AMARIZ SANTE

Attractive health insurance benefits and a comprehensive level of medical cover for people living in France

ARTEX INSURANCE BROKERS (EUROPE) PCC LIMITED – AMARIZ CELL
THE LANDMARK LEVEL 1, SUITE 2,
TRIQ L-ILJUN, QORMI, QRM 3800, MALTA

Email: info@amariz.eu
www.amariz.fr/en

FOUR HEALTH INSURANCE SOLUTIONS:

Please tick your chosen level(s) of coverage

❒ **GOLD HEALTH INSURANCE**
Reimbursement of your medical expenses further to accident, illness, chronic illness or maternity

❒ **SILVER HEALTH INSURANCE**
Reimbursement of your medical expenses (consultations and visits excluded)

❒ **HOSPITALISATION INSURANCE**
Reimbursement of your medical expenses linked to a hospitalisation of at least one night

❒ **TOP-UP INSURANCE**
Reimbursement of your medical expenses as a top-up to your basic health insurance scheme
- ❒ **CLASSIC** No medical questionnaire
- ❒ **COMFORT**
- ❒ **LUXURY**

Please attach proof of your basic medical insurance scheme (copy *Carte Vitale/ attestation*)

❒ **EXCLUSION FOR OCCUPATIONAL AND NON-OCCUPATIONAL ACCIDENTS:**
I already have mandatory insurance for medical expenses caused by accidents (please attach proof such as a payslip or a letter from your employer)

Where did you hear about our company? ❒ Google Adwords ❒ Google search ❒ Other internet search ❒ Friend/colleague ❒ Client
❒ Other (please stipulate).....
❒ Referral by existing Policyholder (please indicate their name).....

THE PROPOSER

Title : …… Surname: …….. First name: ……

Address: ……

Post code: …….. Town: ……

Country: …….. Tel: …… Work: ……...

Email: …….. Mob: …….. Fax: ……...

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

For GOLD, HOSPITALISATION and LUXURY TOP-UP cover, please tick here if you are left-handed ❒ (for the personal accident cover)

DATE OF INCEPTION / WAITING PERIOD

DATE OF INCEPTION REQUIRED: …… / …… / …… or ❒ **IMMEDIATE** (the date of receipt of your completed application form by the **Broker**)

WAITING PERIOD:

❒ **YES** I have been without medical cover during the three months prior to joining the AMARIZ SANTE plan and will therefore have a waiting period (see Article 2 of the Policy).

❒ **NO** I have had equivalent medical cover during the last three months and am enclosing proof of this (photocopy of *Carte Vitale* or *Attestation Carte Vitale* or letter of cancellation from previous medical insurer).

If no evidence of previous medical cover is attached to this application form, the waiting period will be applied.

Cover commences at the date requested by the **Policyholder** and on the date his/her application form is received by the **Broker** if it is later, subject to medical acceptance (GOLD, SILVER, HOSPITALISATION and COMFORT & LUXURY TOP-UP insurance). In the event of further medical investigation being necessary for one or more of the persons listed on the application form, such medical evidence must be forwarded to the **Insurer** for acceptance. Until the **Insurer's** decision to cover the applicable person has been received by the **Policyholder**, **Accident** cover only shall be provided for a maximum of two (2) months from the date requested by the **Policyholder** or from the date of receipt of their application form by the **Broker**, if that is later, in respect of such person. The **Insurer** reserves the right to ask for any proof of state of health or medical examination.

You must take care in answering all the following questions which are relevant to the **Insurer** in providing this insurance and setting the terms and premium. Please contact the **Administrator** if you do not understand the question or the nature of the information required. Failure to provide information or the provision of incomplete or inaccurate information may result in loss of cover or other remedies.

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
- ❒ by bank transfer or
- ❒ by debit or credit card

SEPA DIRECT DEBIT MANDATE

Creditor: **AMARIZ LIMITED** Identifier of the Creditor: **FR02ZZZ476535**

By signing this mandate form, you authorise (A) the Creditor to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instructions from the Creditor. As parts 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 are explained in a statement that you can obtain from your bank.

Account Holder's Name and Address

Name…….....

Address …….....

Post Code ……Town.....

Date and signature

ACCOUNT NUMBER TO BE DEBITED

IBAN | | | | | | | |

BIC | | | | | | | | | | | |

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

❒ **I would like my claims payments to be paid into a different account (please attach R.I.B.)**

PERSONS TO BE COVERED

SURNAME				
FIRST NAME				
DATE OF BIRTH				
SEX	M ❒ F ❒	M ❒ F ❒	M ❒ F ❒	M ❒ F ❒

MEDICAL QUESTIONNAIRE – ALL QUESTIONS TO BE ANSWERED FULLY
(GOLD, SILVER, HOSPITALISATION & COMFORT AND LUXURY TOP-UP INSURANCE)

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 or that of any other person to be covered should remain confidential, please send it in a sealed envelope for the attention of the Consulting Doctor. **Please use a separate piece of paper if there is insufficient room for your reply.**

1	Height Weight	……M ……Kg	……M ……Kg	……M ……Kg	……M ……Kg
2	**Blood pressure (COMPULSORY)** **Systolic / Diastolic**	…… / …… mmHg	…… / …… mmHg	…… / …… mmHg	…… / …… mmHg
3	Do you smoke?	YES ❒ NO ❒	YES ❒ NO ❒	YES ❒ NO ❒	YES ❒ NO ❒
4	Do you suffer from any allergies? If so, please provide details	YES ❒ NO ❒ ……	YES ❒ NO ❒ ……	YES ❒ NO ❒ ……	YES ❒ NO ❒ ……
5	Have you had any medical consultation/investigations/treatment in the last 6 months or is any planned? If so, please provide full details?	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……
6	Have you ever been or are you currently signed off work by a doctor for medical reasons? If so, please provide details	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……
7	Have you ever been hospitalised or had surgery? If so, please provide date and reason for hospitalisation	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……
8	Do you need to be hospitalised or have surgery? If so, please provide date and reason for hospitalisation	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……
9	Have you received or are you currently receiving medical treatment (medication, physiotherapy, psychotherapy, equipment)? If so, please provide details	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……
10	Do you suffer from a chronic or long-term illness? If so, please provide details	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……
11	Do you have any aftereffects from an accident, illness or disability? If so, please provide details	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……	YES ❒ NO ❒ …… ……
12	Do you have any dentures, dental implants or orthodontic work planned within the next 12months? **(Gold, Silver, Comfort & Luxury)**	YES ❒ NO ❒ …… If yes, please attach a quote.	YES ❒ NO ❒ …… If yes, please attach a quote.	YES ❒ NO ❒ …… If yes, please attach a quote.	YES ❒ NO ❒ …… If yes, please attach a quote..
13	Are you pregnant?	YES ❒ NO ❒	YES ❒ NO ❒	YES ❒ NO ❒	YES ❒ NO ❒

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: ……

Signed in …… on the ……

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

SIGNATURE

I declare on behalf of all persons to be covered that the information on this application is to the best of my/our knowledge and belief both accurate and complete. I have taken care not to make any misrepresentation in the disclosure of this information and understand that all information provided is relevant to the acceptance and assessment of this insurance, the terms on which it is accepted and the premium charged.

I on behalf of all persons to be covered will tell the **Broker** on behalf of the **Insurer** if any of the information on this application form changes during the period of insurance and I understand that if any of the information is not true, or becomes untrue, the persons covered may not have insurance cover or other remedies under the health insurance policy to which this application form relates.

By completing this application, I am applying on behalf of all persons to be covered on this insurance and am doing so with their full consent. I also agree to receive all plan-related documentation on behalf of all persons to be covered.

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

GDPR CONSENT

YOUR PERSONAL INFORMATION: We need your consent to use the sensitive details about you in this application form in connection with your insurance cover. You do not have to give your consent and you may withdraw your consent at any time. However, if you do not give your consent, or you withdraw your consent, this may affect our ability to provide you with insurance cover or to handle your claims.

❒ **I consent to the use of data and information about my health in connection with my insurance cover**

OTHER PEOPLE'S DETAILS YOU PROVIDE TO US: Where you provide us with details about other people to be insured, we also need their consent to use the sensitive details about in this application form them in connection with your insurance cover. You should obtain their consent before providing these details to us.

❒ **I have obtained the consent of each other person listed in this application form to the use of data and information about their health in connection with my insurance cover**

CONSENT FOR CLAIMS

YOUR PERSONAL INFORMATION: We need your consent to use sensitive details about you relating to your health in connection with claims. You do not have to give your consent and you may withdraw your consent at any time. However, if you do not give your consent, or you withdraw your consent, this may prevent us from handling or otherwise affect our ability to handle your claims.

❒ **I consent to the use of data and information about my health in connection with my claims under this policy**

OTHER PEOPLE'S DETAILS YOU PROVIDE TO US: Where you provide us with details about other people on your policy, we also need their consent to use their sensitive details relating to their health in connection with claims. You should obtain their consent before providing these details to us.

❒ **I have obtained the consent of each other person listed on this application form to the use of data and information about their health in connection with claims under this policy**

MARKETING PREFERENCES

We take your privacy seriously and will only use your personal information to administer your policy and to provide the products and services your have requested from us.

However, from time to time we would like to contact you **by email** with details of other products and services we provide. If you consent to us contacting you for this purpose **please tick to confirm** ❒

We will not share your email address with any third parties and you can withdraw your consent at any time.

WHERE TO SEND YOUR APPLICATION FORM

Please send your completed application form to the following address:

ARTEX INSURANCE BROKERS (EUROPE) PCC LIMITED - AMARIZ CELL, THE LANDMARK LEVEL 1 SUITE 2, TRIQ L-ILJUN, QORMI, QRM 3800, MALTA
info@amariz.eu

Before sending your application, please check that you have:

SIGNED:

❒ The box in the Signature section above

❒ The Direct Debit Mandate

❒ The Medical Questionnaire (completed in its entirety)

ATTACHED:

❒ Evidence of your previous equivalent health cover

❒ Your Relevé d'Identité Bancaire (for direct debits/claims)

❒ Proof of your accident cover (if applicable)

❒ Proof of your basic health insurance scheme (if applicable)

PLEASE ENSURE THAT YOU HAVE ALSO PROVIDED THE BLOOD PRESSURE OF ALL PERSONS TO BE INSURED

AMARIZ
PRIVACY NOTICE

Introduction
This privacy notice explains how Amariz Limited deals with the personal information we need to collect and use in order to provide our services. In doing this we act as a Data Controller. Our contact details are: Amariz Limited, Imperial House, 1 Harley Place, Bristol, BS8 3JT, UK. Telephone: 0117 974 5770. Email: info@amariz.co.uk.

We consider the lawful and correct treatment of personal information as being very important to our relationship with our customers. Any information provided to Amariz Limited will be dealt with in accordance with the requirements of the General Data Protection Regulation (GDPR). We respect an individual's right to privacy and handle all information with appropriate confidentiality.

What personal information do we hold?
We may receive the following personal information about you when you contact Amariz Limited, for example by doing any of the following:

Requesting a quote:
Name, address, telephone number, email address, date of birth or age.
Purchasing a policy:
Name, address, telephone number, email address, occupation, date of birth, sex, height and weight, blood pressure, tobacco use, medical history, bank details.
Making a claim:
Name, address, date and type of treatment, medical condition and date of first diagnosis, bank details.
Making a complaint:
Name, address, email address.

As well as basic personal information such as your name and contact details, we may process s*ensitive personal information* such as information relating to your health. We will always be clear to explain when and why we need this information and the purposes for which we will use it and will obtain your explicit consent to use sensitive personal information. For example, in order to process an application for insurance, we will need details of your medical history to determine your conditions of acceptance and, in the event of a claim, we will ask you for the nature of the illness and the date of first diagnosis in order to assess whether your treatment is covered by your policy. If you provide sensitive personal information about another person (for example a family member), we will ask you to confirm on their behalf that they have provided their consent to the processing of their information.

In order to provide insurance cover and deal with insurance claims, we therefore need to process sensitive personal information. You do not have to give your consent and you may withdraw your consent at any time. However, if you do not give your consent, or you withdraw your consent, this may impact on our ability to provide insurance or pay claims.

What do we do with the information we gather?
We will use and share certain personal data for *the performance of the contract or to take steps prior to entering into the contract of insurance*.

The following processing activities are used for this legal purpose:
- providing quotations,
- underwriting and providing terms for policies,
- administrating policies including premium payments,
- handling claims including requests for reimbursement of medical expenses, direct settlement of medical expenses to third parties, requests for direct settlement of hospitalisation expenses and requests for prior authorisation for medical treatment,
- handling third party claims,
- the prevention of fraud,
- handling complaints.

Who will your personal information be shared with?
Your *personal information* may be shared with the following parties:
- Your insurance broker or intermediary (if any),
- Medical professionals, for example in the event of a request for direct settlement of your hospitalisation expenses or the payment of a bill from a pharmacy.

Your *sensitive personal information* may be shared with the following parties:
- The Insurer's consulting doctor if we need more information on a particular medical condition in order to process your application for insurance or pay a claim,
- A broker situated outside the European Economic Area (EEA) for the purposes of negotiating the conditions of acceptance of your insurance cover or the payment of a claim with the insurer.

Where your personal data is transferred outside the EEA, such transfers are safeguarded by strict contractual obligations with third parties to ensure that your personal information remains protected in accordance with the GDPR.

We are committed to ensuring that your personal information is treated in accordance with this privacy notice wherever it may be sent.

Where is your personal information kept?

Your personal information will be kept electronically and on paper in our office in Bristol. Paper archives are also stored off-site with a reputable document storage company.

How long will we keep your data for?

We will keep your personal data only for as long as it is required for the administration of your insurance policy and to handle claims. We will retain your personal information for a period of 10 years if you cancel your policy to assist us in assessing future applications for insurance that you may wish to make and to enable us to respond to a question or a complaint. We may also keep your data for longer than 10 years if we cannot delete it for legal, regulatory or technical reasons. If you contact us for a quote and do not take out a policy, your personal information shall be kept for a period of 2 years.

Security of your personal information
We are committed to ensuring that your personal information is secure. In order to prevent unauthorised access or disclosure we have put in place physical, electronic and managerial procedures to safeguard and secure the personal information we collect from you.

Personal information and our website
You are welcome to browse our website without providing us with personal information and we do not use 'cookies' to collect user information from the site.

You may choose to provide us with limited personal information (for example your name, postal address, telephone number and email address) in order to obtain further information on the services outlined in our website. We will only use the personal information you provide for the purposes of supplying the specific services you have requested. We will not disclose personal information provided via our website to any other third parties and personal information will not be used for direct marketing by Amariz Limited without your consent.

Please note that email is not a secure means of communication and we would recommend that you do not send sensitive personal information to us by this means.

Personal information that you supply voluntarily in emails may subsequently be used to administer your insurance cover, process claims and improve the service we provide.

Keeping your personal information accurate and up-to-date
To help us ensure that your personal information remains accurate and up-to-date, please inform us of any changes to the contact details you have provided.

Your rights in relation to your personal information:
You have the following rights:

- **Right to be informed** about what data we have collected about you,
- **Right of access:** to request a copy of your personal data free of charge,
- **Right to rectification:** have incorrect or incomplete personal data about you corrected,
- **Right to erasure:** to have your personal data erased in certain circumstances (the right to be forgotten),
- **Right to restriction of processing** of your personal data,
- **Right to withdraw consent** for the processing of your personal data,
- **Right to object** to the processing of your personal data,
- **Right to data portability**, i.e. to be able to transfer your personal data to another service provider,
- **Right to not be subject to automated decision-making** including profiling,
- **Right to remedy:** to be compensated for any unauthorised collection or use of data.

Please note that withdrawing consent and requests for restriction/erasure may affect our ability to provide you with a contract of insurance or pay a claim. Some of the above rights are subject to limitations in order for us to comply with a number of legal and regulatory obligations.

Marketing
From time to time, we would like to send you information on our products and services that may be of interest to you by email, but we will only do this where you have provided your consent. If you have agreed to receive marketing information by email, you may opt out at any time by contacting us by email or post. We will never share your email address with any third parties.

Contacting us regarding your personal information
If you have a query about the way we protect personal information or to exercise any of the above rights, please contact:

The Data Protection Officer
Amariz Limited
Imperial House
1 Harley Place
Bristol
BS8 3JT
Email: info@amariz.co.uk.

If you wish to make a complaint on how we have handled your personal data, you can contact our Data Protection Officer who will investigate the matter: email info@amariz.co.uk or write to The Data Protection Officer, Amariz Limited, Imperial House, 1 Harley Place, Bristol, BS8 3JT.

If you are not satisfied with our response or believe that we are not processing your personal data in accordance with the law, you can complain to the Information Commissioner's Office (ICO):

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
Tel: +44 (0)303 123 1113 +44 (0)1625 545 745
Email: casework@ico.org.uk

Registration information

Amariz Limited is registered with the Information Commissioner's Office as a Data Controller (Registration number Z6967521).

Changes to our privacy policy

We keep our privacy notice under regular review and will put the most recent version on our website.