Application Form

This plan is a top-up cover to supplement your reimbursement of **complementary medical fees for services provided** by Joint Sickness Insurance Scheme of the European Communities (JSIS) and/or any private insurance(s).

Before you start, please consider that:

- If you choose to complete a printed version of this form, PLEASE COMPLETE IT IN BLOCK CAPITALS.
- You must complete the application form for each person applying for cover/upgrading the cover in the following circumstances:
  - Since joining JSIS, you are within six months of planned retirement.
  - You wish to upgrade your cover from the Hospi Safe Sickness and/or Hospi Safe Sickness and Accident options to the Hospi Safe Plus option.
- You must complete this form in full and disclose 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.
- If you already have one of our healthcare plans, please tell us about any medical conditions you have claimed for since joining us.
- On page 8, for the 'Approvals' section:
  - The applicant and each named dependant above 18 need to sign this section.
  - All adult applicants must provide consent as detailed in Sections 8 and 12. In line with the Data Protection Regulations, we won't be able to process your application for cover without these signatures. A parent or guardian should complete these sections for any applicants under the age of 18.
  - All adult applicants wishing to appoint a broker as the main point of contact for this policy must provide consent as detailed in Section 10.

Just for clarity...

You will see that we often refer to the following phrases in this form. This is what we mean:

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 Insurance Year.

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

1 Applicant's details (The applicant will be the policyholder)

Your contact details will also be used to communicate with you on important things regarding your policy. You must tell us if your contact details change over time so we can ensure that correspondence reaches you.

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other ☐

First name

Surname

Date of birth (DD/MM/YYYY) / / Gender at birth: Male ☐ Female ☐

Home country

Nationality

Principal country of residence

Tax ID (mandatory for people residing in Spain, Italy and Portugal)

Address in principal country of residence (mandatory)

City/Town (mandatory)

Country (mandatory)

Primary phone number COUNTRY CODE AREA CODE

Secondary phone number COUNTRY CODE AREA CODE

Personal email address (mandatory, please print)

Occupation (mandatory – if you are a student, please state it)

Employment agency

Start date of employment (DD/MM/YYYY) / /

In what language do you wish to receive your policy documents?

English ☐ German ☐ French ☐

2 Your dependants' details

You can add dependants to your policy. Dependants are your spouse/partner and any children financially dependent on you up to the day before their 26th birthday.

	Dependant 1	Dependant 2	Dependant 3
Relationship to applicant	Spouse/Partner ☐ Child ☐	Spouse/Partner ☐ Child ☐	Spouse/Partner ☐ Child ☐
First name			
Surname			
Date of birth (DD/MM/YYYY)	/ /	/ /	/ /
Gender at birth	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Occupation (mandatory, please state if student)			
Personal email address (mandatory for dependants over 18)			
Home country			
Principal country of residence			
Nationality			
Current policy number (if applicable)			

3 Reason for cover

Please select the appropriate reason for cover.

Retirement ☐
(you are within six months of planned retirement. You can submit your application for medical underwriting up to the day before your retirement date)

Please specify your planned retirement date (DD/MM/YYYY): ____ / ____ / ____

Hospi Safe Plus upgrade ☐

4 Start date of your cover

For retirees, you will have confirmation that your application for cover has been accepted when we issue you the Insurance Certificate. Your cover will be valid from the start date shown on the Certificate.

For members upgrading to Hospi Safe Plus, our acceptance of your application for cover is effective from the 1st January as shown on your Insurance Certificate.

Please note that we can't backdate the cover.

5 Plan details

Select your Core Plan

Please refer to the Benefit Guide and Table of Benefits for details on the various plans listed below.

	Hospi Safe Plus Plan	Hospi Safe Sickness and Accident Plan
Policyholder	☐	☐
Dependant 1	☐	☐
Dependant 2	☐	☐
Dependant 3	☐	☐

6 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 will consider any medical condition to be pre-existing if we can determine that you or your dependants would have known about it. Your policy will cover pre-existing conditions unless we tell you otherwise in writing.

Any medical conditions that arise between the date you completed the Application Form and the later of the following we will also treat as pre-existing:

- the date we issue your Insurance Certificate, or
- the start date of your policy.

Please note that you/your dependants must provide any further information that we might request. Full and accurate completion of this Application Form and disclosure of all relevant information is a requirement for cover. You need to disclose all material facts likely to influence our assessment and acceptance of this application. Failure to do so will invalidate the policy. If there is any doubt as to whether a fact is relevant, then it must be disclosed. If any pre-existing medical conditions are not disclosed, they will not be covered.

7 Your health

Please answer the following questions based on your own and your dependants' full medical history. You must disclose all material facts (i.e. facts likely to influence our assessment and acceptance of this application). 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
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 NO	Yes ☐ No ☐ /week	Yes ☐ No ☐ /week	Yes ☐ No ☐ /week	Yes ☐ No ☐ /week

1. Does your present state of health prevent you from fulfilling your professional duties? Yes ☐ No ☐
2. Do you suffer from any pre-existing medical condition such as, but not limited to, a mental, physical or chronic disability, either from birth or as a result of a disease, disorder, accident or injury? Yes ☐ No ☐
3. Are you currently taking any prescribed medication, specialised drugs, therapy, dialysis, undergoing rehabilitation or using any artificial medical device? Yes ☐ No ☐
4. Are you under any continuing medical supervision, observation or expecting to have a medical review with a doctor, specialist or clinic? Yes ☐ No ☐
5. Within the last 10 years, have you or any of your dependants undergone any tests/investigations which resulted in referral for medical advice, any kind of surgical intervention, medical procedure or medical treatment? Yes ☐ No ☐

   Please do NOT disclose results of any genetic (DNA or RNA) tests, as these are not required for medical underwriting.
6. Within the past two years, have you experienced any recurrent or ongoing symptoms or medical complaints such as, but not limited to: Yes ☐ No ☐
   - Fever (103°F/39.4°C or above) and/or continuous cough
   - 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
   - Joint pain/stiffness
7. Are you currently receiving or have you been advised to receive any of the following treatments in the next six months? Please respond to each question below by either YES or NO. All questions must be answered.
   - Hospitalisation Yes ☐ No ☐
   - Surgical intervention Yes ☐ No ☐
   - Out-patient treatment Yes ☐ No ☐
   - Dental treatment Yes ☐ No ☐
8. Have you ever had, or are you in the process of having a 100% reimbursement from the JSIS for a medical condition? Yes ☐ No ☐
9. Do you have any other information to give us about your medical history and health status such, as but not limited to, medical tests/investigations, consultation, advice, counselling, surgical operation, medication or treatment that you had, are currently having or been advised to undergo but did not already mention in the questions above? Yes ☐ No ☐

Please complete question 10 only if you are purchasing Hospi Safe Plus.

10. 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 ☐

Additional information for 'Yes' answers

If you answered Yes to any part of the questions from 1 to 10 above, 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	Name of the person affected	Diagnosis – where applicable state the area of the body (e.g. left arm, right foot or tooth affected)	Exact date of onset of the condition	Date and frequency of last symptoms (Daily, Weekly, Monthly, Irregular)	Past and current treatment, investigations, blood tests or readings (please include name, dosage and frequency of usage of medication and provide dates of when treatment started, frequency of treatment and if it is ongoing)	Current status (e.g. any complications, complete recovery, recurrent or ongoing). Please also indicate if you continue to see a dentist for an ongoing issue, or have stopped attending recommended routine dental checkups.

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 (and dentist, where applicable) for everyone included in this application. Please use a separate sheet if the space provided is not sufficient.

8 Declaration

Please read the following declarations carefully. You will need to sign below in the '**Approvals**' section to confirm 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 and myself, and that any false, incorrect or misleading statement or non-disclosure of material information may make this insurance null and void, in accordance with the applicable legislation.
- I undertake to inform Allianz 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.
- My personal data and any medical data relating, on a case by case basis, to me or my dependants can be used for the sole purpose of the performance and the management of the contract. If the information provided is incomplete, gives rise to doubt, or the Insurer is unable to investigate thoroughly its obligation to pay the claim, the Insurer's advising medical expert is entitled to request data from the health authorities or medical practitioners as per the terms and conditions explained in the Privacy Notice.
- Subject to legal restrictions, Allianz (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.
  - I have received, read and understood the Insurance Product Information Document, the Information Leaflet and the Benefit Overview Guide and I accept the terms and conditions as summarised there.
  - 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 or email 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.
  - 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 Allianz may not be suitable if my dependants and I are or become resident in countries where local compulsory health insurance restrictions are in place.

9 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 consent to this in the '**Approvals**' section below.

The policyholder will be authorised to act on behalf of all dependents in the administration of this policy. This may include the disclosure of sensitive medical information. This authorisation will remain in place until I or any dependant on cover request from ask Allianz in writing to revoke it.

10 Broker appointment (if applicable)

By consenting below in the '**Approvals**' section. I authorise the named broker to act on my behalf of all dependants 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 in writing to revoke it.

11 Your personal data

Our Data Protection Notice explains how we protect your privacy and process your personal data. You should read it before sending us any personal data. To read our Data Protection Notice, visit: **www.allianzcare.com/en/privacy.html**

Alternatively, you can contact us on 0800 70 528 (toll-free from Belgium) or +353 1 630 1301 (outside Belgium) to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, please email us at: **AP.EU1DataPrivacyOfficer@allianz.com**

12 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

- **Permission to collect, store and use my health data.** Allianz 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 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 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 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.** Allianz 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. I understand that Allianz has put in place arrangements with these institutions to protect my data. I agree to release all individuals at these institutions and Allianz 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, such as risk assessments and claims handling, where:
    - these services involve the collection and use of my health and other data, and
    - Allianz would not be able to administer my policy or pay any claims due to me without such data.
  - With co-insurers to distribute the cover of the insurance risk jointly with other companies to which Allianz 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 know by emailing AP.EU1DataPrivacyOfficer@allianz.com.

13 Marketing preferences

I (the applicant) and my dependants agree that Allianz 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 ticking the boxes below.

	Name of applicant	Name of dependant 1	Name of dependant 2	Name of dependant 3
Information that Allianz 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 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	☐	☐	☐	☐

14 Approvals

Please indicate the section you're providing consent for.

8. Declaration**	☐
9. Policyholder appointment	☐
10. Broker appointment (if applicable)	☐
11. Your personal data**	☐
12. Data consent**	☐
13. Marketing preferences	☐

Broker name:

Signatures

The applicant and each named dependant above 18 need to sign this Application here. By signing, you are consenting to the relevant sections ticked above.

Applicant's signature	Dependant 1's signature	Dependant 2's signature	Dependant 3's signature
Date (DD/MM/YYYY)	Date (DD/MM/YYYY)	Date (DD/MM/YYYY)	Date (DD/MM/YYYY)
/ /	/ /	/ /	/ /

** Please note that we won't be able to process your application if you have not provided consent for the marked sections in the Approvals' box above.

15 Payment details

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

Please note that your premium can only be paid in Euro.

Payment frequency and method

Please tick to indicate your preferred payment frequency and method:

	Annual	Quarterly*
Direct Debit**	☐	☐
Card	☐	☐

*Quarterly payments are only available for Hospi Safe Plus.
**If you choose to pay by direct debit, please complete and submit the relevant direct debit mandate, available from:
www.allianzcare.com/en/business/insurance-partners/affinity/afiliatys-partnership/hospisafe.html

Card payment

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

Card type MasterCard ☐ VISA ☐ American Express ☐ JCB ☐ Diners Club ☐ Discover ☐

Cardholder's name

Card number Expiry date (MM/YY) /

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 card details from the application form and destroy them.

Card authorisation

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

Cardholder's signature Date (DD/MM/YYYY) / /

Please return your fully completed form by:

Email: individual.joining@e.allianz.com

Post: Allianz
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: 0800 70 528 (toll-free from Belgium) or +353 1 630 1301 (outside Belgium).

www.facebook.com/AllianzCare
www.linkedin.com/company/allianz-care
www.youtube.com/c/allianzcare
www.instagram.com/allianzcare/
x.com/AllianzCare
www.tiktok.com/@allianzcare

FRM-Affiliatys-APP-EN-0826

The Underwriter and administrator of your insurance is AWP Health & Life SA, a limited company with a capital of € 95,551,314 governed by the French Insurance Code, with its registered office at 7 Rue Dora Maar, 93400 Saint-Ouen, France. Registered in France: 401 154 679 RCS Bobigny. VAT number: FR 84 401 154 679.