APPLICATION FORM

Sana private medical insurance is underwritten and operated by GasanMamo Insurance Ltd. Co. Reg. Number C.3143. GasanMamo Insurance Ltd. is authorised to carry on business of insurance regulated by the MFSA.

Please complete all relevant sections of this form in **BLOCK CAPITALS** and specify your choices by ticking the relevant boxes ensuring that you have signed and dated the declaration.

If you have any queries please call Customer Care on (+356) 21 345123 or email: sana@gasanmamo.com

Intermediary Details

1 Principal applicant details

Title	Name	Surname
Gender M ☐ F ☐	I.D. No. / Passport No.	
Place of Issue		Date issued
Nationality		Date of birth
Group / Company name (if applicable)		Occupation
Smoker Yes ☐ No ☐	Height in cm.	Weight in kg.
House name / no.	Street	
Town	Postcode	Tel. No.
Email		Mobile No.

2 Your choice of Sana Plan (tick required option):

Sana Vital Plan in-patient ☐ in & out patient ☐	**Sana Key Plan** in-patient ☐ in & out patient ☐	**Sana International Plan** ☐
Optional benefits	Preventive Treatment Package ☐	Repatriation ☐
Preferred commencement date		

3 Other medical insurances

Do you or have you had a health insurance policy with any other insurer, including Sana? Yes ☐ No ☐ If Yes, please give details

Name of insurer	
Policy number	Name of plan

4 Details of residency

What is your principal country of residence including that of your dependants? (The country in which you live for at least 240 days in any 12 month period)

Are you or any dependants listed in this application form residing away from the principal country of residence for more than 125 days in any 12 month period? ☐ Yes ☐ No If Yes, please give details

5 Additional persons to be covered

1st Dependant	Title	First Name	Surname
Gender M ☐ F ☐		I.D. No. / Passport No.	Date of birth
Height in cm.	Weight in kg.	Occupation	Smoker Yes ☐ No ☐

2nd Dependant	Title	First Name	Surname
Gender M ☐	F ☐	I.D. No. / Passport No.	Date of birth
Height in cm.	Weight in kg.	Occupation	Smoker Yes ☐ No ☐
3rd Dependant	Title	First Name	Surname
Gender M ☐	F ☐	I.D. No. / Passport No.	Date of birth
Height in cm.	Weight in kg.	Occupation	Smoker Yes ☐ No ☐
4th Dependant	Title	First Name	Surname
Gender M ☐	F ☐	I.D. No. / Passport No.	Date of birth
Height in cm.	Weight in kg.	Occupation	Smoker Yes ☐ No ☐

6 Medical history

Please ensure that you disclose any known or suspected medical conditions and symptoms experienced by anybody included in this application. This applies even if professional advice has not yet been sought. Medical conditions include, but are not limited to, allergies, backaches, bunions, piles, gynaecological or menstrual problems, varicose veins, any ear, nose or throat problems, any pains, swellings or lumps and any dental problems.

Please make sure you answer each question fully and accurately.

Failure to disclose material facts could affect your policy and may make the policy invalid.

PART 6A

Please read the following questions. They apply to each person named in this application. Answer each question by ticking one of the YES or NO boxes.	Applicant		1st dependant		2nd dependant		3rd dependant		4th dependant	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Have you had any in-patient treatment in a hospital or nursing home in the **last 5 years**?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Has any therapist/specialist been consulted and/or provided prescriptions for any drugs or medication within the **last 5 years**?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Has any General Practitioner been consulted and/or provided prescriptions or any drugs or medication within the **last 2 years**?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Do you have a **chronic/long term** medical or dental condition or any disability or recurring illness/injury?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Is there any **known** or **foreseeable** reason why you may have to consult a doctor ?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Are you **currently** taking any medication or is there any foreseeable reason why you may have to?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. Have you **ever** had any pregnancy/childbirth complications? (If applicable)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Have you **ever** had a surgical operation for any reason?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Have you experienced any symptoms, medical conditions or injuries within the last year for which you did not consult a doctor?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Do you participate in any organised or dangerous sports activities? If yes please give details in the space provided in the next page.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

PART 6B (Please use **BLOCK CAPITALS**)

Please complete this section if you have ticked any **Yes** boxes in **Part 6A**. Please use the columns below to disclose all medical conditions (or undiagnosed medical conditions) relating to your answers in **6A**.

1 Name of Applicant or Dependant	2 Question Number in part 6A	3 Medical condition / symptoms	4 Treatment & consultations received including dates or approximate dates	5 Treatment or consultations required in the future	6 Name of medical practitioner

Please give details below if you answered yes to question 10 in part 6A.

If there is insufficient space, please use a separate sheet and indicate that you have done so.

7 Declaration

In view of the declaration below it is essential that complete information is supplied.

It is GasanMamo's intention to provide a good service to our policyholder at all times. However, if you have any cause for dissatisfaction please write to the Managing Director,

GasanMamo Insurance Ltd., Msida Road, Gżira GZR 1405. The law of Malta will apply to this contract unless you and us agree otherwise.

I understand that benefits may not be payable if I do not fully disclose any material facts which could influence GasanMamo's assessment and acceptance of my application. I agree to disclose facts even when I am in doubt as to whether they are material or relevant.

I agree to inform GasanMamo of any changes which may alter my policy and which have occurred since the policy started or since the last renewal date. Failure to do so may invalidate the policy or reduce cover.

I apply to become a policyholder together with the dependants listed in this application who are to form part of my policy. In this regard, I hereby declare that I have obtained consent to provide information regarding the dependants for health insurance purposes. I declare that to the best of my knowledge and belief, the information given in this application is true and complete. I agree that all the rules of the GasanMamo plan / policy will be binding on me and all the dependants included in my policy.

Processing your data

I give explicit and unqualified consent to GasanMamo Insurance Ltd. within the provisions of the Professional Secrecy Act 1994 and the Data Protection Act 2001 to obtain and make use of personal information relating to myself and my dependants in order to allow GasanMamo to process this application.

To the extent that the information supplied, whether orally or in writing, constitutes personal data, including sensitive data within the provisions of the Data Protection Act, I consent to the processing of such data for purposes of administering my proposal for insurance, my policy, underwriting, handling of claims and also for the purposes of detecting, preventing and suppressing fraud and of keeping statistics.

We may be required to collect further information from our Tied Insurance Intermediary, other insurance companies, insurance intermediaries or insurance associations. In addition, we may seek further information from any doctor, hospital, clinic, laboratory or any related practitioner to provide us with further medical information. This helps us to check the information provided. When you tell us about an incident which may or may not give rise to a claim, we may pass information relating to it to the Malta Insurance Association, other insurance companies, Tied Insurance Intermediary, brokers, or medical advisers for the purpose shown in the declaration.

We and other companies within our group would like, on occasion, to keep you informed of our products and services, by mail, fax, email or other electronic means. Please inform us in writing if you do not wish to receive this information or if you wish to receive such information solely from GasanMamo Insurance Ltd.

You have the right to request access to, and rectification of, your personal data held by us by directing your request in writing signed by yourself to the Data Protection Officer, GasanMamo Insurance Ltd., Msida Road, Gżira GZR 1405.

GasanMamo Insurance Ltd. reserves the right to DECLINE ANY APPLICATION. No insurance cover shall be in force until the application has been accepted by GasanMamo Insurance Ltd.

Signature______________________________ Date______________

Name (in **BLOCK CAPITALS**)__________________________________

Direct Credit Details

Kindly complete your bank details below if you would like to receive payment of your claim directly into your bank account.

Account Holder's details	
Name & Surname	
Passport/ I.D. No.	
Address	
Town/City	Country

Bank & Account details	
Name of Bank	
IBAN No.	
BIC code	
Country	Account holder's signature
Date	

Card Payment

Should you wish to pay by Credit Card or Debit Card please complete this section (PLEASE USE BLOCK CAPITALS).

Card Payment Authority

I authorise you to charge my card account, in respect of subscriptions for Sana Private Medical policy/ies.

(Please tick)		
Visa ☐	Master Card ☐	QuickCash ☐
Cashlink ☐	APS Premier ☐	
Other		
Cardholder's name: As it appears on credit card		
Please fill in your Card Number		
Valid From	Expiry Date	
Cardholder's Signature		
Date		