Application form – Indigo Expat CFE
CFE Top-up individual policies

Please read the following carefully, completing all relevant information in **BLOCK CAPITALS** and ticking ☑ the relevant boxes to subscribe to Indigo Expat

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. Allianz Care will consider applicants for cover up to the day before their 70th birthday.

M.☐ Mrs☐ Ms ☐ Other _____ Surname _____

First name _____

_____

Date of birth (dd/mm/yy) _____ 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 (dd/mm/yy) _____

Are you enrolled with or have you submitted an application form to:
- La Caisse des Français de l'Etranger (CFE - France) : Yes ☐ No ☐
- Sécurité sociale d'outre-mer (ONSS - Belgique) : Yes ☐ No ☐

Social security number or CFE _____

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 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 70th birthday. If there is insufficient space in the table below for all your dependants, please use another Application Form.

Dependant 1:

Relationship to applicant: Spouse ☐ Child ☐
M.☐ Mrs☐ Ms ☐ Other _____ Surname _____
First name _____
Date of birth (dd/mm/yy) _____ Gender Male ☐ Female ☐
Occupation (mandatory); please state if student _____

Home country _____
Principal country of residence _____
Nationality _____
Email address _____
(mandatory if >18 years old)

Details of any current domestic or international health insurance:
Name of Insurer _____
Policy number _____ Start date (dd/mm/yy) _____
Details of your dependant social security number or CFE (if applicable) _____

Dependant 2:

Relationship to applicant: Spouse ☐ Child ☐
M.☐ Mrs☐ Ms ☐ Other _____ Surname _____
First name _____
Date of birth (dd/mm/yy) _____ Gender Male ☐ Female ☐
Occupation (mandatory); please state if student _____

Home country _____
Principal country of residence _____
Nationality _____
Email address _____
(mandatory if >18 years old)

Details of any current domestic or international health insurance:
Name of Insurer _____
Policy number _____ Start date (dd/mm/yy) _____
Details of your dependant social security number or CFE (if applicable) _____

Dependant 3:

Relationship to applicant: Spouse ☐ Child ☐
M.☐ Mrs☐ Ms ☐ Other _____ Surname _____
First name _____
Date of birth (dd/mm/yy) _____ Gender Male ☐ Female ☐
Occupation (mandatory); please state if student _____

Home country _____
Principal country of residence _____
Nationality _____
Email address _____
(mandatory if >18 years old)

Details of any current domestic or international health insurance:
Name of Insurer _____
Policy number _____ Start date (dd/mm/yy) _____
Details of your dependant social security number or CFE (if applicable) _____

Dependant 4:

Relationship to applicant: Spouse ☐ Child ☐
M.☐ Mrs☐ Ms ☐ Other _____ Surname _____
First name _____

_____

Date of birth (dd/mm/yy) _____ Gender Male ☐ Female ☐
Occupation (mandatory); please state if student _____

Home country _____
Principal country of residence _____
Nationality _____
Email address _____
(mandatory if >18 years old)

Details of any current domestic or international health insurance:
Name of Insurer _____
Policy number _____ Start date (dd/mm/yy) _____
Details of your dependant social security number or CFE (if applicable) _____

3. Commencement of cover

Please indicate the date you require cover from *(dd/mm/yyyy)*: _____/_____/ **2019**

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

4. Plan details

4.1. Select ☑ your Area of cover — Worldwide excluding USA ☐ Worldwide ☐

4.2. Select ☑ your Indigo Expat CFE plan — ONSS outre-mer Top-Up ☐ CFE Top-Up ☐

Select ☑ your Indigo Expat CFE benefits
Indigo Expat CFE **100** ☐
Indigo Expat CFE **90** ☐
Indigo Expat CFE **80** ☐

4.3. Select ☑ deductible of 500 E / 700 USD / 550 CHF on out patient benefits : Without deductible ☐ With deductible ☐

We have created a bundled package specifically for individual clients which includes the Indigo Expat Core Plan, an Out-patient Plan (choice of three) and a Dental Plan. Please note that these plans are not available for sale separately.

4.4. Select ☑ your option(s) Evacuation and Repatriation ☐ Maternity ☐

There are 2 optional plans which can be purchased with this package – the Indigo Expat Evacuation and Repatriation Plan and the Indigo Expat Maternity Plan (a spouse/partner must also be insured under the policy if the Maternity Plan is selected).

Your plan selection can only be amended at policy renewal. If you want to increase your level of cover, full medical underwriting and waiting periods may apply and an additional premium amount will be payable. Please note that each plan chosen will apply to all policy members.

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 dependants (if applicable) complete medical past. **All material facts (facts likely to influence the insurer's 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	Dependant 4
Height	_____cm	_____cm	_____cm	_____cm	_____cm
Weight	_____kg	_____kg	_____kg	_____kg	_____kg
Have you consumed any form of tobacco in the past year?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If yes, state amount per day:	_____	_____	_____	_____	_____
Do you drink any alcohol?	Yes ☐ No ☐	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")	_____	_____	_____	_____	_____
Do you wear glasses or contact lenses? If yes, please state:	Yes ☐ No ☐	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 ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
b) Any dermatological disease or disorders such as, but not limited to psoriasis, dermatitis, eczema, allergy or acne?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	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 ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	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 ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	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 ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	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 ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	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 ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	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 ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	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 ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	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 ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	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 ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	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 ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
m) Any other accident, injury, disease or disorder not already disclosed?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	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 ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	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 ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	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 ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐

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

3. Is any person included in this application currently undergoing or been advised to undergo any dental treatment?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐

If Yes, please complete a Dental Questionnaire, which can be downloaded on the following page 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 ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
(b) Have any missing teeth, crowns, inlays, implants, fillings or bridges?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
If yes, please state 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 the 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 report/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 not sufficient space for your additional information, 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.

(a) I declare that all information supplied above is true and complete, including those answers that are not in my own handwriting. 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, and that any false, incorrect or misleading statement or non-disclosure of material medical information may render this insurance null and void.

(b) **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.**

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

(d) I confirm that
- (i) I have read and understood the full definitions, benefits, exclusions and conditions of this policy including the details relating to pre-existing conditions.
- (ii) 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.

(e) I understand:
- (i) That this Application Form is valid for two months from the date of completing and signing it.
- (ii) 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:
- (i) 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.
- (ii) This policy will be subject to the standard policy terms and conditions effective at the time of policy commencement contained within the Benefit Guide.
- (iii) 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 requirements are in place (e.g. Switzerland).
- (iv) 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.

(g) I authorize the exchange of administrative and medical information relating to me and my dependants between Allianz Care, the CFE and A&C Moncey, where required for the purposes of administration and for processing claims. I also authorize 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 (dd/mm/yy) _____

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 member that is under the age of 18.

I, the Applicant, Dependant 1, Dependant 2, Dependant 3 and Dependant 4 agree with the following:

Name of Applicant	Name of Dependant 1	Name of Dependant 2	Name of Dependant 3	Name of Dependant 4

1. **Permission to collect, store and use and 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 insurance 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 insurance 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 ☐	Yes ☐ No ☐	Yes ☐ No ☐

Intermediary appointment

I hereby authorise (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 - Broker details and stamp

Applicant's signature Date (dd/mm/yy)	Dependant 1's Signature Date (dd/mm/yy)	Dependant 2's Signature Date (dd/mm/yy)	Dependant 3's Signature Date (dd/mm/yy)	Dependant 4's Signature Date (dd/mm/yy)

9. 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

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.**

4.1 Payment currency

Tick ☑ to indicate your preferred payment currency: EURO ☐ US Dollars USD ☐ Swiss Franc CHF ☐

Direct Debit facility is available for payments in Euro and CHF, but not in US Dollars (USD)

4.2 Payment frequency and method

Please tick ☑ to indicate you preferred payment frequency and method

	Annual	Half yearly	Quarterly	Monthly
Direct Debit (payments in Euro, CHF)*	☐	☐	☐	☐
Credit Card	☐	☐	☐	☐
Cheque	☐	☐	☐	not available
Bank transfer	☐	☐	☐	not available

Payment charges and details

***** 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-healthinsurance/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.

• Payment charges 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.

• Our premiums are expressed in whole numbers (i.e. without any cents or pence etc), so please note that payment frequency surcharge percentages may be slightly higher or lower than those stated.

• Cheques must be made payable to Allianz Care. The name of the policy holder and the policy number should be indicated on the back of the cheque.

• Bank transfers must include policyholder's name and policy number.

• For payment by cheque / bank transfer, please ensure that payments are received in time, to avoid possible delays to claims processing.

• Allianz Care does not accept liability for any payment which does not clearly identify the policyholder.

If Insurance Premium Tax and other government levies apply, these will be stated on your invoice/payment details letter.

Please return your fully completed form by:

Post to Assurances Indigo Expat
63 rue de Provence
75009 Paris, France

Scan and email to : moncey@moncey-assurances.com

Insurance Broker Details

ASSURANCES ET CONSEILS MONCEY

Tel: +33 (0)1 53 16 42 61

FRANCE

Credit card payment details
Individual policies Indigo Expat

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

Card type MasterCard ☐ VISA ☐

Cardholder's name _____

Card number _____ Expiry date _____

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

Credit card authorisation

I authorize 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 (dd/mm/yy) _____