



INTERNATIONAL HEALTHCARE PLANS FOR RUSSIA

APPLICATION FORM

PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS

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

Wherever the following words and phrases appear in this form, they will always have the meanings as defined below:

Home country: A country for which you (or your dependants, if applicable) hold a current passport or is your 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 76th birthday.

Mr. Mrs. Ms. Miss Other First name

Surname

Date of birth / / 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

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

English Russian

Details of any current domestic or international health insurance:

Name of insurer

Policy number Start date / /

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 18th birthday, or up to the day before their 24th birthday if in full-time education. Where the child is 18 years of age or older, please attach a letter from the college/university confirming student status or a copy of the student's 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	Dependant 4
Relationship to applicant	Spouse <input type="checkbox"/> Child <input type="checkbox"/>	Spouse <input type="checkbox"/> Child <input type="checkbox"/>	Spouse <input type="checkbox"/> Child <input type="checkbox"/>	Spouse <input type="checkbox"/> Child <input type="checkbox"/>
First name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Surname	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Occupation (mandatory), please state if student	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Home country	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Principal country of residence	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Nationality	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Details of any current domestic or international health insurance

Name of insurer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Policy number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

HEALTH DECLARATION (continued)

1. Has any person included in this application ever suffered from, been in hospital with, or received treatment, tests or investigations for:
- (a) Rheumatism, gout, arthritis, paralysis, muscular or skeletal disorder or any form of neck or back disorder? Yes No
 - (b) Epilepsy or other neurological disorders such as/but not limited to migraine, Multiple Sclerosis or nerve damage? Yes No
 - (c) Any digestive disorder including oesophageal, stomach, liver or bowel/colon problems? Yes No
 - (d) Anxiety, depression, ME, psychological, psychiatric or other mental illness? Yes No
 - (e) Any reproductive, gynaecological or genital disorders? Yes No
 - (f) Any disorder of the kidneys, urinary tract or gall bladder, or pancreas including diabetes? Yes No
 - (g) Any growth, lump, cyst, mole or cancer? Yes No
 - (h) Any eye, ear, nose, thyroid or skin disorder such as acne, eczema or dermatitis? Yes No
 - (i) Any heart disease or disorder, arrhythmia, murmur, chest pain, stroke, haemorrhage, clots, blood disorder, abnormal blood pressure or high cholesterol? Yes No
 - (j) Asthma, bronchitis or any other respiratory condition such as/but not limited to rhinitis, sinusitis or allergy? Yes No
 - (k) Alcohol excess or misuse of drugs? Yes No
 - (l) Any other illness or injury requiring medical attention (excluding colds and influenza) not mentioned above? Yes No

2. Has any person included in this application:
- (a) Ever tested positive for HIV, Hepatitis B or C or are they currently awaiting the results of such a test? Yes No
If the result is negative, having a HIV test will not, in itself, have any effect on your acceptance terms for insurance.
 - (b) Been in hospital for any injury, disease or disorder which required treatment of any kind, or been off work for more than 14 days at any one time? Yes No
 - (c) Undergone cancer screening or check-ups within the last five years? Yes No

3. Is any person included in this application:
- (a) Currently suffering from or been advised to seek medical advice or treatment or been referred for further tests due to accident, injury, disease or other disorder not mentioned above, or is any person included in this application still awaiting further investigation, tests or treatment? Yes No
 - (b) Currently taking any medication (including over the counter medication) on a regular basis? Yes No

4. Have any of your parents, brothers or sisters (living or deceased) suffered from diabetes, heart disease, high blood pressure or cholesterol, cancer, kidney disease, polyposis of the colon, Motor Neurone Disease or any other hereditary disorder before the age of 65 ? Yes No

If Yes, please state:

Who was affected (e.g. mother) of Applicant Dependant 1 Dependant 2 Dependant 3 Dependant 4 Other

Age at diagnosis

Condition

Who was affected (e.g. father) of Applicant Dependant 1 Dependant 2 Dependant 3 Dependant 4 Other

Age at diagnosis

Condition

Who was affected (e.g. brother) of Applicant Dependant 1 Dependant 2 Dependant 3 Dependant 4 Other

Age at diagnosis

Condition

QUESTIONS 5 AND 6 SHOULD ONLY BE COMPLETED IF YOU ARE PURCHASING DENTAL COVER

5. Is any person included in this application currently undergoing or been advised to undergo any dental treatment? Yes No

If Yes, please complete a Dental Questionnaire, which can be downloaded from our website: www.allianzworldwidecare.com/russia

6. Does any person included in this application:
- (a) Suffer from periodontitis (extensive disorder of the gum and the tooth-supporting structures) Yes No
 - (b) Have any missing teeth, crowns, inlays, implants, fillings or bridges? Yes No

If Yes, please state name of person, type and quantity of each of the above, including number of teeth affected by bridge (if applicable)?

If there is insufficient space, please use an additional Application Form

7 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 the insurer 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 the insurer 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 the insurer, 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 the insurer, 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 co-insured dependants, including those 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 14 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.
 - the cover provided 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 whether I am subject to any local compulsory health insurance requirements, to ensure that my healthcare cover is legally appropriate in my country of residence 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

8 INTERMEDIARY APPOINTMENT

As the applicant I hereby authorise

INSERT NAME OF BROKER

to act for and on behalf of all persons named in this Application Form 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 the insurer to revoke it.

For office use only — Agent details and stamp

Applicant's signature

Applicant's printed name

Date

9 PAYMENT DETAILS

This section does not need to be completed if you are applying as part of a group scheme and your employer is paying the premium.

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

Payment frequency and method

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

Please note that the payment should be made in Russian Rubles **₽**.

Please tick to indicate your preferred payment frequency:





Annual

Half-yearly

Bank transfer

PLEASE RETURN YOUR FULLY COMPLETED FORM BY:

Scan and email to: AzCareApplication@allianz.ru
Post to: LLC IC Allianz Life, 30 Ozerkovskaya nab, 115184 Moscow, Russia

 www.facebook.com/allianzworldwidecare
 plus.google.com/+allianzworldwidecare
 www.youtube.com/user/allianzworldwide
 www.linkedin.com/company/allianz-worldwide-care

The insurer is LLC Insurance Company Allianz Life (LLC IC Allianz Life). Registered No. (OGRN): 1037727041483, address: 30 Ozerkovskaya nab, 115184 Moscow, Russia, phone: +7 (495) 232-0014, www.allianz.ru. Central Bank License: No SL 3828, dated 28/09/2015.

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