Expat Protect Plan
January 2019

APPLICATION form

Allianz Care

PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS

If you are adding a new dependant, please state your existing Policy Number:

If you are applying to join an existing group scheme, please state:

Group name

Group number

Wherever the following words and phrases appear in this form, they will always have the meanings as defined below:
Home country: A country for which you (or your dependants, if applicable) hold a current passport or is your principal country of residence.
Principal country of residence: The country where you and your dependants (if applicable) live for more than 6 months of the year.

1 APPLICANT DETAILS (Please note that the applicant will be the policyholder)

You must notify us of any change of contact details so we can ensure that correspondence reaches you. We will consider applicants for cover up to the day before their 76th birthday.

Mr.☐ Mrs.☐ Ms.☐ Miss☐ Other First name

Surname

Date of birth D D / M M / Y Y Y Y Gender: Male☐ Female☐

Home country

Nationality

Principal country of residence

Full address in principal country of residence (mandatory)

Primary phone number COUNTRY CODE AREA CODE

Secondary phone number COUNTRY CODE AREA CODE

Email address (mandatory, please print)

Occupation (mandatory), please state if student

Please indicate the language in which you wish to receive your policy documentation:

English☐ French☐

Details of any current domestic or international health insurance:

Name of insurer

Policy number Start date D D / M M / Y Y Y Y

2 DEPENDANTS TO BE COVERED UNDER THE CONTRACT

Dependants can include your spouse/partner and any children financially dependant on the applicant up to the day before their 18th birthday, or up to the day before their 24th birthday if in full-time education. Where the child is 18 years of age or older, please attach a letter from the college/university confirming student status or a copy of the student's ID. We will consider adult dependants for cover up to the day before their 76th birthday. If there is insufficient space for all dependants, please use another Application Form.

	Dependant 1	Dependant 2	Dependant 3
Relationship to applicant	Spouse ☐ Child ☐	Spouse ☐ Child ☐	Spouse ☐ Child ☐
First name			
Surname			
Date of birth	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
Gender	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Occupation (mandatory, please state if student)			
Email address (mandatory for dependants over 18)			
Home country			
Principal country of residence			
Nationality			

Details of any current domestic or international health insurance

Name of insurer			
Policy number			

3 COMMENCEMENT OF COVER

Please indicate the date you require cover from: D D / M M / Y Y Y Y

Cover is conditional upon acceptance of your application, which is only confirmed when an Insurance Certificate is issued to you.

4 PLAN DETAILS (This section does not need to be completed if you are applying as part of a group scheme)

Please note that each plan chosen will apply to all policy members.

Select your Area of Cover

- ☐ Worldwide
- ☐ Worldwide excluding USA (for residents of China, Hong Kong, Israel, Singapore, Switzerland, and United Kingdom)
- ☐ Worldwide excluding USA (for residents of all other countries other than those listed in 4.1. (b))

Select your Cover Type

- ☐ 1st Euro (where reimbursement is offered from the 1st euro incurred on medical treatment covered under the chosen plan)
- ☐ CFE Top-up (where reimbursement is offered on top of the initial reimbursement provided by the CFE, on medical treatment covered under the chosen plan)

Select your Core Plan

- ☐ Pack Premium
- ☐ Pack Confort

Select your Optional Plans

(Please note that Optional Plans can only be purchased in conjunction with a Core Plan)

Out-patient Plan	☐ Pack Premium 80	☐ Pack Premium 90	☐ Pack Premium 100
	☐ Pack Confort 80	☐ Pack Confort 90	☐ Pack Confort 100
Dental Plan	☐ Pack Premium	☐ Pack Confort	
Evacuation and Repatriation Plan	☐ Evacuation and Repatriation Plan		

If your plan is not listed in the sections above, please state your chosen Core Plan and any supplementary plans:

5 PRE-EXISTING CONDITIONS

Pre-existing conditions are medical conditions or any related conditions for which one or more symptoms have been displayed at some point during your lifetime, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition, about which you or your dependants could reasonably have been assumed to have known, will be deemed to be pre-existing. Pre-existing conditions are covered under the policy, unless otherwise advised by us in writing. Conditions arising between completing the Application Form and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered. **Therefore, it is necessary that you advise us of any material changes to the information provided, between submission of this application and acceptance by us**. You are hereby obliged on request to provide any further information that we might require. Full and accurate completion of this Application Form and disclosure of all relevant information is a condition precedent to cover. If you are an existing client, please also include details of any conditions for which you have claimed for since joining.

6 HEALTH DECLARATION

Please answer the following questions on the basis of your own and your dependant's (if applicable) complete medical past. **All material facts (facts likely to influence our assessment and acceptance of this application) must be disclosed**. Failure to do so may invalidate the policy. **If you are in any doubt as to whether a fact is material, then it should be disclosed**. This Health Declaration is valid for two months from the date of completion and the form being signed by the applicant.

	Applicant	Dependant 1	Dependant 2	Dependant 3
Height	cm	cm	cm	cm
Weight	kg	kg	kg	kg
Have you consumed any form of tobacco in the past year?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
If Yes, please state amount per day	/day	/day	/day	/day
Do you drink alcohol?	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
If Yes, how many units of alcohol do you drink per week? (1 short = 1 unit, 250ml beer = 1 unit, 1 glass wine = 1 unit, if none state "zero")	/week	/week	/week	/week
Do you wear glasses or contact lenses? If Yes, please state:	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
• Condition				
• Number of dioptres for each eye (This appears on the prescription from the optician)				

1. **Has any person included in this application ever suffered from, been in hospital with, or received treatment of any kind, tests or investigations for:**

   (a) **Any heart or circulatory disease or disorders** such as, but not limited to heart attack, coronary artery disease, irregular heart beat, murmur, chest pain, clots, blood disorder, abnormal blood pressure or high cholesterol? Yes☐ No☐

   (b) **Any dermatological disease or disorders** such as, but not limited to psoriasis, dermatitis, eczema, allergy or acne? Yes☐ No☐

   (c) **Any endocrine disease or disorders** such as, but not limited to diabetes, weight problems, gout or thyroid problems, or other hormonal imbalances? Yes☐ No☐

   (d) **Any eye, ear, nose and throat disease or disorders** such as, but not limited to cataract, glaucoma, hearing loss, sinus problems or tonsils and adenoids? Yes☐ No☐

   (e) **Any gastrointestinal disease or disorders** such as, but not limited to stomach problems, hernia, haemorrhoids, gall stones, colon polyps, Crohn's disease, colitis or liver problems? Yes☐ No☐

   (f) **Any infectious disease or disorders** such as, but not limited to: hepatitis A-B-C, herpes, HIV, malaria, meningitis, blood infections or sexually transmitted disease? Yes☐ No☐

   (g) **Any muscular and skeletal disease or disorders** such as, but not limited to back, neck or joint pain, arthritis, paralysis, joint replacement or any cartilage and ligament problems? Yes☐ No☐

   (h) **Any neurological disease or disorders** such as, but not limited to stroke, multiple sclerosis, epilepsy, neurodegenerative disorders or seizures, migraine, sciatica or nerve pain? Yes☐ No☐

   (i) **Any oncological disease or disorders** such as, but not limited to any cancer, leukaemia, lymphomas, tumour, skin lesions, growth, lump, cyst, mole, polyp or naevus? Yes☐ No☐

   (j) **Any psychiatric or psychological disorders** such as, but not limited to depression, anxiety, chronic fatigue syndrome, eating disorders or alcohol/drug problem, Alzheimers or other Dementias? Yes☐ No☐

   (k) **Any respiratory disease or disorders** such as, but not limited to Chronic Obstructive Pulmonary Disorder, asthma, bronchitis, sinusitis, or shortness of breath. Yes☐ No☐

   (l) **Any urological or reproductive organs disease or disorders** such as, but not limited to kidneys or urinary tract problems, menstrual impairments, fertility problem, fibroids, endometriosis, testicular or prostate enlargement? Yes☐ No☐

   (m) **Any other accident, injury, disease or disorder** not already disclosed? Yes☐ No☐

2. **Please indicate if any person included in this application:**

   (a) Is currently taking any prescribed drugs, medication (including over the counter), tablets or any other treatment. Yes☐ No☐

   (b) Is expecting to have a medical review, has been referred for further tests/investigations, is awaiting results or any treatment due to accident, injury, disease or disorder not already mentioned. Yes☐ No☐

   (c) Has **undergone any non routine tests or investigations** such as, but not limited to biopsy, colonoscopy, colposcopy, computed tomography (CT), mammogram, magnetic resonance imaging (MRI), Papanicolaou test (PAP), prostate specific antigen test (PSA). Yes☐ No☐

   Please do NOT disclose results of any genetic (DNA or RNA) tests, as these are not required for the medical underwriting process.

QUESTIONS 3 AND 4 SHOULD ONLY BE COMPLETED IF YOU ARE PURCHASING DENTAL COVER.

3. **Is any person included in this application currently undergoing or been advised to undergo any dental treatment?** Yes☐ No☐
   If Yes, please complete a Dental Questionnaire, which can be downloaded from our website:
   www.allianzworldwidecare.com/en/international-individual-health-insurance/paper-applications/

4. **Does any person included in this application:**

   (a) Suffer from periodontitis (extensive disorder of the gum and the tooth-supporting structures)? Yes☐ No☐

   (b) Have any missing teeth, crowns, inlays, implants, fillings or bridges? Yes☐ No☐

   If Yes, please state name of person, type and quantity of each of the above, including number of teeth affected by bridge.

ADDITIONAL INFORMATION FOR "YES" ANSWERS

If you answered **Yes** to any part of questions 1, 2, 3 or 4 within the previous Health Declaration section, please provide details in the table below. **Please advise if a full recovery has been made and if you or your dependants (if applicable) have any condition or disease related to, or arising from, the original diagnosis.** Please enclose supporting up to date medical reports/test results if possible.

Question number	Name of the person affected by the condition	Diagnosis - where applicable state the area of the body affected *(e.g. left arm, right foot)*	Date of onset and date of last symptom	Frequency and severity of symptoms	Investigations, blood tests or readings	Past/Current treatment	Current status *(e.g. ongoing, any complications, complete recovery, recurrent)*

If there is insufficient space in the table above, please use another Application Form

Please provide the name, address and telephone number of the regular/family doctor for all persons included in this application. Please use a separate sheet if the space provided is not sufficient:

7 DECLARATION

Please read the following declarations carefully and only sign below if you understand and accept them.

- I declare that all information supplied above is true and complete. I also declare that I have not suppressed, misrepresented or misstated any material fact. I understand that this application shall be the basis of the contract between Allianz Care and myself. **Incorrect disclosure/non-disclosure or intentional false statement of any material facts, by you or your dependants, which changes the subject or affects our assessment of the risk, including, but not limited to, those material facts declared on the relevant application form or in relation to an increased risk during the term of the policy, will render the contract void from the commencement date or the commencement date of cover, unless we confirm otherwise in writing. If the contract is rendered void due to incorrect disclosure/ non-disclosure or intentional false statement of any material facts, premium in respect of this policy will not be refunded in part or in whole.**
- **I undertake to inform Allianz Care immediately in writing of any changes in my or my dependants' state of health occurring between completing the Application Form and the start date of the policy.**
- I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information and I consent to the fact that Allianz Care, if it considers it appropriate, will check statements concerning my health condition and will check with other healthcare insurers, all statements concerning previous, or existing contracts applied for. I authorise all such practitioners, physicians, dentists, members of medical professions, employees of hospitals and health authorities as well as medical facilities to provide relevant medical information relating to me, if requested by Allianz Care, its medical advisers, its appointed representatives, or to any third party expert(s) in case of disputes, subject to any legal restrictions which may apply. I also make this statement for my dependants under the age of 18 and for dependants who cannot assess the meaning of this statement.
- I confirm that:
  - I have read and understood the full definitions, benefits, exclusions and conditions of this policy including the details relating to pre-existing conditions.
  - I have received, read and understood the Insurance Product Information Document and I accept the terms and conditions as summarised there and further explained in my Benefit Guide. Based on the information provided within these documents and the plan selections that I have made, I believe the product I selected is most suited to my specific insurance needs.
- I understand:
  - that this Application Form is valid for two months from the date of completing and signing it.
  - that I can withdraw my application in writing by letter, email or fax, within 30 days from the date I receive the full terms and conditions of my policy, and provided that I have not submitted a claim, I am entitled to a full refund of the premium.
- I accept that:
  - it is my responsibility to check the accuracy of the information contained within the Insurance Certificate, once issued. If the content is not in accordance with the Application Form, the situation will be considered accepted if I enter no protest within 30 days following the issue date of the Insurance Certificate.
  - this policy will be subject to the standard policy terms and conditions effective at the time of policy commencement contained within the Benefit Guide.
  - the cover provided by Allianz Care may not be suitable if my dependants and I are or become resident in countries where local compulsory health insurance restrictions are in place (e.g. Switzerland).
  - it is my responsibility to check whether I am subject to any local compulsory health insurance requirements to ensure that my healthcare cover is legally appropriate in my country of residence and I have satisfied myself that my insurance cover is legally appropriate.
- I authorise the exchange of administrative and medical information relating to me and my dependants between Allianz Care, and the CFE, where required for the purposes of administration and for processing claims. I also authorise Allianz Care to receive details of the reimbursements made by the CFE to me and for Allianz Care to receive payment from the CFE of medical costs reimbursements in order to provide me with a single reimbursement.

As the applicant, I sign and date this declaration and Application Form for and on behalf of all persons included in this Application Form.

Applicant's signature

Applicant's printed name

Date D D / M M / Y Y Y Y

8 DATA CONSENT

We need your consent to collect and process your health and other data for the insurance policy that you would like to subscribe to. **If you do not provide your explicit consent for the processing of your personal data as outlined below, we will not be able to provide you with the policy that you would like to purchase or process any claims that may be owed to you.** If you agree, your data will be processed for the following reasons and activities.

A parent or guardian should complete the consent for any dependant that is under the age of 18.

☐ **I, the Applicant, Dependant 1, Dependant 2 and Dependant 3 agree with the following:**

NAME OF APPLICANT	NAME OF DEPENDANT 1	NAME OF DEPENDANT 2	NAME OF DEPENDANT 3

1. **Permission to collect, store and use my health data:** The insurer may collect, store and use my health data in order to administer the policy, for example, to provide me with a quote for insurance cover, underwrite the risks to be insured or process any claims. The insurer may store my health data in accordance with the Consumer Code of the law applying to my policy with the insurer or any other applicable law requiring its retention.
2. **Permission to obtain my data from third parties:** The insurer may obtain my health and other data from physicians, nursing and hospital staff, other medical institutions, care homes, statutory health insurance funds, my Plan Sponsor, professional associations and public authorities to provide me with insurance cover, underwrite the risks to be insured or process any claims. I agree to release all individuals at these institutions and the insurer from their respective confidentiality obligations relating to my health data or other data that they are required to share and use for these aforementioned stated purposes.
3. **Sharing my data outside of the insurer:** The insurer may share my health and other data with the institutions set out below for them to use to the same extent, and for the same purposes as the insurer. I understand that the insurer has put in place contractual arrangements with these institutions to protect my data. I agree to release all individuals at these institutions and the insurer from their respective confidentiality obligations relating to my health data or other data that they are required to share and use for the purposes set out below:
   - With independent medical experts if this is necessary to assess insurance risks and any benefits to be paid to me or to the third party providing treatment or service to me, under my policy.
   - With service providers outside of the Allianz Group of companies that perform certain services on behalf of the insurer, such as risk assessments and claims handling that involve the collection and use of my health and other data, without which the insurer would not be able to administer my policy or pay any claims due to me.
   - With coinsurers to distribute the coverage of the insurance risk jointly with other companies to which the insurer issue the policy, and to handle claims jointly.
   - With other insurers/reinsurers that may be covering the same insurance risk at the same time – multiple insurance – to distribute the payment of any compensation that may be owed to me, or to collaborate in the detection or prevention of fraud and financial crime.

If I change my mind about my preferences above, including withdrawing my consent to any of these items, I can let the insurer know by emailing: AP.EU1DataPrivacyOfficer@allianz.com

POLICYHOLDER APPOINTMENT

In order to assist with the administration of the policy you can nominate the policyholder as the main person of contact for the insurance. To do this, simply select "Yes" below.

I hereby authorise _____ INSERT NAME OF POLICYHOLDER

to act for and on my behalf in relation to the administration of this policy which may include the disclosure of sensitive medical information. This authorisation will remain in place until I provide a written request to Allianz Care to revoke it.

Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐

INTERMEDIARY APPOINTMENT

I hereby authorise Assurances et Conseils Moncey 224 303 INSERT NAME OF BROKER

to act for and on my behalf in relation to the administration of this policy which may include the disclosure of sensitive medical information. This authorisation will remain in place until I provide a written request to Allianz Care to revoke it.

For office use only — Agent details and stamp

Assurances et Conseils Moncey 224 303

Applicant's signature	Dependant 1 signature	Dependant 2 signature	Dependant 3 signature
D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y

9 MARKETING PREFERENCES

☐ **I, the Applicant, Dependant 1, Dependant 2 and Dependant 3 agree that the insurer may collect, use and disclose my personal data to provide me with marketing information, and I understand that my personal data will only be processed for the following reasons and activities that I have expressly agreed to by indicating ☑ below.**

NAME OF APPLICANT	NAME OF DEPENDANT 1	NAME OF DEPENDANT 2	NAME OF DEPENDANT 3

- Information that the insurer sends about their products and services, including updates on their latest promotions and new products and services.

☐ ☐ ☐ ☐

- Information sent directly by other Allianz Group companies on their products and services. I understand that you shall disclose my relevant contact information to them for that purpose.

☐ ☐ ☐ ☐

- Information sent directly by the business partners of the insurer on their products and services. I understand that you shall disclose my relevant contact information to them for that purpose.

☐ ☐ ☐ ☐

APPLICANT	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3
Such communications should be sent to me via the following channels:			
☐ Email	☐ Email	☐ Email	☐ Email
☐ In-App Notifications	☐ In-App Notifications	☐ In-App Notifications	☐ In-App Notifications
☐ Telephone	☐ Telephone	☐ Telephone	☐ Telephone
☐ Post	☐ Post	☐ Post	☐ Post

10 WE CARE ABOUT YOUR PERSONAL DATA PROTECTION

Our Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process your personal data and should be read by you before the submission of any personal data to us. To read our Data Protection Notice visit: www.allianzworldwidecare.com/en/privacy.

Alternatively, you can contact us on + 353 1 630 1301 to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, you can always contact us by e-mail at: AP.EU1DataPrivacyOfficer@allianz.com

11 PAYMENT DETAILS

This section does not need to be completed if you are applying as part of a group scheme and your employer is paying the premium.

No payment should be made until you have been notified of your policy number.

Payment currency

Please note that the payment currency is Euro.

Payment frequency and method

Payments are subject to the following administration surcharges: 0% for annual payment, 3% for half-yearly payments, 4% for quarterly payments and 5% for monthly payments.

Please tick to indicate your preferred payment frequency and method:

	Annual	Half-yearly	Quarterly	Monthly
Direct Debit* (For payments in Euro, Sterling and Swiss Franc)	☐	☐	☐	☐
Credit card	☐	☐	☐	☐
Cheque	☐	☐	☐	Not available
Bank transfer	☐	☐	☐	Not available

**If you choose to pay by Direct Debit, please complete and submit the relevant Direct Debit Mandate available from: www.allianzworldwidecare.com/en/international-individual-health-insurance/paper-applications/. Please note that if you are a member of a group scheme and wish to pay by Direct Debit, the monthly payment frequency option must be selected.*

PLEASE RETURN YOUR FULLY COMPLETED FORM BY:

Email to: underwriting@allianzworldwidecare.com
Fax to: + 353 1 629 7117
Post to: Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland

If you have any questions regarding this Application Form or the application process please contact our Helpline on: +353 1 630 1301

CREDIT CARD PAYMENT

If you choose to pay by credit card, please provide the following information:

Card type Mastercard ☐ Visa ☐ American Express ☐

Cardholder's name

Card number — — — Expiry date M M / Y Y

For security reasons, once this information is transferred to our system, the credit card details will be detached from the Application Form and destroyed.

Credit card authorisation

I authorise Allianz Care to charge my credit card account with my healthcare premium (of which I will be notified at acceptance of cover/renewal or upon a request made by me which impacts my premium, such as adding a dependant). This will continue until the instruction is cancelled, by me giving written notice to Allianz Care. I understand I will be given one month's notice of any annual premium rate increase.

Cardholder's signature Date D D / M M / Y Y Y Y