Application form

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

If you are adding a new dependant, please state your existing policy number ______

1. Applicant details

Please enter the details of all persons to be covered under this contract, including the principal member and any dependants. Dependants can include your spouse/partner and any children financially dependant on the principal member 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 applicants for cover up to the day before their 70th birthday.

Principal member

You must notify us of any change of contact details so we can ensure that correspondence reaches you.

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

Other initials ______ Surname ______

Date of birth (dd/mm/yy) ______ Gender : Male ☐ Female ☐

Home country ______

Nationality ______

Country of residence ______

Complete address in country of residence (mandatory) ______

______

______

Home telephone ______ (country code) ______ (area code) ______

Office telephone ______ (country code) ______ (area code) ______

Mobile telephone ______ (country code) ______ (network code) ______

Email address (mandatory – in BLOCK CAPITALS) ______

Occupation (mandatory – please state if student) ______

Please indicate the language in which you want to receive your policy documentation: French ☐ English ☐ German ☐

Next of kin:

Name ______

Address ______

Home telephone ______ (country code) ______ (area code) ______

Mobile telephone ______ (country code) ______ (network code) ______

Email address (mandatory – in BLOCK CAPITALS) ______

Allianz Worldwide Care Limited, part of Allianz Group, is registered in Ireland and regulated by the Irish Financial Services Regulatory Authority.
Registered office 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. No.:310852.

Details of any current domestic or international health insurance:

Name of insurer ____________________

Policy number ____________________ Start date (dd/mm/yy) ____________________

The following details are only to be completed if you are applying to join an existing group scheme:

Group name ____________________

Group number ____________________

Dependant 1:

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

Other initials ____________ Surname ____________________

Date of birth (dd/mm/yy) ____________ Gender : Male ☐ Female ☐

Relationship to principal member: Spouse ☐ Child ☐

Occupation (mandatory – please state if student) ____________________

Home country ____________________

Country of residence ____________________

Nationality ____________________

Details of any current domestic or international health insurance:

Name of insurer ____________________

Policy number ____________________ Start date (dd/mm/yy) ____________________

Dependant 2:

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

Other initials ____________ Surname ____________________

Date of birth (dd/mm/yy) ____________ Gender : Male ☐ Female ☐

Relationship to principal member: Spouse ☐ Child ☐

Occupation (mandatory – please state if student) ____________________

Home country ____________________

Country of residence ____________________

Nationality ____________________

Details of any current domestic or international health insurance:

Name of insurer ____________________

Policy number ____________________ Start date (dd/mm/yy) ____________________

Dependant 3:

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

Other initials ____________ Surname ____________________

Date of birth (dd/mm/yy) ____________ Gender : Male ☐ Female ☐

Relationship to principal member: Spouse ☐ Child ☐

Occupation (mandatory – please state if student) ____________________

Home country ____________________

Country of residence ____________________

Nationality ____________________

Details of any current domestic or international health insurance:

Name of insurer ____________________

Policy number ____________________ Start date (dd/mm/yy) ____________________

Dependant 4:

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

Other initials ______________________ Surname ______________________________

Date of birth (dd/mm/yy) ______________________ Gender : Male ☐ Female ☐

Relationship to principal member: Spouse ☐ Child ☐

Occupation (mandatory – please state if student) ______________________________

Home country ______________________________

Country of residence ______________________________

Nationality ______________________________

Details of any current domestic or international health insurance:

Name of insurer ______________________________

Policy number ______________________ Start date (dd/mm/yy) ______________________

If there is not sufficient space for all dependants, please use another Application Form.

2. Policy commencement date

Please indicate the date you require cover from (dd/mm/yyyy)
(individual policies supplemental to CFE must start on the first day of the month) : ________ /________ / **2012**

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

3. Plan details

Please tick ☑ the type of plan you require : 1er €/£/$ ☐ Supplemental CFE ☐ Supplemental Ossom ☐

We have created a bundled pakcage specifically for individual clients which includes the Indigo Expat Core Plan, an Out patient plan (choice of 3) and a Dental plan. Please note that these plans are not available for sale separetly.

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).

Please note that these plans are only available to individuals who are resident in France, Benelux, Monaco or expatriated from France, Benelux, Monaco or Switzerland

Please tick ☑ the Indigo out patient plan and option(s) you require :

Core plan	Out patient plans	Dental plan	Option Maternity	Option Evacuation
Indigo ☑	Indigo 100% ☐	Indigo ☑	Maternity ☐	Evacuation & Repatriation ☐
	Indigo 90% ☐			
	Indigo 80% ☐			

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

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 tick ☑ to indicate the **area of coverage** you require:

Worldwide (including USA) ☐

Worldwide excluding USA ☐

4. 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

Please tick ☑ to indicate your preferred payment currency ☐ EURO ☐ US Dollars ☐ UK Sterling

4.2 Payment frequency and method

Please tick ☑ to indicate you preferred payment frequency and method:

	Annual	Half yearly	Quarterly	Monthly
Credit card	☐	☐	☐	☐
Cheque	☐	☐	☐	not available
Bank transfer	☐	☐	☐	not available

4.3 Credit card payment details

Please complete the credit card details on the last page of this form. For security reasons, once this information is transferred to our system, the credit card details will be detached from the Application Form and destroyed.

Payment charges and details

• 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.

• 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 Worldwide 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.

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5. Preexisting conditions.

Pre-existing conditions are medical conditions or any related conditions, for which one or more symptoms have been shown at some point during the five years prior to commencement of cover, 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 signing the Application Form and confirmation of acceptance by our Underwriting Team will equally be deemed to be pre-existing and will not be covered if not disclosed. 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.

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6. Health declaration

Please answer the following questions on the basis of your 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. The period of validity is 2 months for this health declaration.

	Principal member		Dependant 1		Dependant 2		Dependant 3		Dependant 4	
1. What is your height/weight?	______ cm ______ kg		______ cm ______ kg		______ cm ______ kg		______ cm ______ kg		______ cm ______ kg	
2. 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	______		______		______		______		______	
3. 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")*	______		______		______		______		______	
5. Have you ever suffered from, been in hospital with, or received treatment, tests or investigations for:										
a) Rheumatism, gout, arthritis, paralysis or skeletal disorder or any form of neck or back disorder?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
b) Epilepsy or other neurological disorders such as migraine, Multiple Sclerosis or nerve damage?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
c) Any digestive disorder including esophageal, stomach, liver or bowel/colon problems?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
d) Anxiety, depression, ME, psychological, psychiatric or other mental illness?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
e) Any reproductive, gynaecological or genital disorders?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
f) Any disorder of the kidneys, urinary or gall bladder, or pancreas including diabetes?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
g) Any growth, lump, cyst, mole or cancer?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
h) Any eye, ear, nose, thyroid or skin disorder such as acne, eczema or dermatitis?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
If you wear glasses or contact lenses, please state: - condition	______		______		______		______		______	
- number of dioptres for each eye	______		______		______		______		______	
i) Any heart disease or disorder, murmur, chest pain, stroke, haemorrhage, clots, blood disorder, abnormal blood pressure or high cholesterol?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
j) Asthma, bronchitis or any other respiratory condition such as rhinitis, sinusitis or allergy?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
k) Alcohol excess or misuse of drugs?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
l) Any other illness or injury requiring medical attention (excluding colds and influenza) not mentioned above?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
5. Are you currently suffering from or have you 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 are you still awaiting further investigation, tests or treatment?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
6. Are you currently taking any medication (including over the counter medication) on a regular basis?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
7. Have you ever tested positive for HIV, Hepatitis B or C or are you awaiting the results of such a test?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐

If the result is negative, having an HIV test will not, in itself, have any effect on your acceptance terms for insurance.

8. Have you been in hospital for any injury, disease or disorder which required treatment of any kind or were you off work for more than 14 days at any one time?					
9. Are you pregnant?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If so when is your due date?	dd/mm/yy	dd/mm/yy	dd/mm/yy	dd/mm/yy	dd/mm/yy
10. Have any of your parents, brothers or sisters (living or deceased) suffered before the age of 65 from diabetes, heart disease, high blood pressure or cholesterol, cancer, kidney disease, polyposis of the colon, Motor Neurone disease or other hereditary disorder such as Alzheimer's, Parkinson's, or M.S?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If Yes, please state: - Who was affected					
- Age at diagnosis					
- Condition					
11. Have you had cancer screenings or check-ups within the last 5 years?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Additional information for YES answers

If you answered "YES" to questions 4, 5, 6, 7, 8, 10 and 11 please provide details in the table below. Please advise if a full recovery has been made and if you have any condition or disease related to or arising from the original diagnosis.

Please enclose supporting medical report/results if possible.

Name	Question number	Diagnosis	Date of onset	Frequency and severity of symptoms	Date of last episod	Test results	Past/current treatment or recovery

If there is not sufficient space for your additional information, please use another Application Form.

Additional information(continued)

Please state the name, address and telephone number of your family doctor.

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

Surname ______________________________

Address ______________________________

____

____

Telephone number __________ (country code)__________ (area code) ______________________

Date of last visit (dd/mm/yy) ______________________________

Please state the date that you first became a patient of this doctor (dd/mm/yy) ______________________

7. Dental declaration

	Principal member		Dependant 1		Dependant 2		Dependant 3		Dependant 4	
a) Are you currently undergoing or been advised to undergo any treatment?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
b) Do you have missing teeth, crowns, inlays, implants, filling or bridges?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
If yes, please state type and quantity of each, including number of teeth affected by bridge (if applicable)	__________		__________		__________		__________		__________	
c) Do you suffer from parodontosis?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐

If you answered “Yes” to question a), please complete a Dental Questionnaire, which can be downloaded from our website: http://www.allianzworldwidecare.com/members?choice=en

8. Data Protection Acts – collection and use of personal information

In these statements, references to information include personal data and information given by you to us, whether in your application, any Claim Form and/or supporting documents or any information we may collect in connection with any product or service we provide. Allianz Worldwide Care, a member of the Allianz Group, is an Irish authorised non-life insurance company and shall be the data controller in respect of all such information.

Uses: Information you supply may be used for the purposes of insurance administration (including underwriting, processing, claims handling, reinsurance and fraud prevention) by us.

Sensitive data: We need to collect sensitive data relating to you (such as medical and health details) in order to assess the terms of insurance we issue/arrange or to administer claims which arise.

Retention: We will not retain your data for longer than is necessary for the purposes for which it is obtained.

Consent: By providing us with your information, you consent to all of your information being used, processed, disclosed and retained as set out above.

Representation: By your signature you warrant and represent to us that you have authority to act on behalf of your dependants in respect of all personal information you provide to us, you have the authority of your dependants to disclose this personal information for the uses listed above and you are consenting to the processing, disclosure, use and retention of your dependants information on their behalf. In these statements, all references to “you” or “your” shall be deemed to include both you and your dependants.

Access: You have the right to request and receive a copy of your personal data held by us. Should you wish to exercise this right, you should write to us under Section 4 of the Data Protection Acts 1988 and 2003, for the attention of the Data Protection Officer, at Allianz Worldwide Care, 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland, or by email to: client.services@allianzworldwidecare.com. A fee of €6.35 is chargeable under the terms of the Data Protection Acts and cheques should be made payable to Allianz Worldwide Care.

9. 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 Worldwide Care and myself, and that any false, incorrect or misleading statement may render this insurance null and void.

(b) **I undertake to inform Allianz Worldwide Care immediately in writing of any changes in my or my dependants' state of health occurring after the Application Form has been signed and before the start date of my policy**.

(c) I understand that this Application Form is valid for two months from the date of completing and signing it.

(d) I understand 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.

(e) 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.

(f) 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 authorize all such practitioners, physicians, dentists, members of medical professions, employees of hospitals and health authorities as well as medical facilities to release my medical records to Allianz Worldwide Care. I also make this statement for my co-insured dependants, including those who cannot assess the meaning of this statement.

(g) I accept that this policy will be subject to the standard policy terms and conditions effective at the time of policy commencement contained within the Benefit Guide. I confirm that I have read and understand the full definitions, benefits, exclusions and conditions of this policy including the details relating to pre-existing conditions.

(h) I hereby authorized Allianz Worldwide Care and A&C Moncey to collect administrative and medical information. I hereby authorized Allianz Worldwide Care to collect reimbursement from CFE for me and my dependants. This will allow Allianz Worldwide Care to provide me with only one reimbursement (CFE + supplemental) on my bank account.

As the principal member, I sign this declaration on behalf of all persons included in this Application Form.

Principal member's signature ____________________

Principal member's printed name ____________________

Date (jj/mm/aa) ____________________

10. Intermediary appointment

As principal member I hereby authorize (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.

As the principal member, I sign this declaration on behalf of all persons included in this Application Form.

Principal member's signature ____________________

Principal member's printed name ____________________

Date (jj/mm/aa) ____________________

Credit card payment details

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

Type of credit card ☐ MasterCard ☐ VISA

Card number ____________________

Expiry date (mm/yy) __________/__________

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 name ____________________

Cardholder's signature ____________________

Date (jj/mm/aa) ____________________

Please return your fully completed form by:

Broker

Post to EQUATUS
31, Boulevard Prince Henri
L - 1724 Luxembourg

Scan and email to info@equatus.com

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