International cover for serious illness

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), 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.

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 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:

Name of insurer

Policy number Start date D D / M M / Y Y Y Y

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

Allianz Care

2 DEPENDANTS TO BE COVERED UNDER THE CONTRACT

If the person applying as the policyholder is an adult, dependants can include:

- The spouse/partner. We will consider adult dependants for cover up to the day before their 65th birthday.
- Any children financially dependent on the adult applicant. Dependant children will be considered for cover from 90 days old up to the day before their 18th birthday, or up to the day before their 24th birthday if they are in full-time education. If they are aged 18 to 23 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.

If the person applying as the policyholder is a minor, dependants can include siblings. We accept dependant babies on cover from when they are at least 90 days old.

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 ☐ Sibling ☐	Spouse/Partner ☐ Child ☐ Sibling ☐	Spouse/Partner ☐ Child ☐ Sibling ☐
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

Please note that you can't backdate your cover.

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.

Do you have any other Allianz Critical Illness/Serious illness policy in force? Yes ☐ No ☐

If yes, please confirm the Allianz entity, policy number and level of cover/maximum benefit.

4 PLAN DETAILS (this section does not need to be completed if you are applying as part of a group scheme)

Please select your plan and refer to the Benefit Guide and Table of Benefits for details of the plans listed below. The plan you select in this section will apply to all persons included in your policy.

Avenue 1	☐
Avenue 1 Plus	☐
Avenue 2	☐
Avenue 2 Plus	☐
Avenue 3	☐
Avenue 3 Plus	☐

Waiting periods apply to all plans. Medical cases that have been diagnosed or treated during the waiting period are not covered under your Avenue Plan, unless they are a direct result of an accident that happened during the waiting period. Such accident related medical cases will be evaluated and covered after the relevant waiting periods are served.

5 PRE-EXISTING MEDICAL CONDITIONS

Pre-eixsting 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
1. Is your BMI (height/weight ratio) above 35? you can find a BMI calculator at: www.allianzcare.com/members	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
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")	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
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")	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
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:				
a) Any Oncological or Pre-Cancerous disease or disorder, such as, but not limited to: a. Benign or Malignant Tumour b. Leukaemia c. Hodgkin's disease d. Lymphoma, Sarcoma or Melanoma, Basal cell carcinoma e. Abnormal cervical smear (CIN 3 or higher) or Mammogram (BIRAD's 3 or higher) f. Leukoplakia g. Dysplastic Naevus h. Presence of polyps in the colon, small intestine, gallbladder and/or stomach i. Elevated tumour markers (e.g. blood (PSA) equal to 4.0 ng / mL or higher)	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
b) Any Organ transplant or End stage organ disease such as, but not limited to: a. Renal Artery Stenosis b. Dialysis c. Bone Marrow Transplant d. Liver Cirrhosis, chronic liver failure or liver fibrosis	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐

	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☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
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☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
e) Any Hematologic disease or disorder such as, but not limited to: a. Severe/Aplastic/Pernicious Anaemia b. Alphathalassemia c. Idiopathic thrombocytopenic purpura d. Von Willebrand Disease e. Myelodysplastic syndrome f. Sickle cell disease	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
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☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
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☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
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☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
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☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐

	Applicant	Dependant 1	Dependant 2	Dependant 3
j) Any other critical illness, disease, disorder, major complicated accident or injury, which: a. Is of a serious complex nature b. Is considered to be life-threatening c. Can lead to disability or complications	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐

5. Have any of your parents, brothers or sister ever had any of the following conditions before age 50:

a. Angina b. Heart Attack c. Bypass surgery d. Angioplasty e. Cardiomyopathy f. Stroke g. Diabetes h. Cancer (Bowel ,Colon, Breast, Ovarian or other site), Familial Polyposis of the Colon i. Polycystic Kidneys j. Multiple Sclerosis k. Huntington's Chorea l. Motor Neuron Disease m. Muscular Dystrophy n. Dementia o. Parkinson's Disease p. Any other hereditary or familial medical condition.	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐

6. Please tell us whether you or your dependants:

a) Has been recommended to have or is scheduled to have a hospital admission or surgery? (excluding for pregnancy, wisdom tooth extraction, limb fracture)	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
b) Has been referred for further tests/investigations, or is awaiting results due to any critical illness, disease, disorder, or major complicated accident and/or injury which: a. Is of a serious complex nature, b. Is considered to be life-threatening c. Can lead to disability or complications Please do NOT disclose results of any genetic (DNA or RNA) tests, as these are not required for medical underwriting	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
c) Within the past 12 month period are experiencing any signs, symptoms or medical complaints which have not yet been investigated, such as, but not limited to: a. Fever (103°F / 39.4°C or above) and continuous cough (within the last 2 weeks) b. Shortness of breath c. Severe/ongoing headache d. Mole or skin marking that has bled, changed or become painful e. Tingling/blurred or double vision f. Unexpected weight loss g. Bleeding per rectum/change in bowel habit or urine frequency h. Loss of sensation/seizures/loss of consciousness i. Abnormal bleeding	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐

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 Care 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 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.
- 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 Care, 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 Care (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 Care 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 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 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 Care 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

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

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 Care 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

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 D D / M M / Y Y Y Y

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 Care know by emailing AP.EU1DataPrivacyOfficer@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 D D / M M / Y Y Y Y

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/en/privacy.html**

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 email 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:** Allianz Care 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 Care 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.
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, Allianz Care 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 Care 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 Allianz Care.** Allianz Care 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 Care. I understand that Allianz Care has put in place arrangements with these institutions to protect my data. I agree to release all individuals at these institutions and Allianz Care 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 Care, such as risk assessments and claims handling, where:
        - these services involve the collection and use of my health and other data, and
        - Allianz Care 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 Care 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 Care know by emailing AP.EU1DataPrivacyOfficer@allianz.com

Applicant's signature	Dependant 1's signature	Dependant 2's signature	Dependant 3's signature
D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y

12 MARKETING PREFERENCES

I (the applicant) and my dependants agree that Allianz Care 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 Allianz Care 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 Allianz Care 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

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	☐
Sterling (GBP)	☐
Swiss Franc (CHF)	☐
US Dollars	☐

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

Payment method

Please tick to indicate your preferred payment method:

Direct Debit* (for payments in Euro, Sterling and Swiss Franc)	☐
Credit card	☐
Cheque	☐
Bank transfer	☐

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/.**

Please return your fully completed form by:

Email: 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: **+353 1 630 1301**

www.facebook.com/AllianzCare/
www.linkedin.com/company/allianz-care
www.youtube.com/c/allianzcare
www.instagram.com/allianzcare/
twitter.com/AllianzCare

FRM-Avenue-APP-EN-0321

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 M M / Y Y

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 Care to charge my credit card account with my healthcare 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 Care. I understand I will be given one month's notice of any annual premium rate increase.

Cardholder's signature _____ Date D D / M M / Y Y Y Y