

This application form and the Advantage Dental Care Plan apply to UK resident employees only

To complete this form please ensure you read the relevant sections before filling in the details below (**block capitals**)

MONTHLY PREMIUM

The premiums for each level of cover can be found online at the plan details page on www.globalmarine-dental.uk or You can obtain a copy by contacting Your employee benefits administrator.

Please note if you add You Partner and/or Children this will increase Your monthly premium accordingly.

NEW MEMBERS

If You wish to join the **Advantage Dental Care Plan** please complete Your details and place a cross in the relevant box in the Choice section. Please note that if You would like to add Your Partner or Children it must be the same level of cover as Yourself. Employees joining the company during the contract year may join the dental plan within one month of their start date with the company.

EXISTING MEMBERS

Existing members need return a completed form only if You wish to cancel or amend Your cover, or add supplemental Dental Implant Upgrade Cover. If no form is received Your cover will continue as previously selected.

IMPORTANT

Complete the application form and return it to enquiries@gmsgl.com to be received no later than the 12th of the month. **Please note that once you have joined the Advantage Dental Care Plan you will be insured for the remainder of the Period of Cover unless You leave the company for any reason.** In the event of this occurring, Your cover and that of Your Partner/Children will cease from the end of the month for which Your last premium deduction was made.

If You take maternity leave You can choose to continue or suspend Your cover. If You suspend cover You can recommence when You return to work.

<p>Policyholder Global Marine</p> <p>NI Number </p> <p>Employee Number </p> <p>Title </p> <p>First Name </p> <p>Surname </p> <p>Address (line 1) </p> <p>Address (line 2) </p> <p>Address (line 3) </p> <p>Address (line 4) </p> <p>Postcode </p> <p>E-mail Address </p> <p>Telephone Number </p> <p>Office Location </p> <p>Date of Birth / /</p> <p>Please indicate here if you are an existing scheme member <input type="checkbox"/></p> <p>Do you require supplemental Dental Implant Upgrade Cover?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Options:- Existing Members <i>tick all that apply</i></p> <p>I <u>do not</u> wish to renew my membership <input type="checkbox"/></p> <p>I am already a member and wish to delete: my partner <input type="checkbox"/> my children <input type="checkbox"/></p> <p>I am already a member and wish to add*: my partner <input type="checkbox"/> my children <input type="checkbox"/></p> <p><i>*please also complete the sections below with the details of your partner and/or children as necessary and select the type and level of cover that you require</i></p> <p>APPLICATION DETAILS FOR YOUR PARTNER AND/OR CHILDREN</p> <p>If You wish to include your Partner and/or Children, place a cross in the appropriate box below and Your premium deductions will increase appropriately. Please complete Your Partner's details, and the details of the first two Children (if applicable) to be covered.</p> <p>IMPORTANT! Please remember to confirm whether each of these members requires supplemental Dental Implant Upgrade Cover</p> <p>Full details are contained within the Supplemental Implant Upgrade Cover wording.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;"><u>First Name</u></th> <th style="text-align: center;"><u>Surname</u></th> <th style="text-align: center;"><u>Date of Birth</u></th> <th style="text-align: center;"><u>Implant Cover</u></th> </tr> </thead> <tbody> <tr> <td><u>Partner</u></td> <td>.....</td> <td>.....</td> <td>..... / /</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td><u>First Child</u></td> <td>.....</td> <td>.....</td> <td>..... / /</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td><u>Second Child</u></td> <td>.....</td> <td>.....</td> <td>..... / /</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> <tr> <td><u>Third Child</u></td> <td>.....</td> <td>.....</td> <td>..... / /</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> </tbody> </table> <p>TYPE OF COVER <i>tick one box only</i></p> <p>Just me..... SINGLE <input type="checkbox"/></p> <p style="text-align: center;">or</p> <p>Myself and my Partner..... PARTNER <input type="checkbox"/></p> <p style="text-align: center;">or</p> <p>Myself, my Partner and our Children..... FAMILY <input type="checkbox"/></p> <p style="text-align: center;">or</p> <p>Myself and my Children..... EMPLOYEE & CHILD(REN) <input type="checkbox"/></p> <p>LEVEL OF COVER <i>tick one box only</i></p> <p style="text-align: right;">PEARL <input type="checkbox"/></p> <p style="text-align: center;">or</p> <p style="text-align: right;">SILVER <input type="checkbox"/></p> <p style="text-align: center;">or</p> <p style="text-align: right;">PLATINUM <input type="checkbox"/></p> <p style="text-align: center;">or</p> <p style="text-align: right;">DIAMOND <input type="checkbox"/></p>		<u>First Name</u>	<u>Surname</u>	<u>Date of Birth</u>	<u>Implant Cover</u>	<u>Partner</u> / /	Yes <input type="checkbox"/> No <input type="checkbox"/>	<u>First Child</u> / /	Yes <input type="checkbox"/> No <input type="checkbox"/>	<u>Second Child</u> / /	Yes <input type="checkbox"/> No <input type="checkbox"/>	<u>Third Child</u> / /	Yes <input type="checkbox"/> No <input type="checkbox"/>
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Please note Your Partner/Child can only have the same level of cover as Yourself or if cancelled will be cancelled with Yourself. A specimen copy of the Policy containing full terms and conditions is available upon request from your employee benefits administrator or HR Department. You are advised to retain a copy of this form and all correspondence.

Privacy & Data Protection

The data controller in relation to any personal data you supply is Hamilton Insurance DAC.
HOW WE USE YOUR PERSONAL DATA/WHO WE SHARE IT WITH
 We may use the personal data we hold about you for the purposes of providing insurance, handling claims and any other related purposes (this may include underwriting decisions made via automated means), for offering renewal terms, research or statistical purposes and to provide you with information, products or services that you request from us or which we feel may interest you. We will also use your data to safeguard against fraud and money laundering and to meet our general legal or regulatory obligations.

SENSITIVE PERSONAL DATA

Some of the personal information, such as information relating to health or criminal convictions, may be required by us for the specific purposes of underwriting or as part of the claims handling process. The provision of such data is conditional for us to be able to provide insurance or manage a claim. Such data will only be used for the specific purposes set out in our notice.

DISCLOSURE OF YOUR PERSONAL DATA

We may disclose Your personal data to third parties involved in providing products or services to us, or to service providers who perform services on our behalf. These include our group companies, affinity partners, brokers, agents, third party administrators, reinsurers, other insurance intermediaries, insurance reference bureaus, credit agencies, medical service providers, fraud detection agencies, loss adjusters, external law firms, external auditors and accountants, regulatory authorities, and as may be required by law.

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INTERNATIONAL TRANSFERS OF DATA

We may transfer Your personal data to destinations outside the European Economic Area ("EEA"). Where We transfer Your personal data outside of the EEA, We will ensure that it is treated securely and in accordance with the Legislation. Please visit www.hamiltongroup.com for further privacy notice information and full contact details of the Data Protection Officer.

Declaration I/We understand the contents of the completed application and I/we declare that the information given is, to the best of my/our knowledge and belief correct and complete. I/We agree that the statements in this application shall form the basis of the contract between the insurer and myself/ourselves and if the risk is accepted I/we undertake to pay the premium when called upon to do so. I/We understand that my/our information may also be disclosed to the Financial Conduct Authority and other regulatory bodies for the purposes of monitoring and/or enforcing the insurer's compliance with any regulatory rules/codes. I/We consent to the information on this form and on any claim I/we may make being supplied to a data administration company so that it can be made available to other insurers. I/We also agree that, in response to any searches that may be made in connection with this application or any claim, such data administration company may supply information it has received from other insurers about other claims I/we have made. I authorise my employer to deduct from my net salary any monthly subscription due, and to forward this to the insurers or their nominated representatives, as the necessary premium, until the next renewal date. This authority shall remain valid thereafter for each successive 12 months from the renewal date until my written cancellation prior to the next anniversary.

<p>Today's Date / /</p>	<p>Signature of Employee </p>
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