Allianz

INTERNATIONAL HEALTHCARE
PLANS FOR LEBANON

Application Form

If you choose to complete a paper version of this form, **PLEASE COMPLETE IT IN BLOCK CAPITALS.**

Quotation Reference No:

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:

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, our Medical Underwriting Team will review the details. If you have told us about any medical conditions we may ask you for more information. We will then assess the information and get back to you with our decision as quickly as possible.
2. If you already have one of our healthcare plans and you are applying for a cover upgrade or for a new plan, please tell us about any medical conditions you have claimed for since joining us.
3. Section 7 must be signed by the policyholder. Sections 8 and 11 must be signed by all adult applicants. In line with the European General Data Protection Regulation (GDPR), 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. Section 9 needs to be signed by all adult applicants wishing to appoint a broker as the main point of contact for this policy.
4. If any person applying for cover is undergoing dental treatment, please ensure a dental questionnaire is completed. You can request this by emailing us at: awc@allianzsna.com

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 six months of the year.

1 Applicant details

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 76th birthday.

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other

First name

Surname

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

Home country

Nationality

Principal country of residence

Full address in principal country of residence (mandatory)

Primary phone number COUNTRY CODE AREA CODE

Secondary phone number COUNTRY CODE AREA CODE

Email address (mandatory, please print)

Occupation (mandatory. If you are a student, please state this here)

Details of any current domestic or international health insurance documents

Name of insurer:

Policy number: Start date (dd/mm/yy): D D / M M / Y Y Y Y

In order to comply with Anti Money Laundering Legislation, please ensure you have included the following as required:

☐ Photocopy of valid identification document for you and any adult dependant named in this Application Form (e.g. photocopy of your current passport, driver's Licence or identity card).

2 Dependants to be covered under the contract

Dependants can include your spouse/partner and any children financially dependent on you up to the day before their 18th birthday, or up to the day before their 25th birthday if they are in full-time education. If they are aged 18 to 24 and in full-time education, please attach either a letter from the college/university confirming their student status or a copy of their student 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/Partner ☐ Child ☐	Spouse/Partner ☐ Child ☐	Spouse/Partner ☐ Child ☐
First name			
Surname			
Date of birth	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
Gender	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Occupation (mandatory, please state if student)			
Email address (mandatory for dependants over 18)			
Home country			
Principal country of residence			
Nationality			

Details of any current domestic or international health insurance

Name of current insurer (if applicable)			
Current policy number (if applicable)			

3 Start date of cover

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

Our acceptance of your application for cover is confirmed when we issue your Insurance Certificate and your cover is valid from the start date shown on the certificate.

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

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

Select your area of cover

The area of cover is subject to full terms and conditions as stated in the Benefit Guide.

☐ Worldwide ☐ Worldwide excluding USA

Select your Core Plan

Please select the Core Plan and any optional plans that you require for your policy. Optional plans can only be purchased with a Core Plan; they can't be bought separately. You can find all details of the plans listed below in the Table of Benefits and Benefit Guide.

☐ Allianz SNA Premier Individual ☐ Allianz SNA Classic Individual ☐ Allianz SNA Essential Individual

Select your Core Plan deductible

Please note that either a Core Plan deductible OR an Out-patient Plan deductible can be chosen (details below). Where a deductible is selected it is payable per person, per Insurance Year. Also, our premiums are expressed in whole numbers (i.e. without any cents or pence etc.), therefore, percentages may be slightly higher or lower than those stated below.

☐ No deductible ☐ US$ 610 ☐ US$ 1,015 ☐ US$ 2,025

☐ US$ 4,050 ☐ US$ 8,100 ☐ US$ 13,500

Select your optional plans
Please note that you can purchase the optional plans only in conjunction with a Core Plan.

Out-patient Plan

☐ Allianz SNA Gold Individual ☐ Allianz SNA Bronze Individual ☐ Allianz SNA Crystal Individual

Select your Out-patient Plan deductible
Please note that either an Out-patient Plan deductible OR a Core Plan deductible can be chosen. Where a deductible is selected it is payable per person, per Insurance Year.

☐ No deductible ☐ US$ 10 ☐ US$ 14 ☐ US$ 15

☐ US$ 20 ☐ US$ 25 ☐ US$ 50

Wellness Plans

☐ Allianz SNA Gold Health, Wellbeing & Optical Plan (Can be purchased with any of the Core Plans)

☐ Allianz SNA Silver Health, Wellbeing & Optical Plan (Can be purchased with any of the Core Plans)

☐ Allianz SNA Bronze Health, Wellbeing & Optical Plan (Can be purchased with any of the Core Plans)

Maternity Plan
Maternity Plans are available to couples and families i.e. a spouse/partner must also be insured on the policy.

☐ Allianz SNA Premier Maternity (Only available if you selected the Allianz SNA Premier Individual Core Plan and any Out-patient Plan)

☐ Allianz SNA Club Maternity (Only available if you selected the Allianz SNA Classic Individual Core Plan and any Out-patient Plan)

Dental Plan

☐ Allianz SNA Dental 1 (Only available if you selected the Allianz SNA Premier Individual Core Plan and the Allianz SNA Gold Individual Out-patient Plan)

☐ Allianz SNA Dental 2 (Can be purchased with any of the Core Plans)

☐ Allianz SNA Dental 3 (Can be purchased with any of the Core Plans)

Repatriation Plan

☐ Allianz SNA Repatriation Plan

5 Pre-existing medical conditions

Pre-existing conditions are medical conditions for which one or more symptoms have appeared at some point during your or your dependants' lifetime. This applies regardless of whether you or your dependants sought any medical advice or treatment.

We would deem any such condition to be pre-existing if we could reasonably assume you or your dependants have known about it. Your policy will cover pre-existing conditions unless we tell you otherwise in writing.

We will also treat as pre-existing any medical conditions that arise between the date you complete the Application Form and the later of the following:

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

Pre-existing conditions will be subject to full medical underwriting and if they are not disclosed, they will not be covered. **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 or to any material facts (facts likely to influence our assessment and acceptance of this application).** In addition, you will need to provide further information, if requested.

If you already have one of our healthcare plans and are applying for a cover upgrade or for a new policy, please tell us about any medical conditions you have claimed for since joining us.

6 Health declaration

Please answer the following questions based on your own and your dependants full medical history. **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.**

	Policyholder	Dependant 1	Dependant 2	Dependant 3
Height	☐☐☐ cm	☐☐☐ cm	☐☐☐ cm	☐☐☐ cm
Weight	☐☐☐ kg	☐☐☐ kg	☐☐☐ kg	☐☐☐ kg
Have you used any form of tobacco in the past year? If yes, how much per day on average? 1 cigarette = 1 unit, 1 medium cigar = 2 units, 1 gram roll-your-own tobacco = 2 units, 1 pipe bowl tobacco = 2.5 units, 10mg e-cigarette nicotine = 1 unit, if none state NO	Yes☐ No☐ ☐☐☐ /day	Yes☐ No☐ ☐☐☐ /day	Yes☐ No☐ ☐☐☐ /day	Yes☐ No☐ ☐☐☐ /day
Do you drink alcohol? 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"	Yes☐ No☐ ☐☐☐ /week	Yes☐ No☐ ☐☐☐ /week	Yes☐ No☐ ☐☐☐ /week	Yes☐ No☐ ☐☐☐ /week
Do you wear glasses or contact lenses? If yes, please state:	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
• Condition				
• Number of dioptres for each eye (this appears on the prescription from the optician)	☐☐☐ Right eye ☐☐☐ Left eye	☐☐☐ Right eye ☐☐☐ Left eye	☐☐☐ Right eye ☐☐☐ Left eye	☐☐☐ Right eye ☐☐☐ Left eye

1. Has any person included in this application ever suffered from, been in hospital with, or had tests, investigations or treatment of any kind, for the following conditions?

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

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

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

(d) **Any eye, ear, nose and throat disease or disorder,** such as, but not limited to, cataract, glaucoma, detached retina, hearing loss, ear infections, sinus problems, tonsillitis, adenoiditis etc. Yes☐ No☐

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

(f) **Any infectious or viral disease or disorder,** such as, but not limited to, hepatitis A/B/C, herpes, HIV, SARS-CoV-2 / COVID-19, malaria, meningitis, blood infection, sexually transmitted disease, etc. Yes☐ No☐

(g) **Any muscular or skeletal disease or disorder,** such as, but not limited to, back, neck or joint pain, arthritis, fibromyalgia, joint replacement, any cartilage and ligament problem, carpal tunnel syndrome, etc. Yes☐ No☐

(h) **Any neurological disease or disorder,** such as, but not limited to, stroke, multiple sclerosis, epilepsy, neurodegenerative disorder, paralysis, seizures, migraine, Alzheimer's or other form of dementia, etc. Yes☐ No☐

(i) **Any oncological disease or disorder,** such as, but not limited to, any cancer, leukaemia, lymphoma, tumour, skin lesion, growth, lump, cyst, mole, polyp, naevus, etc. Yes☐ No☐

(j) **Any psychiatric or psychological disorder,** such as, but not limited to, attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, depression, anxiety, chronic fatigue syndrome, eating disorder, obsessive-compulsive disorders, phobic disorders, alcohol/drug problem, etc. Yes☐ No☐

(k) **Any respiratory or lung disease or disorder,** such as, but not limited to, chronic obstructive pulmonary disorder, sarcoidosis, asthma, bronchitis, sinusitis, shortness of breath, allergy, etc. Yes☐ No☐

(l) **Any urological or reproductive organs disease or disorder,** such as, but not limited to, kidney or urinary tract problem, menstrual impairment, fertility problem, fibroids, endometriosis, testicular or prostate problem, etc. Yes☐ No☐

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

2. Please tell us whether you or your dependants:

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

(b) Are expecting to have a medical review, has been referred for further tests/investigations, or is awaiting results or any treatment due to accident, injury, disease or disorder. Yes☐ No☐

(c) Have undergone any tests or investigations within the last 10 years which resulted in referral for further medical advice or treatment, such as, but not limited to biopsy, colonoscopy, colposcopy, computed tomography (CT), mammogram, magnetic resonance imaging (MRI), Papanicolaou test (PAP), or prostate specific antigen test (PSA), echocardiogram (Echo), ultrasound (US), etc. Yes ☐ No ☐

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

(d) Within the past 2 years have you experienced any recurrent or ongoing symptoms or medical complaints NOT related to a condition already disclosed such as, but not limited to: Yes ☐ No ☐

- Fever and continuous cough (within the last 2 weeks)
- Shortness of breath
- Hoarseness
- Severe/ongoing headache
- Mole or skin marking that has bled, changed or become painful
- Tingling,
- Blurred or double vision
- Unexpected weight loss
- Bleeding per rectum, change in bowel habit or urine frequency,
- Loss of sensation, seizures, loss of consciousness
- Abnormal bleeding, etc.
- Joint pain/stiffness etc.

(e) Within the past 30 days, have you been recommended or decided to self-isolate? Yes ☐ No ☐

Please complete question 3 only if you are purchasing dental cover

3. Is any person included in this application currently undergoing or have they been advised to undergo any dental treatment, dental surgery, dental prosthesis, orthodontics or periodontics? Yes ☐ No ☐

If yes, please complete a Dental Questionnaire, which you can request by emailing to awc@allianzsna.com or obtain by calling our Helpline at +961 5 422 416.

Additional information for "Yes" answers

If you answered **Yes** to any part of the questions 1, 2 or 3 within the previous Health Declaration section, please provide details in the table below.
Please tell us if a full recovery has been made or if you or your dependants have any medical condition or disease related to or arising from the original diagnosis.

Please enclose supporting up-to-date medical reports/test results if possible.

Question number	Name of the person affected by the medical condition	Diagnosis - where applicable state the area of the body affected (e.g. left arm, right foot)	Exact date of onset of the condition	Frequency and severity of symptoms and date of last symptoms	Investigations, blood tests or readings (please include the dates, results and any diagnosis)	Past and current treatment (please include name, dosage and frequency of usage of medication and provide dates of when treatment started, how often it was required and when it ended)	Current status (e.g. any complications, complete recovery, recurrent or ongoing)

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 everyone included in this application.
Please use a separate sheet if the space provided is not sufficient.

7 Declaration

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

- I declare that all information supplied above is true and complete, 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 SNA 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 SNA 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 the fact that Allianz SNA, 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 SNA (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 by Allianz SNA, its medical advisers, its appointed representatives, or to any third party expert(s) in case of disputes, subject to any legal restrictions which may apply. I also make this statement for my dependants under the age of 18 and for dependants who cannot assess the meaning of this statement.
- I confirm that:
  - I have read and understood the full definitions, benefits, exclusions and conditions of this policy including the details relating to pre-existing conditions.
  - I have received, read and understood the Insurance Product Information Document and I accept the terms and conditions as summarised there and further explained in my Benefit Guide.
  - Based on the information provided within these documents and the plan selections that I have made, I believe the product I selected is most suited to my specific insurance needs.
- I understand that:
  - This Application Form is valid for two months from the date of completing and signing it.
  - 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.
  - My policy will be activated upon Allianz SNA receiving the full payment of my 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 policy terms and conditions that apply at the start or renewal date of policy and are set out in the Benefit Guide.
  - The cover provided by the Insurance Company may not be suitable if my dependants and I are or become resident in countries where local compulsory health insurance restrictions are in place (e.g. Switzerland).
  - It is my responsibility to check 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, I sign and date this form for and on behalf of everyone included in this application

Applicant's signature

Applicant's printed name

Date D D / M M / Y Y Y Y

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 for and 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 SNA in writing to revoke it

Dependant 1's signature

D D / M M / Y Y Y Y

Dependant 2's signature

D D / M M / Y Y Y Y

Dependant 3's signature

D D / M M / Y Y Y Y

9 Broker appointment (if applicable)

I authorise INSERT NAME OF BROKER

to act for and on 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 the Insurance Company in writing to revoke it.

For office use only — Agent details and stamp

Applicant's signature D D / M M / Y Y Y Y

Dependant 1's signature D D / M M / Y Y Y Y

Dependant 2's signature D D / M M / Y Y Y Y

Dependant 3's signature D D / M M / Y Y Y Y

10 We care about your personal data protection

Our Data Protection Notice explains how we Allianz Care, the administrators (data processors) acting on behalf of your insurer protect your privacy and process your personal data. You must read it before sending us any personal data to us. To read our Data Protection Notice, visit: **www.allianzcare.com/en/privacy**.

Alternatively, you can contact us on **+961 5 422000** (when calling from inside Lebanon) and on **+ 353 1 630 1301** (when calling from outside Lebanon) to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, you can always contact us by e-mail at: AP.EU1DataPrivacyOfficer@allianz.com.

11 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

1. **Permission to collect, store and use my health data:** The insurer may collect, store and use my health data in order to administer the policy, for example to provide me with a quote for insurance cover, underwrite the risks to be insured or process any claims. The insurer may store my health data in accordance with the Consumer Code of the law applying to this insurance policy with the insurer or any other applicable law requiring the retention of the data.
2. **Permission to obtain my data from third parties.** To provide me with insurance cover, underwrite the risks to be insured or process any claims, 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. 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 have to share and use for the purposes stated above.
3. **Sharing my data outside of the insurer.** The insurer 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 the insurer. I understand that the insurer has put in place 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 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 the insurer, such as risk assessments and claims handling, where:
        - these services involve the collection and use of my health and other data, and
        - The insurer 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 the insurer 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 the insurer know by emailing AP.EU1DataPrivacyOfficer@allianz.com

Applicant's signature D D / M M / Y Y Y Y

Dependant 1's signature D D / M M / Y Y Y Y

Dependant 2's signature D D / M M / Y Y Y Y

Dependant 3's signature D D / M M / Y Y Y Y

12 Marketing preferences

I (the applicant) and my dependants agree that the insurer 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
Information that the insurer sends about their products and services, including updates on their latest promotions and new products and services.	☐	☐	☐	☐
Information sent directly by other Allianz Group companies on their products and services. I understand that you will disclose my relevant contact information to them for that purpose.	☐	☐	☐	☐
Information sent directly by the business partners of the insurer on their products and services. I understand that you will disclose my relevant contact information to them for that purpose	☐	☐	☐	☐
Such communications should be sent to me by the following methods:				
Email	☐	☐	☐	☐
In-app notifications	☐	☐	☐	☐
Phone	☐	☐	☐	☐
Post	☐	☐	☐	☐

13 Payment details

Please don't make any payments until you receive your policy number.

Payment currency and method

Full payment of your premium should be made in US Dollars by bank transfer.

Payment frequency

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

Please tick to indicate your preferred payment frequency

	Annual	Half-yearly	Quarterly
Bank transfer	☐	☐	☐

Please return your fully completed form by:

Email: awc@allianzsna.com

Fax : +961 (05) 956 624

Post: PO BOX 16-6528 Beirut,
Lebanon,
Allianz SNA,
Allianz SNA Building,
Hazmieh,
Lebanon

If you have any questions regarding this Application Form or the application process please contact our Helpline on: +961 5 422 416.