Medical Questionnaire

A separate Medical Questionnaire is required for each person applying for cover.

1 Applicant details

Please indicate if this form is being completed for or on behalf of (please tick one):

Applicant/policyholder ☐ **Dependant** ☐

Applicant/policyholder:

Surname

First name

Full address in principal country of residence (mandatory)

Dependant to be insured (please also complete the applicant details):

Surname

First name

Date of birth D D M M Y Y

Gender: Male ☐ Female ☐

Address if different

2 Pre-existing conditions

Pre-existing conditions are medical conditions or any related conditions for which one or more symptoms have been displayed at some point during your lifetime, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition, about which you or your dependants could reasonably have been assumed to have known, will be deemed to be pre-existing. Pre-existing conditions are covered under the policy, unless otherwise advised by us in writing. Conditions arising between completing the Medical Questionnaire and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered. **Therefore, it is necessary that you advise us of any material changes to the information provided, between submission of this questionnaire and acceptance by us.** You are hereby obliged on request to provide any further information that we might require. Full and accurate completion of this Medical Questionnaire and disclosure of all relevant information is a condition precedent to cover.

3 Health Declaration

3.1 Please provide the following information:

Height (cm) Weight (kg)

3.2 Does your present state of health prevent you from fulfilling your professional duties? Yes ☐ No ☐

If Yes, please provide further details:

3.3 Do you suffer from any Mental, Physical or Chronic disability either from birth or as a result of illness or accident? Yes ☐ No ☐

If Yes, please provide further details:

3.4 Have you undergone a surgical intervention or medical treatment (**medicinal or otherwise**) in the last 10 years? Yes ☐ No ☐

If Yes, please provide further details (including date and surgery/treatment type)

3.5 Are you currently receiving or have you been advised to receive any of the following treatments in the next six months?

Treatment	Yes/No	
Hospitalisation	Yes ☐ No ☐	Please specify type:
Surgical Intervention	Yes ☐ No ☐	Please specify type:
Out-patient treatment	Yes ☐ No ☐	Please specify type:
Dental treatment	Yes ☐ No ☐	Please specify type:

3.6 Do you qualify for a 100% reimbursement from the JSIS? Yes ☐ No ☐

If yes, please specify for which medical condition

Allianz

Allianz Worldwide Care

4 Data Protection Acts – Collection and use of personal information

References to information include personal information given by you to us, in your Application or Claim Form and/or supporting documents/information we collect in connection with products or services we provide. Allianz Worldwide Care, part of the Allianz Group, is the data controller for this information.

Uses: Personal information may be used for insurance administration (e.g. underwriting, claims handling, fraud prevention). We may use third parties to process data on our behalf. Such processing, which may take place outside the European Economic Area (EEA), is subject to contractual restrictions regarding confidentiality and security in line with Data Protection obligations.

Sensitive data: We need to collect sensitive data relating to you (e.g. health details), to assess insurance terms and/or administer claims.

Disclosure: We may share your information with our agents, members of the Allianz Group, other insurers and their agents, service providers, any intermediary acting on your behalf or governing/regulatory bodies (of which we are a member or by which we are governed). In certain circumstances, we may use private investigators to investigate a claim you have submitted.

Retention: We are obliged to retain your records for six years from the date the insurance relationship ends. We will not retain your data for longer than necessary and will hold it only for the purposes for which it was obtained.

Representation and Consent: By signing this form you confirm that you have the authority to act on behalf of your dependants in respect of all personal information you provide to us, and that you consent to the disclosure, processing, usage and retention of this information in relation to yourself and on behalf of your dependants.

Access: You have the right to request and receive a copy of your personal data held by us. If you wish to do this, please write to the Data Protection Officer at the address provided on this form or via client.services@allianzworldwidecare.com.

Call recording: Calls to our Helpline will be recorded and may be monitored for training, quality and regulatory purposes.

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 Worldwide 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 Worldwide Care immediately in writing of any changes in my or my dependants' state of health occurring between completing the Medical Questionnaire 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 Worldwide 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 Worldwide 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 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 Medical Questionnaire 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 Medical Questionnaire, 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 this declaration and Medical Questionnaire for and on behalf of all persons included in this Medical Questionnaire.

Applicant's signature

Applicant's printed name

Date D D M M Y Y

Please return your fully completed form by:

Scan and email to: underwriting@allianzworldwidecare.com
Fax to: + 353 1 629 7117
Post to: Allianz Worldwide 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

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