



International cover for serious illness for the UK

# APPLICATION FORM

PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS IF YOU ARE NOT COMPLETING IT DIGITALLY

If you are adding a new dependant to an existing policy, please state your policy number:

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

Group name

Group number

## Guidelines on how to complete this Application Form

1. You must complete the Application form in full and tell us all relevant information. Once you have sent us your application, we will review any medical conditions, and get back to you with our decision as quickly as possible.
2. Section 7 must be signed by the policyholder. Section 11 must be signed by all adult applicants. In line with the European General Data Protection Regulation (GDPR) and the Data Protection Act 2018, we won't be able to process your application without these signatures. A parent or guardian should complete these sections for any applicants under the age of 18. Sections 8 and 9 need to be signed by all adult applicants or parents/guardians of minor applicants wishing to appoint either the policyholder and/or a broker as the main point of contact for this policy.

Wherever the following words and phrases appear in this form, they will have the meanings as defined below.

**Home country:** A country for which you (or your dependants, if applicable) hold a current passport or which is your principal country of residence.

**Principal country of residence:** The country where you and your dependants (if applicable) live for more than eight months of the year.

**We/us/our:** refers to Allianz Assistance as the insurer and Allianz Care as the administrator of the policy.

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

You must tell us if your contact details change so we can ensure that correspondence reaches you. We will consider applicants for cover up to the day before their 65th birthday. If the person applying as the policyholder is a baby, we will consider him/her for cover from when he/she is at least 90 days old. A parent or a legal guardian must complete and sign all sections of this form if the applicant is a minor.

Mr.  Mrs.  Ms.  Miss  Other  First name

Surname

Date of birth  /  /  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. If you are a student, please state this here)

### Details of any current domestic or international health insurance:

Name of insurer

Policy number  Start date  /  /

### If the applicant is a minor, a parent or guardian must complete the below section:

Parent/guardian's full name

Full address (if different from the applicant's details)

Phone number COUNTRY CODE  AREA CODE

Email address



## 5 PRE-EXISTING MEDICAL CONDITIONS

Pre-existing conditions are medical conditions for which one or more symptoms presented in the 10 year period up to the start date of your policy. This applies regardless of whether you or your dependants sought any medical advice or treatment, irrespective of whether any diagnosis was made. We would deem any such condition to be pre-existing if we could reasonably assume you or your dependants would have known about it.

We will also treat as pre-existing any medical conditions that arise between the date you completed the application form and the later of the following:

- The date we issue your Insurance Certificate or
- The start date of your policy

Therefore, it is important that in the periods outlined above, you inform us if there is any change to your and your dependants' health status. If they are not disclosed, they may invalidate your policy from the start date.

We will take into consideration any declared pre-existing conditions and decide the terms of acceptance for the medical cases defined in this Benefit Guide. We will only consider medical conditions that happened in the 10 year period up to the start date of your policy.

Please refer to the Benefit Guide and Table of Benefits for further details in relation to pre-existing medical conditions.

Failing to tell us about any pre-existing conditions may result in your claim being declined and/or invalidate your policy from the start date.

## 6 HEALTH DECLARATION

Please answer the following questions based on your own and your dependants' full medical history. You don't need to disclose 'minor' medical conditions such as, but not limited to, hay fever, sinusitis, ear ache, indigestion, muscle strain, sore throat, common cold, etc. We consider these to be conditions of an uncomplicated nature which can be self-treated, requiring no referral for further investigation or treatment and a complete recovery is made. **All material facts (facts likely to influence our assessment and acceptance of this application) must be disclosed. If you are in any doubt about whether a fact is material, then you should disclose it to us. Failure to disclose all material facts may invalidate the policy. This health declaration is valid for two months from the date you complete and sign the form.**

Applicant	Dependant 1	Dependant 2	Dependant 3
<p>1. Is your BMI (height/weight ratio) above 35? you can find a BMI calculator at: <a href="http://www.allianzcare.com/members">www.allianzcare.com/members</a></p>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<p>2. If tobacco of any form was used in the past year, is the average daily consumption more than 40 cigarettes? (Cigarette = 1 unit, 1 medium cigar = 2 units, 1 gram of roll-your-own tobacco = 2 units, 1 bowl of pipe tobacco = 2.5 units, E-cigarette containing 10mg of nicotine = 1 unit, if none state "No")</p>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<p>3. If alcohol is consumed, is the weekly amount of units more than 30? (short = 1 unit, 250ml beer = 1 unit, 1 glass wine = 1 unit, if none state "No")</p>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<p>4. In the last 10 years, has any person included in this application suffered from, been in hospital with, received medical advice, had symptoms, tests/ investigations or treatment of any kind (including surgery) for the following:</p>			
<p>a) Any Oncological or Pre-Cancerous disease or disorder, such as, but not limited to:</p> <ul style="list-style-type: none"> <li>a. Benign or Malignant Tumour</li> <li>b. Leukaemia</li> <li>c. Hodgkin's disease</li> <li>d. Lymphoma, Sarcoma or Melanoma, Basal cell carcinoma</li> <li>e. Abnormal cervical smear (CIN 3 or higher) or Mammogram (BIRAD's 3 or higher)</li> <li>f. Leukoplakia</li> <li>g. Dysplastic Naevus</li> <li>h. Presence of polyps in the colon, small intestine, gallbladder and/or stomach</li> <li>i. Elevated tumour markers (e.g. blood (PSA) equal to 4.0 ng / mL or higher)</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<p>b) Any Organ transplant or End stage organ disease such as, but not limited to:</p> <ul style="list-style-type: none"> <li>a. Renal Artery Stenosis</li> <li>b. Dialysis</li> <li>c. Bone Marrow Transplant</li> <li>d. Liver Cirrhosis, chronic liver failure or liver fibrosis</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

	Applicant	Dependant 1	Dependant 2	Dependant 3
c) Any Heart or Cardiovascular disease or disorder such as, but not limited to: a. Angina Pectoris b. Cardiomyopathy c. Abnormal heart rhythms or Arrhythmia d. Ischaemic heart disease e. Coronary artery disease or Heart valve abnormalities f. Diabetes Mellitus (excluding Gestational Diabetes), impaired glucose tolerance g. Uncontrolled Hypertension or uncontrolled Hypercholesterolaemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
d) Any Autoimmune disease or disorder; such as, but not limited to: a. Hyperthyroidism b. Sjögren syndrome c. Rheumatoid Arthritis d. Systemic lupus erythematosus e. Guillain-Barre syndrome f. Vasculitis/Kawasaki disease g. Inflammatory bowel disease (Crohns, Ulcerative Colitis) h. Chronic inflammatory demyelinating polyneuropathy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
e) Any Hematologic disease or disorder such as, but not limited to: a. Severe/Aplastic/Pernicious Anaemia b. Alphasthalassaemia c. Idiopathic thrombocytopenic purpura d. Von Willebrand Disease e. Myelodysplastic syndrome f. Sickle cell disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
f) Any Infectious or Viral disease or disorder, such as, but not limited to: a. Chronic hepatitis B b. Hepatitis C c. HIV/AIDS d. Meningitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
g) Any Neurological disease or disorder such as, but not limited to: a. Dementia b. Multiple sclerosis c. Epilepsy d. Parkinson's e. Alzheimer's f. Seizures g. Paraplegia h. Cerebral palsy or other developmental neurological abnormalities	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
h) Any Respiratory disease or disorder, such as, but not limited to: a. Chronic obstructive pulmonary disorder b. Interstitial lung disease c. Cystic fibrosis, Sarcoidosis d. Pulmonary hypertension e. Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
i) Any vascular or circulatory condition such as, but not limited to: a. Stroke b. Peripheral Artery Disease (PAD) c. Abdominal Aortic Aneurysm (AAA) d. Carotid Artery Disease (CAD) e. Arteriovenous Malformation (AVM) f. Critical Limb-Threatening Ischemia (CLTI) g. Pulmonary embolism (blood clots) h. Deep Vein Thrombosis (DVT) i. Chronic venous insufficiency j. Brain tumours or brain artery aneurysms k. Atherosclerosis l. Transient ischemic attack (TIA) brain haemorrhage (bleeding) m. Carotid stenosis n. Abnormal blood vessels in the neurocranium or spinal cord	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>



## 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, 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 will be the basis of the contract between Allianz Assistance and myself, and that any false, incorrect or misleading statement or non-disclosure of material medical information may make this insurance null and void.
- I undertake to inform Allianz Assistance 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 in the context of this application for insurance. I consent to allow Allianz Assistance, if it considers it appropriate, to check statements concerning my health condition and to check with other healthcare insurers all statements concerning previous or existing contracts I may have applied for.
- Subject to legal restrictions, Allianz Assistance (or its medical advisers, appointed representatives or third-party experts in case of disputes) may request medical information about me from medical professionals. In these circumstances I authorise all such practitioners, physicians, dentists, members of medical professions, and employees of hospitals, health authorities and medical facilities to provide relevant medical information as requested. 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 and waiting periods.
  - 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.
  - 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. Provided that I have not submitted a claim, I am then 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 but I enter no protest within 30 days following the issue date of the Insurance Certificate, I will be considered to have accepted the offer of cover.
  - Cover will be subject to the standard terms and conditions that apply at the start or renewal date of the policy and are set out in the Benefit Guide.
  - The cover provided by Avenue is not suitable as a substitute for local compulsory health insurance. Cover in some countries may be subject to local health insurance restrictions and it is my responsibility to ensure that my health cover is legally appropriate.
  - The cover provided by Allianz Assistance may not be suitable if my dependants and I change country of residence after our cover has started,
  - It is my responsibility to check if I am subject to any local compulsory health insurance requirements in my country of residence and I can confirm that my healthcare cover is legally appropriate.

As the applicant (or parent/legal guardian of the minor applicant), I sign and date this form for and on behalf of everyone included in this application.



Applicant's signature

Applicant's printed name

Date

## 8 POLICYHOLDER APPOINTMENT

This section must be completed by all dependants wishing to appoint the policyholder as the main point of contact.

To help us administer the policy, you can nominate the policyholder as the main contact for the insurance. To do this, simply sign below.

I authorise

INSERT NAME OF POLICYHOLDER

to act on my behalf in the administration of this policy. This may include the disclosure of sensitive medical information. This authorisation will remain in place until I ask Allianz Assistance in writing to revoke it.



Dependant 1's signature



Dependant 2's signature



Dependant 3's signature

## 9 BROKER APPOINTMENT

This section must be completed by the applicant and their dependant(s) or parents/guardians of minor applicants wishing to appoint a broker as the main point of contact.

I authorise \_\_\_\_\_ INSERT NAME OF BROKER \_\_\_\_\_

For office use only — Agent details and stamp

to act on my behalf in relation to the administration of this policy. This may include the disclosure of sensitive medical information. This authorisation will remain in place until I ask Allianz Assistance in writing to revoke it.



Applicant's signature

/  /

Dependant 1's signature

/  /

Dependant 2's signature

/  /

Dependant 3's signature

/  /

**If the applicant or any of the dependants is a minor, a parent or guardian must complete the below section:**

Parent/guardian's full name

Date of birth  /  /

Email address

I confirm that I am the parent or legal guardian of the above listed minor(s) (i.e. applicant and/or dependants under the age of 18). I am fully entitled to authorise disclosure of their medical and personal data, for the purpose of the administration of their insurance cover, to the above named insurance broker. If I change my mind regarding the above consent, including withdrawing it, I can let Allianz Assistance know by emailing [AzPUKDP@allianz.com](mailto:AzPUKDP@allianz.com)

This consent will be valid for the entire duration of the policy, until the minor reaches the age of 18. At any time from that point, he/she will have the right to change or revoke this consent.



Parent/guardian's signature \_\_\_\_\_

Date  /  /

## 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. You should read it before submitting any personal data to us. To read our Data Protection Notice, visit: [www.allianzcare.com/uk-privacy-notice](http://www.allianzcare.com/uk-privacy-notice).

Alternatively, you can contact us on 020 8603 9853 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 email at: [AzPUKDP@allianz.com](mailto:AzPUKDP@allianz.com)

## 11 DATA CONSENT

We need your consent to collect and process your health and other personal data. If you do not give explicit consent, we may not be able to provide you with your policy or process any claims you may be entitled to make. If you agree, we will process your data for the following reasons and activities.

A parent or guardian should complete the consent for any member under the age of 18.

**I (the applicant), and the dependants named below agree with the following:**

Name of applicant	Name of dependant 1	Name of dependant 2	Name of dependant 3
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

- Permission to collect, store and use my health data:** Allianz Assistance may collect, store and use my health data 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. Allianz Assistance may store my health data in accordance with the Consumer Code of the law applying to this insurance policy or with any other applicable law requiring the retention of the data.
- Permission to obtain my data from third parties.** To provide me with insurance cover, underwrite the risks to be insured or process any claims, Allianz Assistance 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. I agree to release all individuals at these institutions and Allianz Assistance from their respective confidentiality obligations relating to my health data or other data that they have to share and use for the purposes stated above.
- Sharing my data outside of Allianz Assistance.** Allianz Assistance may share my health and other data with the experts or institutions set out below. They will only use the data to the same extent and for the same purposes as Allianz Assistance. I understand that Allianz Assistance has put in place arrangements with these institutions to protect my data. I agree to release all individuals at these institutions and Allianz Assistance from their respective confidentiality obligations relating to my health data and other data that they have to share and use for the purposes set out below:
  - With independent medical experts to enable them 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 Allianz Assistance, such as risk assessments and claims handling, where:
    - these services involve the collection and use of my health and other data, and
    - Allianz Assistance would not be able to administer my policy or pay any claims due to me without such data.

- With co-insurers to distribute the coverage of the insurance risk jointly with other companies to which Allianz Assistance issues 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
  - 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 Allianz Assistance know by emailing [AzPUKDP@allianz.com](mailto:AzPUKDP@allianz.com)**



Applicant's signature

/   /

Dependant 1's signature

/   /

Dependant 2's signature

/   /

Dependant 3's signature

/   /

## 12 MARKETING PREFERENCES

I (the applicant) and my dependants agree that Allianz Assistance may collect, use and disclose my personal data to provide me with marketing information. I understand that my personal data will only be used for the following reasons and activities, which I have expressly agreed to by indicating  below.

Name of applicant	Name of dependant 1	Name of dependant 2	Name of dependant 3
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Information that Allianz Assistance sends about their products and services, including updates on their latest promotions and new products and services.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

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

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

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

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Such communications should be sent to me by the following methods:

Email	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-app notifications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 13 PAYMENT DETAILS

You don't need to complete this section if you are applying as part of a group scheme and your employer is paying the premium.

Please don't make any payments until you receive your policy number. Your premium will be annual through the duration of your cover.

### Payment currency

Please tick to indicate your preferred payment currency:

Euro	<input type="checkbox"/>
Sterling (GBP)	<input type="checkbox"/>
US Dollars	<input type="checkbox"/>

You can use direct debit for payments in euro and sterling (GBP), but not US dollars (USD)

### Payment method

Please tick to indicate your preferred payment method:

Direct Debit* (for payments in euro or sterling)	<input type="checkbox"/>
Credit card	<input type="checkbox"/>
Cheque	<input type="checkbox"/>
Bank transfer	<input type="checkbox"/>

If you choose to pay by direct debit, please complete and submit the relevant direct debit mandate, available from: [www.allianzcare.com/en/international-individual-health-insurance/paper-applications/](http://www.allianzcare.com/en/international-individual-health-insurance/paper-applications/).



## Please return your fully completed form by:

Email: [underwriting@allianzworldwidecare.com](mailto:underwriting@allianzworldwidecare.com)

Fax: +353 1 629 7117

Post: 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: 0203 5642 546.

- [www.facebook.com/AllianzCare/](https://www.facebook.com/AllianzCare/)
- [www.linkedin.com/company/allianz-care](https://www.linkedin.com/company/allianz-care)
- [www.youtube.com/c/allianzcare](https://www.youtube.com/c/allianzcare)
- [www.instagram.com/allianzcare/](https://www.instagram.com/allianzcare/)
- [twitter.com/AllianzCare](https://twitter.com/AllianzCare)

The insurer is AWP P&C SA, registered as a foreign company in England and Wales with foreign company n. FC030280. Registered office: 7 Rue Dora Maar, 93400 Saint-Ouen, France. AWP P&C SA acts through its UK branch AWP P&C UK, registered in the United Kingdom as a branch of AWP P&C SA (registered branch number: BR015275, registered office: 102 George Street, Croydon, Surrey CR9 6HD).

AWP P&C SA is authorised by L'Autorité de Contrôle Prudenciel et de Résolution in France. Deemed authorised by the Prudential Regulation Authority. Subject to regulation by the Financial Conduct Authority and limited regulation by the Prudential Regulation Authority. Details of the Temporary Permissions Regime, which allows EEA-based firms to operate in the UK for a limited period while seeking full authorisation, are available on the Financial Conduct Authority's website.

This policy is supported by AWP Health & Life SA, a limited company governed by the French Insurance Code and acting through its Irish Branch. Part of the Allianz Group, AWP Health & Life SA is registered in France: No. 401 154 679 RCS Bobigny. Irish Branch is registered in the Irish Companies Registration Office, registered No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. Allianz Care and Allianz Partners are registered business names of AWP Health & Life SA.

## CREDIT CARD PAYMENT

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

Card type    MasterCard     VISA     American Express     JCB     Diners Club     Discover

Cardholder's name

Card number     Expiry date  /  /  /

CVV code\*

\* VISA, MasterCard, Discover and Diners Club: the last three-digits on the signature panel on the back of the card.

American Express: four-digit number printed on the front of the card above the card number.

For security reasons, once we have transferred this information to our system, we will detach the credit card details from the application form and destroy them.

### Credit card authorisation

I authorise Allianz Assistance to charge my credit card account with my Avenue premium. I understand I will be notified of the premium when my cover/renewal is accepted or if I make a request that affects the premium, such as adding a dependant. This payment will continue until I cancel the instruction by giving written notice to Allianz Assistance. I understand I will be given one month's notice of any annual premium rate increase.

Cardholder's signature     Date  /  /  /