MEDICAL QUESTIONNAIRE

Please complete this form in **BLOCK CAPITALS**.
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 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 Y Y Gender: Male ☐ Female ☐

Address if different than above

2 PRE-EXISTING 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 would deem any such condition to be pre-existing if we could reasonably assume you or your dependants have known about it. Your policy will cover pre-existing conditions unless we tell you otherwise in writing.

We will also treat as pre-existing any medical conditions that arise between the date you complete the application form and the later of the following:

- The date we issue your Insurance Certificate or
- The start date of your policy

Pre-existing conditions will be subject to full medical underwriting and if they are not disclosed, they will not be covered. **Therefore, it is important that in the periods outlined above, you inform us if there is any change to your and your dependants' health status or to any material facts (facts likely to influence our assessment and acceptance of this application).** In addition, you will need to provide further information, if requested.

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	Please specify type:
Hospitalisation	☐	☐	
Surgical Intervention	☐	☐	
Out-patient treatment	☐	☐	
Dental treatment	☐	☐	

3.6 Have you ever had, or are you in the process of having a 100% reimbursement from the JSIS for a medical condition? Yes ☐ No ☐

If yes, please specify for which medical condition

Allianz Care

4 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 and should be read by you before the submission of any personal data to us. To read our Data Protection Notice visit: https://www.allianzcare.com/en/privacy.html

Alternatively, you can contact us on + 32 2 210 6501 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 e-mail at: AWC.DataPrivacyOfficer@allianz.com

5 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 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 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.
- I undertake to inform Allianz 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.
- 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 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 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 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 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 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.
- 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.
  - the cover provided by Allianz Care 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 Medical Questionnaire for and on behalf of all persons included in this Medical Questionnaire.

Applicant's signature ______________________ Date D D / M M / Y Y Y Y

Applicant's printed name ______________________

PLEASE RETURN YOUR FULLY COMPLETED FORM BY:

Email to: underwriting@allianzworldwidecare.com
Fax to: +353 1 629 7117
Post to: Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland

If you have any questions regarding this Medical Questionnaire or the application process, please contact our Helpline on: +353 1 630 1301

AWP Health & Life SA, acting through its Irish Branch, is a limited company governed by the French Insurance Code. Registered in France: No. 401 154 679 RCS Bobigny. Irish Branch registered in the Irish Companies Registration Office, registered No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. Allianz Partners and Allianz Care are registered business names of AWP Health & Life SA.