Application Form for policies with moratorium

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

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

Guidelines on how to complete this Application Form

1. You must complete the Application Form in full and tell us all relevant information.
2. Section 6 must be signed by the policyholder. Sections 7 and 10 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 8 needs to be signed by all adult applicants wishing to appoint 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 six 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.

Mr.☐ Mrs.☐ Ms.☐ Miss☐ Other First name

Surname

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

Weight kg Height cm

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

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 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. We will consider adult applicants for cover up to the day before their 65th birthday If there is insufficient space for all dependants, please use another Application Form and ensure that all relevant Declaration(s) and Consent(s) are signed and dated.

	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 ☐
Height	cm	cm	cm
Weight	kg	kg	kg
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

Select your area of cover:

☐ Worldwide ☐ Worldwide excluding USA

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

Select your 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.

Select your Core Plan

	Care Pro	Care Plus	Care
Policyholder	☐	☐	☐ If you select Care, this Core Plan and any optional plans you select will apply to all persons included on your policy.
If you select Care Pro or Care Plus, you can either select the same Core Plan for all of your dependants (if any) or you can choose between Care Pro or Care Plus for each of your dependants:			
Dependant 1	☐	☐	
Dependant 2	☐	☐	
Dependant 3	☐	☐	

Select your optional plans

Out-patient Plans

Policyholder	☐ Active Pro OR ☐ Active Plus OR ☐ Active	☐ Active
Dependant 1	☐ Active Pro OR ☐ Active Plus OR ☐ Active	
Dependant 2	☐ Active Pro OR ☐ Active Plus OR ☐ Active	
Dependant 3	☐ Active Pro OR ☐ Active Plus OR ☐ Active	

Maternity Plans

Policyholder	☐ Bloom Plus OR ☐ Bloom	Our Maternity Plans are not available with the Care Core Plan.
Dependant 1	☐ Bloom Plus OR ☐ Bloom	
Dependant 2	☐ Bloom Plus OR ☐ Bloom	
Dependant 3	☐ Bloom Plus OR ☐ Bloom	

Dental Plans

If you select Smile Plus for anyone, all other applicants on your policy must select the Dental Plan available under their chosen Core Plan.

Policyholder	☐ Smile Plus	☐ Smile	☐ Smile
Dependant 1	☐ Smile Plus	☐ Smile	
Dependant 2	☐ Smile Plus	☐ Smile	
Dependant 3	☐ Smile Plus	☐ Smile	

Repatriation Plan

Policyholder	☐ Repatriation Plan	☐ Repatriation Plan
Dependant 1	☐ Repatriation Plan	
Dependant 2	☐ Repatriation Plan	
Dependant 3	☐ Repatriation Plan	

If your plan is not listed in the sections above, please state your chosen Core Plan and any supplementary plans:

Select your Core Plan deductible

To reduce your Core Plan premium, simply select an optional deductible from the list below and read across to find the relevant premium discount. The level of discount will depend on whether you have selected a Maternity Plan. Please note that either a Core Plan deductible OR an Out-patient Plan co-payment can be chosen (details follow). 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.

Optional Core Plan Deductibles	Discount if a Maternity Plan is not included on your policy	Discount if a Maternity Plan is included on your policy
☐ No deductible	0% premium discount	0% premium discount
☐ £374/€450/$610 deductible	5% premium discount	2.5% premium discount
☐ £625/€750/$1,015 deductible	10% premium discount	5% premium discount
☐ £1,245/€1,500/$2,025 deductible	20% premium discount	10% premium discount
☐ £2,490/€3,000/$4,050 deductible	35% premium discount	17.5% premium discount
☐ £4,980/€6,000/$8,100 deductible	50% premium discount	25% premium discount
☐ £8,300/€10,000/$13,500 deductible	60% premium discount	30% premium discount

Select your Out-patient Plan co-payment

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

Optional Out-patient Plan co-payments	Discount
☐ No co-payment	0% premium discount
☐ 10% co-payment, max. £1,255/€1,480/$2,000	12% premium discount
☐ 20% co-payment, max. £2,461/€2.962/$4,000	24% premium discount
☐ 30% co-payment, max. £3,076/€3,705/$5,000	35% premium discount

5 Your moratorium terms and pre-existing medical conditions

As you are applying for a policy with moratorium terms, we want to clarify the conditions and procedures that will apply to your moratorium cover. Please ensure that you read the definition below which summarises how the moratorium will work – the full terms and conditions are detailed in the Benefit Guide.

Moratorium (MORI) is a waiting period of 24 months from either your start date or the date shown in the special terms section of your Insurance Certificate that must have passed before claims for any pre-existing medical conditions may become eligible under the plan.

Your claim will not be paid if it's relating to a pre-existing medical condition, should one or more of the following have applied within the 24-month period before your start date (or the date shown in your Insurance Certificate):

- It could be reasonably foreseen that the medical condition would occur after your start date.
- The condition clearly showed itself.
- You had signs or symptoms of the condition.
- You asked for advice about the condition.
- You received treatment for the condition, or
- To the best of your knowledge, you were aware you had the condition.

Once you've completed a continuous 24-month period after your date of joining we may cover your pre-existing medical condition provided you've not had symptoms, needed or received treatment, medication, a special diet or advice, or had any other indications of the condition.

6 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 understand that this application will be the basis of the contract between Allianz Assistance and myself, and that any false, incorrect or misleading statement or non-disclosure of material information may make this insurance null and void.
- I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information in the context of this application for insurance. I consent to allow Allianz Assistance, if it considers it appropriate, to check statements concerning my health condition and to check with other healthcare insurers all statements concerning previous or existing contracts I may have applied for.
- Subject to legal restrictions, Allianz Assistance (or its medical advisers, appointed representatives or third-party experts in case of disputes) may request medical information about me from medical professionals. In these circumstances I authorise all such practitioners, physicians, dentists, members of medical professions, and employees of hospitals, health authorities and medical facilities to provide relevant medical information as requested. I also make this statement for my dependants under the age of 18 and for dependants who cannot assess the meaning of this statement.
- I confirm that:
  - I have read and understood the full definitions, benefits, exclusions and conditions of this policy, including the details relating to pre-existing conditions and moratorium terms.
  - 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 Allianz Assistance 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

7 Policyholder appointment

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

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

I authorise INSERT NAME OF POLICYHOLDER

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

Dependant 1's signature

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

8 Broker appointment (if applicable)

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 Assistance 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

9 We care about your personal data protection

Our Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process your personal data. You should read it before submitting any personal data to us. To read our Data Protection Notice, visit: **www.allianzcare.com/uk-privacy-notice**

Alternatively, you can contact us on 020 8603 9853 to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, you can always contact us by email at: **AzPUKDP@allianz.com**

10 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 Assistance may collect, store and use my health data to administer the policy, for example to provide me with a quote for insurance cover, underwrite the risks to be insured or process any claims. Allianz Assistance may store my health data in accordance with the Consumer Code of the law applying to this insurance policy or with any other applicable law requiring the retention of the data.
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 Assistance may obtain my health and other data from physicians, nursing and hospital staff, other medical institutions, care homes, statutory health insurance funds, my plan sponsor, professional associations and public authorities. I agree to release all individuals at these institutions and Allianz Assistance from their respective confidentiality obligations relating to my health data or other data that they have to share and use for the purposes stated above.
3. **Sharing my data outside of Allianz Assistance.** Allianz Assistance may share my health and other data with the experts or institutions set out below. They will only use the data to the same extent and for the same purposes as Allianz Assistance. I understand that Allianz Assistance has put in place arrangements with these institutions to protect my data. I agree to release all individuals at these institutions and Allianz Assistance from their respective confidentiality obligations relating to my health data and other data that they have to share and use for the purposes set out below:
    - With independent medical experts to enable them to assess insurance risks and any benefits to be paid to me or to the third party providing treatment or service to me under my insurance policy.
    - With service providers outside of the Allianz Group of companies that perform certain services on behalf of Allianz Assistance, such as risk assessments and claims handling, where:
        - these services involve the collection and use of my health and other data, and
        - Allianz Assistance would not be able to administer my policy or pay any claims due to me without such data.
    - With co-insurers to distribute the coverage of the insurance risk jointly with other companies to which Allianz Assistance issues the policy, and to handle claims jointly.
    - With other insurers/reinsurers that may be covering the same insurance risk at the same time (multiple insurance) to:
        - distribute the payment of any compensation that may be owed to me, or
        - collaborate in the detection or prevention of fraud and financial crime.

If I change my mind about my preferences above, including withdrawing my consent to any of these items, I can let Allianz Assistance know by emailing AzPUKDP@allianz.com

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

11 Marketing preferences

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

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

12 Payment details

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

Payment currency

Please tick to indicate your preferred payment currency:

Euro	☐
Sterling (GBP)	☐
US Dollars	☐

You can use direct debit for payments from EU accounts in Euro and Sterling (GBP), but not US dollars (USD)

Payment frequency and method

Payments are subject to the following administration surcharges: 0% for annual payment, 3% for half-yearly payments, 4% for quarterly payments and 5% for monthly payments.

Please tick to indicate your preferred payment frequency and method:

	Annual	Half-yearly	Quarterly	Monthly
Direct Debit* (For payments from EU accounts in Euro or Sterling)	☐	☐	☐	☐
Card	☐	☐	☐	☐
Bank transfer	☐	☐	☐	Not available

* 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/**

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 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 card details from the application form and destroy them.

Card authorisation

I authorise Allianz Assistance to charge my 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 Assistance. 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

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: **0203 5642 546**

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