EuroSanté Supplementary Healthcare Plans

APPLICATION form

EuroSanté applicants must be eligible for cover under the JSIS to apply. Supplementary cover for EuroSanté policyholders (and their dependants where applicable) is conditional upon continued eligibility under the JSIS.

Allianz Care

PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS

If you are adding a new dependant, please state your existing Policy Number:

Wherever the following words and phrases appear in this form, they will always have the meanings as defined below:
Home country: is a country for which the insured person holds a current passport or is their principal country of residence.
Principal country of residence: The country where you and your dependants (if applicable) live for more than 6 months of the year.

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

You must notify us of any change of contact details so we can ensure that correspondence reaches you. We will consider applicants for cover up to the day before their 68th birthday. Please note that applications must be submitted at least 6 months prior to retirement.

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), please state if student

Employment agency Start date of employment D D / M M / Y Y Y Y

Please indicate if you are a member of Union Syndicale Brussels: Yes☐ No☐ (If yes, this will be subject to validation by Union Syndicale Brussels).

Please indicate the language in which you wish to receive your policy documentation:

English☐ German☐ French☐

2 DEPENDANTS TO BE COVERED UNDER THE CONTRACT

Dependants can include your spouse/partner and any children financially dependant on the applicant up to the day before their 26th birthday. We will consider adult dependants for cover up to the day before their 68th birthday. If there is insufficient space for all dependants, please use another Application Form.

	Dependant 1	Dependant 2	Dependant 3
Relationship to applicant	Spouse ☐ Child ☐	Spouse ☐ Child ☐	Spouse ☐ 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			

3 COMMENCEMENT OF COVER

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

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

4 PLAN SELECTION

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

☐ EuroSanté Tranquillité	☐ EuroSanté Equilibre	☐ EuroSanté Optimum

5 DECLARATION

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

(a) I declare that all information supplied above is true and complete, including those answers that are not in my own handwriting. I also declare that I have not suppressed, misrepresented or misstated any material fact. I understand that this application shall be the basis of the contract between Allianz Care and myself, and that any false, incorrect or misleading statement or non disclosure of material medical information may render this insurance null and void.

(b) I undertake to inform Allianz Care immediately in writing of any changes in my or my dependants' state of health occurring between completing the Application Form and the start date of the policy.

(c) I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information and I consent to the fact that Allianz Care, if it considers it appropriate, will check statements concerning my health condition and will check with other healthcare insurers, all statements concerning previous, or existing contracts applied for. I authorise all such practitioners, physicians, dentists, members of medical professions, employees of hospitals and health authorities as well as medical facilities to provide relevant medical information relating to me, if requested by Allianz Care, its medical advisers, its appointed representatives, or to any third party expert(s) in case of disputes, subject to any legal restrictions which may apply. I also make this statement for my dependants under the age of 18 and for dependants who cannot assess the meaning of this statement.

(d) 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.

(e) I understand:

- That this Application Form is valid for two months from the date of completing and signing it.
- That I can withdraw my application in writing by letter, email or fax, within 30 days from the date I receive the full terms and conditions of my policy, and provided that I have not submitted a claim, I am entitled to a full refund of the premium.

(f) I accept that:

- 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.
- This policy will be subject to the standard policy terms and conditions effective at the time of policy commencement contained within the Benefit Guide.

(g) I accept that it is my responsibility to check whether I am subject to any local compulsory health insurance requirements and I have satisfied myself that my insurance cover is legally appropriate.

As the applicant, I sign and date this declaration and Application Form for and on behalf of all persons included in this Application Form.

Applicant's signature

Applicant's printed name

Date D D / M M / Y Y Y Y

6 WE CARE ABOUT YOUR PERSONAL DATA PROTECTION

Our Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process your personal data and should be read by you before the submission of any personal data to us. To read our Data Protection Notice visit: www.allianzworldwidecare.com/en/privacy.

Alternatively, you can contact us on + 353 1 630 1301 to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, you can always contact us by e-mail at: AP.EU1DataPrivacyOfficer@allianz.com

7 DATA CONSENT

We need your consent to collect and process your health and other data for the insurance policy that you would like to subscribe to. **If you do not provide your explicit consent for the processing of your personal data as outlined below, we will not be able to provide you with the policy that you would like to purchase or process any claims that may be owed to you.** If you agree, your data will be processed for the following reasons and activities.

A parent or guardian should complete the consent for any dependant that is under the age of 18.

☐ **I, the Applicant, Dependant 1, Dependant 2 and Dependant 3 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 my policy with the insurer or any other applicable law requiring its retention.
2. **Permission to obtain my data from third parties:** The insurer may obtain my health and other data from physicians, nursing and hospital staff, other medical institutions, care homes, statutory health insurance funds, my Plan Sponsor, professional associations and public authorities to provide me with insurance cover, underwrite the risks to be insured or process any claims. I agree to release all individuals at these institutions and the insurer from their respective confidentiality obligations relating to my health data or other data that they are required to share and use for these aforementioned stated purposes.
3. **Sharing my data outside of the insurer:** The insurer may share my health and other data with the institutions set out below for them to use to the same extent, and for the same purposes as the insurer. I understand that the insurer has put in place contractual arrangements with these institutions to protect my data. I agree to release all individuals at these institutions and the insurer from their respective confidentiality obligations relating to my health data or other data that they are required to share and use for the purposes set out below:
   - With independent medical experts if this is necessary to assess insurance risks and any benefits to be paid to me or to the third party providing treatment or service to me, under my policy.
   - With service providers outside of the Allianz Group of companies that perform certain services on behalf of the insurer, such as risk assessments and claims handling that involve the collection and use of my health and other data, without which the insurer would not be able to administer my policy or pay any claims due to me.
   - With coinsurers to distribute the coverage of the insurance risk jointly with other companies to which the insurer issue the policy, and to handle claims jointly.
   - With other insurers/reinsurers that may be covering the same insurance risk at the same time – multiple insurance – to distribute the payment of any compensation that may be owed to me, or to collaborate in the detection or prevention of fraud and financial crime.

If I change my mind about my preferences above, including withdrawing my consent to any of these items, I can let the insurer know by emailing: AP.EU1DataPrivacyOfficer@allianz.com

POLICYHOLDER APPOINTMENT

In order to assist with the administration of the policy you can nominate the policyholder as the main person of contact for the insurance. To do this, simply select "Yes" below.

I hereby authorise _____ INSERT NAME OF POLICYHOLDER

to act for and on my behalf in relation to the administration of this policy which may include the disclosure of sensitive medical information. This authorisation will remain in place until I provide a written request to Allianz Care to revoke it.

Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

INTERMEDIARY APPOINTMENT

I hereby authorise _____ INSERT NAME OF BROKER

to act for and on my behalf in relation to the administration of this policy which may include the disclosure of sensitive medical information. This authorisation will remain in place until I provide a written request to Allianz Care to revoke it.

For office use only — Agent details and stamp

Applicant's signature	Dependant 1 signature	Dependant 2 signature	Dependant 3 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

8 MARKETING PREFERENCES

☐ **I, the Applicant, Dependant 1, Dependant 2 and Dependant 3 agree that the insurer may collect, use and disclose my personal data to provide me with marketing information, and I understand that my personal data will only be processed for the following reasons and activities that 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 shall 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 shall disclose my relevant contact information to them for that purpose.

☐	☐	☐	☐

MARKETING PREFERENCES (CONTINUED)

APPLICANT	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3
Such communications should be sent to me via the following channels:			
☐ Email	☐ Email	☐ Email	☐ Email
☐ In-App Notifications	☐ In-App Notifications	☐ In-App Notifications	☐ In-App Notifications
☐ Telephone	☐ Telephone	☐ Telephone	☐ Telephone
☐ Post	☐ Post	☐ Post	☐ Post

9 PAYMENT DETAILS

No payment should be made until you have been notified of your policy number.

Payment frequency and method

Please note that the EuroSanté Tranquillité plan is only available on an annual payment basis. The EuroSanté Equilibre and EuroSanté Optimum plans are available on an annual, half-yearly or quarterly payment basis.

Please tick to indicate your preferred payment frequency and method:

	Annual	Half-yearly	Quarterly	Monthly
SEPA Direct Debit*	☐	☐	☐	☐
Credit card	☐	☐	☐	☐
Cheque	☐	☐	☐	Not available
Bank transfer	☐	☐	☐	Not available

**If you choose to pay by Direct Debit, please complete and submit the SEPA Direct Debit Mandate available from: http://www.allianzworldwidecare.com/eurosante*

PLEASE RETURN YOUR FULLY COMPLETED FORM BY:

Email to: underwriting@allianzworldwidecare.com
Fax to: + 353 1 629 7117
Post to: 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

CREDIT CARD PAYMENT

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

Card type Mastercard ☐ Visa ☐ American Express ☐

Cardholder's name

Card number — — — Expiry date M M / Y Y

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

Credit card authorisation

I authorise Allianz Care to charge my credit card account with my healthcare premium (of which I will be notified at acceptance of cover/renewal or upon a request made by me which impacts my premium, such as adding a dependant). This will continue until the instruction is cancelled, by me giving written notice to Allianz Care. I understand I will be given one month's notice of any annual premium rate increase.

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