

Application Form

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 in full and tell us 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 and you are applying for a cover upgrade or for a new plan, please tell us about any medical conditions you have claimed for since joining us.
- On page 12, 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 11. In line with the General Data Protection Regulations, 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.
 - All adult applicants wishing to appoint a broker as the main point of contact for this policy must provide consent as detailed in Section 9.

Are you completing this form to join an existing company policy? Please state:

Group name

Group number

If you are already included in your company policy and you want to add a new dependant, please state your policy number:

Policy number

Allianz Medical Expert (AME) - our automated underwriting tool:

We may use an automated medical underwriting tool to determine whether we can provide cover to you and if so, on what terms. This tool is used to process personal and medical information you provide us in order to calculate the cost of your International Healthcare cover. Without this information we are unable to calculate the premium for your insurance which is relevant to your needs.

We regularly assess the way our automated underwriting tool works to ensure we continue to offer a fair assessment. This assessment is based on the plans you select and on the personal and medical information you provide to us on this application.

Permission to automate the underwriting decision

By ticking this box you accept and agree that Allianz may use an automated medical underwriting tool to evaluate your personal and health data in order to make the underwriting decision on the risks to be insured. This is performed in accordance with GDPR guidelines on the processing of data using an automated underwriting tool.

Once the automated underwriting decision has been made, you have the right to request that we reconsider our decision which will involve a review by our medical underwriting team. If you wish to invoke this right please contact us at individual.joining@e.allianz.com.

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 hold a passport/ personal identification (ID), your birth country or your principal country of residence.

Principal country of residence: The country where you and your dependents (if applicable) live for more than six months of the Insurance Year.

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.

We will consider applicants for cover up to the day before their 76th birthday. Please note that it is a requirement for obtaining cover under the GlobalPass Healthcare Plans that your country of residence is in the Caribbean or Latin America (excluding Brazil, as GlobalPass Healthcare Plans are not available to applicants who are resident in Brazil).

Applicant's details

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

Full address in principal country of residence (mandatory)

Dependant 1

Dependant 2

Dependant 3

Details of any current domestic or international health insurance

Name of current insurer
(if applicable)

Current policy number
(if applicable)

3. Start date of your cover

From what date do you require cover?

Start date (DD/MM/YYYY) / /

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.

4. Plan details

This section does not need to be completed if you are applying as part of a group scheme.

Select your area of cover

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

Worldwide	Latin America and Caribbean only	Worldwide excluding USA, Hong Kong, China, Canada, Singapore, Switzerland, UK and Brazil
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Select your plan

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

GlobalPass Individual Choice 1 with Dental Plan	GlobalPass Individual Choice 1 without Dental Plan	GlobalPass Individual Connect with Dental Plan	GlobalPass Individual Connect without Dental Plan	GlobalPass Individual Choice 2
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Select your Plan deductible

Single person with max. one dependant
(deductibles apply per person, per Insurance Year)

US\$ 1,000 US\$ 2,000

US\$ 5,000 US\$ 10,000

US\$ 20,000 US\$ 50,000

Family of 3+ members
(deductibles apply per family, per Insurance Year)

US\$ 1,500 US\$ 3,000

US\$ 6,000 US\$ 9,000

US\$ 15,000 US\$ 50,000

If your plan is not listed in the sections above, please state your chosen Plan:

5. Medical Underwriting terms available

Full medical underwriting

This means we assess your health history when considering your insurance application and likely terms of cover. If you have a pre-existing condition (as defined below), you must declare this accurately, honestly and completely ensuring you answer all questions asked in the 'Your Health' section below for all applicants.

Pre-existing conditions

Pre-existing conditions are medical conditions where one or more symptoms presented 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.

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 issued 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.

6. 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?	Yes	No	Yes	No	Yes	No	Yes	No
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.	/day		/day		/day		/day	

	Applicant		Dependant 1		Dependant 2		Dependant 3	
	Yes	No	Yes	No	Yes	No	Yes	No
Do you drink alcohol?								
If Yes, how many units of alcohol do you drink per week?		/week		/week		/week		/week
1 short = 1 unit, 250ml beer = 1 unit, 1 glass wine = 1 unit. If none, state NO.								

Has any person included in this application ever suffered from, been in hospital with, or had tests, investigations or treatment of any kind, for the following conditions?

a)	Any heart or circulatory disease or disorder , such as, but not limited to, heart attack, coronary artery disease, vascular disease, irregular heartbeat, murmur, chest pain, clots, blood disorder, abnormal blood pressure or high cholesterol.	Yes	No
b)	Any dermatological disease or disorder , such as, but not limited to, psoriasis, dermatitis, eczema, allergy or acne.	Yes	No
c)	Any endocrine disease or disorder , such as, but not limited to, diabetes, pancreatitis, weight problems, gout or thyroid problems or other hormonal imbalances.	Yes	No
d)	Any eye, ear, nose and throat disease or disorder , such as, but not limited to, cataract, glaucoma, detached retina, hearing loss, ear infections, sinus problems, tonsillitis, adenoiditis or myopia with levels greater than -6.	Yes	No
e)	Any gastrointestinal disease or disorder , such as, but not limited to stomach problems, hernia, haemorrhoids, gall stones, colon polyps, Crohn's disease, colitis or liver problems.	Yes	No
f)	Any infectious or viral disease or disorder , such as, but not limited to, hepatitis A/B/C, herpes, HIV, SARS-CoV-2 / COVID-19, malaria, meningitis, blood infection or sexually transmitted disease.	Yes	No
g)	Any muscular or skeletal disease or disorder , such as, but not limited to back, neck or joint pain, arthritis, fibromyalgia, joint replacement, any cartilage and/or ligament problem or carpal tunnel syndrome.	Yes	No
h)	Any neurological disease or disorder , such as, but not limited to stroke, multiple sclerosis, epilepsy, neurodegenerative disorder, paralysis, seizures, migraine, Alzheimer's or other form of dementia.	Yes	No
i)	Any oncological disease or disorder , such as, but not limited to any cancer, leukaemia, lymphoma, tumour, skin lesion, growth, lump, cyst, mole, polyp or naevus.	Yes	No
j)	Any psychiatric or psychological disorder , such as, but not limited to attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, depression, anxiety, chronic fatigue syndrome, eating disorder, obsessive-compulsive disorders, phobic disorders or alcohol/drug problems.	Yes	No
k)	Any respiratory or lung disease or disorder , such as, but not limited to chronic obstructive pulmonary disorder, sarcoidosis, asthma, bronchitis, sinusitis, shortness of breath or allergy.	Yes	No
l)	Any urological or reproductive organs disease or disorder , such as, but not limited to kidney or urinary tract problems, menstrual impairment, fertility problems, fibroids, endometriosis, testicular or prostate problems.	Yes	No

m)	Any congenital disease or disorder present at or before birth, such as but not limited to, adrenal hyperplasia, cystic fibrosis, Down syndrome, haemophilia, heart defects, Huntington's disease, Klinefelter's syndrome, Marfan syndrome, malformations and spina bifida.	Yes	No
	Please do NOT disclose results of any genetic (DNA or RNA) tests as these are not required for the underwriting process.		
n)	Any other accident, injury, disease or disorder not already disclosed.	Yes	No

Please tell us whether you or your dependants:

o)	Are currently taking any prescribed or over-the-counter drugs, medication, tablets or other treatment.	Yes	No
p)	Are expecting to have a medical review, have been referred for further tests/investigations, or are awaiting results or any treatment due to accident, injury, disease or disorder.	Yes	No
q)	Have undergone any tests or investigations within the last 10 years which resulted in referral for further medical advice or treatment, such as, but not limited to biopsy, colonoscopy, colposcopy, computed tomography (CT), mammogram, magnetic resonance imaging (MRI), Papanicolaou test (PAP) or prostate-specific antigen test (PSA), echocardiogram (Echo) or ultrasound (US).	Yes	No
	Please do NOT disclose results of any genetic (DNA or RNA) tests, as these are not required for medical underwriting.		
r)	Have experienced, within the past two years, any recurrent or ongoing symptoms or medical complaints NOT related to a condition already disclosed such as, but not limited to: <ul style="list-style-type: none"> • 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 	Yes	No

Please complete the following question only if you are purchasing dental cover.

s)	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
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Additional information for 'Yes' answers

If you answered Yes to any part of the questions from a) to s) 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	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
Policyholder						
Dependant 1						
Dependant 2						
Dependant 3						

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.

7. 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.
- 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, 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 (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 Benefit Guide and Table of Benefits 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.
 - 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.

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 consent to this in the 'Approvals' section below.

The policyholder will be authorised to act on 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 or any dependant on cover request from Allianz in writing to revoke it.

9. Broker appointment (if applicable)

By consenting below in the 'Approvals' section, I authorise the named 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 in writing to revoke it.

10. Your personal data

Our Data Protection Notice explains how we protect your privacy and process your personal data. You must 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 + 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, please email us 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

- **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 coverage 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

12. 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.

	Applicant	Dependant 1	Dependant 2	Dependant 3
Name				
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				

13. Approvals

Please indicate the section you're providing consent for

7 Declaration**

8 Policyholder appointment

9 Broker appointment (if applicable)

Broker name

10 Your personal data**

11 Data consent**

12 Marketing preferences

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)

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** 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.

14. 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.

Payment currency

Please note that the payment should be made in US\$.

Payment frequency and method

Payments are subject to the following administration surcharges: 0% for annual payment, 4% for half-yearly payments, 6% for quarterly payments, 9% for monthly payments.

Please tick to indicate your preferred payment frequency and method:

	Annual	Half-yearly	Quartly	Monthly
Card				
Cheque				Not available
Bank wire transfer				Not available

For payment by cheque or bank wire transfer, please ensure that payments are received on, or before, your premium due date to avoid possible delays to claims processing.

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.

Signature	Date (DD/MM/YYYY)	/	/
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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: +353 1 630 1301

 www.facebook.com/AllianzCare

 www.instagram.com/allianzcare/

 www.linkedin.com/company/allianz-care

 x.com/AllianzCare

 www.youtube.com/c/allianzcare