date of Inception/Signature section
 The Medical Questionnaire (completed in its entirety)
 The Direct Debit Mandate

ATTACHED:

- A cheque for € 15.24 payable to AMARIZ LTD (if applicable)
 A copy of your 'Attestation Carte Vitale' (Option 3)
 Evidence of your previous equivalent health cover
 Your Relevé d'Identité Bancaire (for payment by Direct Debit)