Expat Protect Plan

Application Form

Allianz Worldwide Care

Assurances et Conseils Moncey
224 303

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 six 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 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

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	D D / M M / Y Y	D D / M M / Y Y
Gender	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Occupation (mandatory), please state if student			
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

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.

1 Select your Area of Cover

☐ a) Worldwide ☐ b) Worldwide excluding USA *(for residents of China, Hong Kong, Israel, Singapore, Switzerland, and United Kingdom)*

☐ c) Worldwide excluding USA *(for residents of all other countries other than those listed in 4.1. (b) above)*

2 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)*

3 Select your Core Plan

☐ Pack Premium ☐ Pack Confort

4 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 Confort 80

☐ Pack Premium 90 ☐ Pack Confort 90

☐ Pack Premium 100 ☐ 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 in respect of individual policies. 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.

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 could render your contract void or result in a claim being denied or reduced. **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? *If Yes, please state amount per day*	Yes ☐ No ☐ _____ /day	Yes ☐ No ☐ _____ /day	Yes ☐ No ☐ _____ /day	Yes ☐ No ☐ _____ /day
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:* • Condition • Number of dioptres for each eye *(This appears on the prescription from the optician)*	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Health Declaration (continued)

1. **Has any person included in this application ever suffered from, been in hospital with, or received treatment, tests or investigations for:**
   - (a) Rheumatism, gout, arthritis, paralysis, muscular or skeletal disorder or any form of neck or back disorder? Yes ☐ No ☐
   - (b) Epilepsy or other neurological disorders such as/but not limited to migraine, Multiple Sclerosis or nerve damage? Yes ☐ No ☐
   - (c) Any digestive disorder including oesophageal, stomach, liver or bowel/colon problems? Yes ☐ No ☐
   - (d) Anxiety, depression, ME, psychological, psychiatric or other mental illness? Yes ☐ No ☐
   - (e) Any reproductive, gynaecological or genital disorders? Yes ☐ No ☐
   - (f) Any disorder of the kidneys, urinary tract or gall bladder, or pancreas including diabetes? Yes ☐ No ☐
   - (g) Any growth, lump, cyst, mole or cancer? Yes ☐ No ☐
   - (h) Any eye, ear, nose, thyroid or skin disorder such as acne, eczema or dermatitis? Yes ☐ No ☐
   - (i) Any heart disease or disorder, arrhythmia, murmur, chest pain, stroke, haemorrhage, clots, blood disorder, abnormal blood pressure or high cholesterol? Yes ☐ No ☐
   - (j) Asthma, bronchitis or any other respiratory condition such as/but not limited to rhinitis, sinusitis or allergy? Yes ☐ No ☐
   - (k) Alcohol excess or misuse of drugs? Yes ☐ No ☐
   - (l) Any other illness or injury requiring medical attention (excluding colds and influenza) not mentioned above? Yes ☐ No ☐
2. **Has any person included in this application:**
   - (a) Ever tested positive for HIV, Hepatitis B or C or are they currently awaiting the results of such a test? Yes ☐ No ☐
     If the result is negative, having an HIV test will not, in itself, have any effect on your acceptance terms for insurance.
   - (b) Been in hospital for any injury, disease or disorder which required treatment of any kind, or been off work for more than 14 days at any one time? Yes ☐ No ☐
   - (c) Undergone cancer screening or check-ups within the last five years? Yes ☐ No ☐
3. **Is any person included in this application:**
   - (a) Currently suffering from or been advised to seek medical advice or treatment or been referred for further tests due to accident, injury, disease or other disorder not mentioned above, or is any person included in this application still awaiting further investigation, tests or treatment? Yes ☐ No ☐
   - (b) Currently taking any medication (including over the counter medication) on a regular basis? Yes ☐ No ☐
4. **Have any of your parents, brothers or sisters (living or deceased) suffered from diabetes, heart disease, high blood pressure or cholesterol, cancer, kidney disease, polyposis of the colon, Motor Neurone Disease or any other hereditary disorder before the age of 65?** Yes ☐ No ☐

   If Yes, please state:

   Who was affected *(e.g. mother)* of

   ☐ Applicant ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 Other

   Age at diagnosis Condition

   Who was affected *(e.g. father)* of

   ☐ Applicant ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 Other

   Age at diagnosis Condition

   Who was affected *(e.g. brother)* of

   ☐ Applicant ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 Other

   Age at diagnosis Condition

If there is insufficient space, please use an additional Application Form

Questions 5 and 6 should only be completed if you are purchasing dental cover.

5. **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/members**
6. **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 (if applicable)

If there is insufficient space, please use an additional Application Form

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 medical reports/test results if possible.**

Name of the person affected by the condition	Question number	Diagnosis	Date of onset	Frequency and severity of symptoms	Date of last episode	Test results	Past / current treatment or recovery

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 Data Protection Acts – Collection and use of personal information

References to information include personal information given by you to us, in your Application, Claim or Treatment Guarantee Form and/or supporting documents/information we collect in connection with products or services we provide. Allianz Worldwide Care, part of the Allianz Group, is the data controller for this information.

Uses: Personal information may be used for insurance administration (e.g. underwriting, claims handling, fraud prevention). We may use third parties to process data on our behalf. Such processing, which may take place outside the European Economic Area (EEA), is subject to contractual restrictions regarding confidentiality and security in line with Data Protection obligations.

Sensitive data: We need to collect sensitive data relating to you (e.g. health details), to assess insurance terms and/or administer claims.

Disclosure: We may share your information with our agents, members of the Allianz Group, other insurers and their agents, service providers, any intermediary acting on your behalf or governing/regulatory bodies (of which we are a member or by which we are governed). In certain circumstances, we may use private investigators to investigate a claim you have submitted.

Retention: We are obliged to retain your records for six years from the date the insurance relationship ends. We will not retain your data for longer than necessary and will hold it only for the purposes for which it was obtained.

Representation and Consent: By signing this form you confirm that you have the authority to act on behalf of your dependants in respect of all personal information you provide to us, and that you consent to the disclosure, processing, usage and retention of this information in relation to yourself and on behalf of your dependants.

Access: You have the right to request and receive a copy of your personal data held by us. If you wish to do this, please write to the Data Protection Officer at the address provided on this form or via client.services@allianzworldwidecare.com.

Call recording: Calls to our Helpline will be recorded and may be monitored for training, quality and regulatory purposes.

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8 Declaration

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

(a) 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 Worldwide 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.**

(b) I undertake to inform Allianz Worldwide 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.

(c) 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 Worldwide 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 Worldwide 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 co-insured dependants, including those who cannot assess the meaning of this statement.

(d) 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.

(e) 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.

(f) 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 Worldwide 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).

(g) I authorise the exchange of administrative and medical information relating to me and my dependants between Allianz Worldwide Care, and the CFE, where required for the purposes of administration and for processing claims. I also authorise Allianz Worldwide Care to receive details of the reimbursements made by the CFE to me and for Allianz Worldwide Care to receive payment from the CFE of medical costs reimbursements in order to provide me with a single reimbursement.

(h) I accept that 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.

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

9 Intermediary appointment

As the applicant I hereby authorise INSERT NAME OF BROKER to act for and on behalf of all persons named in this Application Form 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 Worldwide Care to revoke it.

For office use only — Agent details and stamp

Assurances et Conseils
Moncey
224 303

Applicant's signature

Applicant's printed name

Date D D / M M / Y Y

10 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.

(a) Payment currency

Please note that the payment currency is Euro.

(b) 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*	☐	☐	☐	☐
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/application-form-for-international-healthcare-plans. 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.*

Credit card payment

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

Card type Mastercard ☐ Visa ☐

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 Worldwide 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 Worldwide 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

Please return your fully completed form by:

Scan and email to: underwriting@allianzworldwidecare.com
Fax to: + 353 1 629 7117
Post to: Allianz Worldwide 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 (English) or +353 1 630 1303 (French).

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plus.google.com/+allianzworldwidecare
www.youtube.com/user/allianzworldwide
www.linkedin.com/company/allianz-worldwide-care

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Financial Strength Rating A.M. BEST A+ Superior

Rating effective from 17th December 2015. For the latest rating, please visit www.ambest.com

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