

Health Insurance PROPOSAL FORM



YOUR WORLD | OUR COVER

Return this proposal form duly signed to Citadel Insurance p.l.c. If the proposal form is received more than 3 weeks after completion we may ask you to complete a new proposal form. If you are joining a group scheme please forward this proposal form to your group administrator. We recommend that you retain copies of all information/documentation that you submit to us for your records.

For any queries contact us on tel: (+356) 2557 9000 / freephone 8007 2322 / e-mail: health@citadelplc.com

Kindly tick this box if you would like to receive policy documentation by e-mail, to contribute towards our environment.

1. Subscriber Details

Title:	Name:	Surname:
Date of Birth: DD/MM/YYYY	Gender: M/F	Occupation:
ID / Passport No:	Date / Country of Issue:	
Address (This is used for all correspondence - please keep us informed of any changes to your contact details):		
Telephone:	Mobile:	Email:
Company name (if joining a group policy):		

Details of GP / Family Doctor (s)

Name and clinic address:	How many years have you known this GP?
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2. Dependants to be Covered

	Title	Name	Surname	Gender	DOB	ID/ Passport No	Occupation	Relation to Subscriber
2.				M/F	DD/MM/YYYY			
3.				M/F	DD/MM/YYYY			
4.				M/F	DD/MM/YYYY			
5.				M/F	DD/MM/YYYY			

3. Residency Details

Nationality	Subscriber (1)	Dependant (2)	Dependant (3)	Dependant (4)	Dependant (5)
Principal country of residence. (The country where you live for at least 245 days in a year)	Subscriber (1)	Dependant (2)	Dependant (3)	Dependant (4)	Dependant (5)
Do you reside / intend to reside away from Malta in any policy period? If yes give details.	Subscriber (1)	Dependant (2)	Dependant (3)	Dependant (4)	Dependant (5)

4. Cover Details

Step 1: Plan Type	Core Plan <input type="checkbox"/>	Comfort Plan <input type="checkbox"/>	Comfort IDM Plan <input type="checkbox"/>	Comfort IDM + Rep. <input type="checkbox"/>	Complete Plan <input type="checkbox"/>
Step 2: Level of Cover	1 (in-patient & day-patient cover only): <input type="checkbox"/>	2 (in-patient, day-patient & out-patient cover): <input type="checkbox"/>	3 (in-patient, day-patient, out-patient cover & routine health checks): <input type="checkbox"/>	4 (in-patient, day-patient, out-patient & routine health checks, dental crowns & implants cover): <input type="checkbox"/>	
Or: Child Plan (not applicable for groups; not applicable with any plan options above) <input type="checkbox"/>					

5. Policy Start Date (leave blank if joining a group policy)

Please indicate the date you require cover from (this cannot be more than 21 days from the date on this proposal form, and cannot be in the past).	DD/MM/YYYY
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6. Medical Declaration

- Please ensure that all questions are answered fully and accurately in respect of each applicant, even if you have been insured previously with us or any other insurer. If the answer to any of the questions is YES, please give full details for each separate question and for each applicant in the space provided.
- All applicants must fully disclose any known or suspected medical conditions and symptoms, even if professional advice has not yet been sought and/or a remedy is being taken which has not been prescribed by a medical practitioner. Failure to notify us of a medical condition or to disclose material facts may result in your policy being invalidated and future claims being rejected. If in doubt you must disclose the medical condition. You must notify us immediately in writing of any illness or injury which arises before the date of issue of your member certificate, or any other information which affects or changes the information given on this proposal form.
- No liability will be accepted for any medical condition which originated or was foreseeable prior to the proposal date unless such medical condition has been declared to and accepted by us.

The numbers correspond to the member details on previous page (1 being the subscriber)

Have you, or anyone to be covered by this policy, experienced symptoms of, received any treatment, had consultations or been admitted to hospital for any of the following:

	1	2	3	4	5
1 Heart or circulatory disorders e.g. high blood pressure, high cholesterol, angina/chest pains, heart attack, heart failure, abnormal heart beat, aneurysms, septal heart defect, varicose veins, anaemia, auto-immune disorders	Y/N	Y/N	Y/N	Y/N	Y/N
2 Endocrine (glandular) disorders e.g. diabetes, thyroid, adrenal, pituitary problems	Y/N	Y/N	Y/N	Y/N	Y/N
3 Breathing or respiratory disorders e.g. shortness of breath, chest infections, bronchitis, asthma, allergies (including anaphylaxis and hay fever), pneumonia, tuberculosis	Y/N	Y/N	Y/N	Y/N	Y/N
4 Digestive, liver or gall bladder disorders e.g. stomach inflammation / ulcers, irritable bowel, change in bowel habits, abdominal pain, haemorrhoids, rectal bleeding, liver inflammation, cirrhosis, gall stones, hernia	Y/N	Y/N	Y/N	Y/N	Y/N
5 Cancers, tumours or growths e.g. polyps, benign growths / lumps, cysts or moles, cancer of any type	Y/N	Y/N	Y/N	Y/N	Y/N
6 Skin disorders e.g. eczema, acne, warts, dermatitis, rashes, psoriasis, allergic conditions, solar keratosis	Y/N	Y/N	Y/N	Y/N	Y/N
7 Brain or nervous system disorders e.g. stroke, dementia, repeated headaches, multiple sclerosis, epilepsy / fits, nerve pain (including sciatica and shingles), meningitis	Y/N	Y/N	Y/N	Y/N	Y/N
8 Muscle or skeletal disorders e.g. arthritis, back pain, neck / shoulder problems, cartilage and ligament problems, joint replacements, fractures, osteoporosis, gout	Y/N	Y/N	Y/N	Y/N	Y/N
9 Urinary disorders e.g. kidney or bladder problems, urinary tract infections, incontinence, renal calculi	Y/N	Y/N	Y/N	Y/N	Y/N
10 Reproductive system disorders e.g. pregnancy / childbirth problems (including birth by Caesarean section), irregular periods, fibroids, endometriosis, infertility, abnormal smears, testicular or prostate disorders	Y/N	Y/N	Y/N	Y/N	Y/N
11 Eye, ear, nose, throat or dental disorders e.g. cataracts, glaucoma, deafness, eye / ear infections, tonsillitis, wisdom teeth trouble	Y/N	Y/N	Y/N	Y/N	Y/N
12 Mental disorders / Addictive conditions e.g. depression, stress, anxiety, schizophrenia, compulsive or eating disorders, alcohol / drug dependency	Y/N	Y/N	Y/N	Y/N	Y/N

Are you, or anyone to be covered by this policy:

13 Receiving any other treatment not mentioned above, or are likely or expected to have any review, investigations or treatment for any current or past medical problem, or taking any medication?	Y/N	Y/N	Y/N	Y/N	Y/N
14 Experiencing any signs or symptoms of any medical problem not mentioned above, regardless of whether a medical advisor has been consulted?	Y/N	Y/N	Y/N	Y/N	Y/N
15 Pregnant at the time of completing this proposal form? If Yes, please give expected date of delivery: DD/MM/YYYY	Y/N	Y/N	Y/N	Y/N	Y/N
16 Smoking (currently or within last 12 months) If Yes, how many per day:	Y/N	Y/N	Y/N	Y/N	Y/N
17 Height in centimetres: _____ Weight in kilograms: _____					

Have you, or anyone to be covered by this policy:

18 Been insured previously under any other private health insurance policy, or have current health insurance cover? If Yes, please specify name of insurance company, plan type, dates of insurance cover and attach a copy of the relevant insurance certificate(s) detailing terms of cover	Y/N	Y/N	Y/N	Y/N	Y/N
19 Ever been refused health, life or accident & sickness insurance cover? If Yes, please specify name of insurance company and reason for cover refusal	Y/N	Y/N	Y/N	Y/N	Y/N
20 Ever had any special terms, conditions or premium loadings imposed? If Yes, please specify name of insurance company and details of special arrangements	Y/N	Y/N	Y/N	Y/N	Y/N
21 Please indicate when the dental implants and crowns were completed and confirm whether treatment was carried out in Malta or abroad. Date: DD/MM/YYYY	Treatment carried out in Malta? Yes <input type="checkbox"/> No <input type="checkbox"/>				

Name	Qs No	Please provide the date of first diagnosis/consultation, name of treating physician, frequency and severity of symptoms, date of last episode as well as details of any past, ongoing, or planned treatment. Copies of any relevant medical records (such as test results and hospital discharge letters) must be included.

7. Method of Payment

- Cheques must be made payable to Citadel Insurance p.l.c. with the subscriber's name and quote number on the back of the cheque.
- Citadel Insurance p.l.c. does not accept liability for any payment which does not clearly identify the policy details.

Cash Cheque Internet Banking Other _____

8. Data Protection Notice

The controller of your data is Citadel Insurance p.l.c. and its subsidiaries ("the Company").

Should you have any queries, you may contact us by:

- Telephone: (+356) 2557 9000
- E-mail: dpadmin@citadelplc.com
- Post: Casa Borgo, 26, Market Street, Floriana FRN 1082

If you wish to address the Company's Data Protection Officer directly, you may do so by:

- Telephone: (+356) 2759 5000
- E-mail: dpo@citadelplc.com
- Post: DPO, 170 Pater House, Psaila Street, B'Kara BKR 9077

PURPOSES AND LEGAL BASES FOR PROCESSING

The personal data provided about you on this proposal form or subsequently, whether in writing or orally, is necessary to perform the contract of insurance and/or to take steps at your request prior to entering into the contract. The Company may process such data to assess risk, underwrite and issue present and future contracts of insurance, collect premiums, assess and respond to your queries, and transfer data to and receive data from other insurance and reinsurance companies to underwrite your contract of insurance. The Company may process your data to carry out due diligence, where necessary, and to prevent, detect, suppress and/or report insurance fraud or any other criminal activity, as required by law. The Company may also process your data to establish, exercise and/or defend itself in legal action, to carry out research and compile statistics, perform actuarial science, and to protect its data systems, thus protecting its legitimate interests.

RECIPIENTS OF THE DATA

Your personal data will be received by the Company, or an intermediary on the Company's behalf, and it may be disclosed or shared, only as is strictly necessary in accordance with the purposes outlined above, with the Company's employees, subsidiaries, associates, intermediaries, joint controllers, the Company's external actuaries, consultants, legal advisors, auditors, risk assessors, loss adjusters and surveyors, repairers, healthcare and other medical institutions and professionals, banks, credit referencing agencies, risk intelligence agencies, vehicle history and valuation databases, the Malta Insurance Association and other insurance and reinsurance companies, other professionals, and public, legal and/or judicial authorities. The Company may also disclose your data to third parties if it is called upon to do so by a competent authority, or by a Court or tribunal, only to the extent required and allowed by law. The transfers of personal data to third parties located outside the EEA and countries of equivalent level of data protection on a regular basis will only be carried out under appropriate safeguards or in emergency cases using a derogation as specified in the GDPR.

DATA RECEIVED FROM OTHER SOURCES

The Company may receive personal data about you, such as identifying information, information regarding your insurance history, financial details, and medical information, from third party sources, such as the recipients listed above or from others, such as the ETARS traffic accident database and public government websites. The data is collected for the purposes outlined above. The Company may also record telephone conversations for training, security and quality control purposes. CCTV cameras are in use throughout the Company's premises.

RETENTION PERIOD

The Company makes every effort to store personal data only for as long as it is necessary for the purposes outlined above. If the Company does not provide you a quote on your proposal, or provides you a quote which you do not accept, the Company will store the data provided by you for five (5) years. If a policy is issued, further information on retention periods will be provided in your policy document.

YOU HAVE THE RIGHT TO:

- Acquire access to your data, including confirmation from the controller as to whether data about you is being processed and to receive further information about that processing;
- Amend inaccurate personal data;
- Request the erasure of data processed about you, on the basis of certain grounds, such as where the data is no longer necessary for the purposes for which it was collected, and is no longer necessary for regulatory compliance or where consent for processing that requires consent has been withdrawn, among other grounds;
- Request the data controller to restrict its processing activities on your data, on the basis of certain grounds, such as where the accuracy of the data is contested;
- Receive the personal data provided by you in a structured, commonly used and machine-readable format or to request that such data be transferred in such format to another data controller;
- Withdraw your consent to processing that is based on your consent, such as direct marketing;
- Lodge a complaint with the competent supervisory authority in Malta (IDPC), which can be made on their website <https://idpc.org.mt>;
- Object to processing that is carried out for the legitimate interests of the controller, by reference to your specific situation. You may, at all times, object to direct marketing.

Should you wish to exercise any of your rights, you may do so by contacting us, our DPO, or by visiting our website.

All applicants over 18 years are required to sign

Signature of Subscriber:

Date:

DD/MM/YYYY

Name:

Signature of Dependant:

Date:

DD/MM/YYYY

Name:

Signature of Dependant:

Date:

DD/MM/YYYY

Name:

Signature of Dependant:

Date:

DD/MM/YYYY

Name:

Signature of TII / broker (where applicable):

Date:

DD/MM/YYYY

Name & Official Stamp:

Keep Me Posted

Do you wish to keep yourself updated with our products?

Yes No

Important Information

The information that you provide is necessary for the performance of your contract of insurance, or to take steps at your request prior to entering into a contract. Failure to provide the Company with information as necessary throughout the lifetime of your policy might render the Company unable to fulfil its obligations under your contract.

The Company engages in insurance industry standard profiling, wherein the assessment of risk is partially made by automated means. However, all final decisions which produce any legal effects on data subjects, including without limitation, the decision on whether to underwrite a risk and issue a contract of insurance, are taken with human intervention.

If you are acquiring a quote or an insurance policy through an insurance broker, such broker may be considered a joint controller.

If a policy is issued, a more detailed Data Protection Notice will be provided in your policy document. It is also available on our website.

Declaration

I/We declare that the information given in the Proposal Form is to the best of my/our knowledge true, accurate and complete. Further, I/We agree that if my/our answers are not in my/our handwriting and/or have been written by any other person on my/our behalf, then such person shall for that purpose be regarded as my/our agent. I/We further declare that no material fact has been withheld and I/we understand that failure to disclose a material fact may result in the contract being declared void and that a claim under the policy may not be paid. I/We understand that if I/we fail to disclose a material fact, I/we may also encounter difficulty in trying to purchase insurance elsewhere. A material fact is one which is likely to influence Citadel Insurance p.l.c. in the best assessment and acceptance of this proposal.

The Proposal Form and Declaration will be considered the basis of the contract and will form part of the Policy. I/We understand that the cover under the policy will not be operative until Proposal Form has been accepted by Citadel Insurance p.l.c. the relative premium has been paid and received by Citadel Insurance p.l.c. By signing this form, you confirm that you have brought this Data Protection Notice to the attention of all other persons specified in this form.

I/We have read and understood the Data Protection Notice and Declaration.

 Floriana | 2557 9000 - Freephone | 800 72322 info@citadelplc.com citadelplc.com

Citadel Insurance p.l.c. • Casa Borgo • 26 Market Street • Floriana FRN 1082 • Malta

Branches: • Birkirkara • Haż-Żebbuġ • In-Naxxar • Il-Mosta • Iż-Żejtun • Paola • Ta' Xbiex • Il-Mellieħa • Victoria, Gozo
Tied Insurance Intermediaries: • Malta • Gozo

Citadel Insurance p.l.c. is a company authorised under the Insurance Business Act, Cap. 403, to carry on general and long term business of insurance and is regulated by the Malta Financial Services Authority.