

Group Member Declaration Form

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

Before you start, please consider that:

- 1. You must complete this form in full and tell us all relevant information.
- 2. The policyholder must sign Section 4.
- 3. All adults applicants must sign Section 7. In line with our legal obligations for processing data, we won't be able to process your application without these signatures. A parent or guardian should complete this section for any applicants under the age of 18.

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 (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.

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's policy and you want to add a new dependant, please state your policy number:

1 Applicant's details (please note that 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 continues reaching you.

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 - if you are a student, please state it)

Details of any current domestic or international health insurance:

Name of insurer

Policy number Start date / /

2 Your dependant's details

You can add dependants to your policy. 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 26th birthday if they are in full-time education. If they are aged 18 to 25 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. If there is insufficient space for all dependants, please use another Declaration Form and ensure that all relevant declaration(s) and consent(s) sections are signed and dated.

	Dependant 1	Dependant 2	Dependant 3
Relationship to applicant	Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/>	Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/>	Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/>
First name			
Surname			
Date of birth	<input type="text" value="D D"/> / <input type="text" value="M M"/> / <input type="text" value="Y Y Y Y"/>	<input type="text" value="D D"/> / <input type="text" value="M M"/> / <input type="text" value="Y Y Y Y"/>	<input type="text" value="D D"/> / <input type="text" value="M M"/> / <input type="text" value="Y Y Y Y"/>
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"/>
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 Your health

- a) Have you or any of your dependants ever had a past history of cancer (including benign brain tumours), a heart condition or stroke, joint replacement, psychiatric or mental illness? Yes No
- b) In the last 12 months, have you or any of your dependants had any signs or symptoms that may require a visit to a medical professional or are you or any of your dependants awaiting any reviews, treatment or investigation for any current or past medical problems? Yes No
- c) Do you or any of your dependants have any long-term, ongoing or chronic condition for which you have regular appointments or need a review or treatment for? Yes No
- d) If the plan includes maternity cover, are you or any of your dependants currently pregnant? Yes No
- e) In the last two years, have you or any of your dependants on this application had any other problems or concerns about their health which are not dealt with in questions a) to d) above? Yes No

Additional information for 'Yes' answers

If you answered Yes to any of the questions from a) to e) 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.

Name of the person and question being answered	Person's weight and height	Does this person smoke?	Symptom and/or medical condition, including the date it started.	What treatment, medication or special diet have you been given? Please include dates and specify names of drugs and dosage.	What follow-up consultation, medical investigations, diagnostic tests or procedures are needed or have been recommended?	Do you still have this medical condition or symptom?	What date did you last see any health care professional for this medical condition or symptom?
Name: Question:	<input type="text" value=""/> kg <input type="text" value=""/> cm	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text" value="D D"/> / <input type="text" value="M M"/> / <input type="text" value="Y Y Y Y"/>				<input type="text" value="D D"/> / <input type="text" value="M M"/> / <input type="text" value="Y Y Y Y"/>

5 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 Global Corporate & Specialty SE, Hong Kong Branch in writing to revoke it.



Dependant 1's signature

DD / MM / YYYY



Dependant 2's signature

DD / MM / YYYY



Dependant 3's signature

DD / MM / YYYY

6 Your personal data

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.agcs.allianz.com/footer/privacy-notice.html

Alternatively, you can contact us on +852 3077 5486 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: AP.EU1DataPrivacyOfficer@allianz.com

7 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 Global Corporate & Specialty SE, Hong Kong Branch 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 Global Corporate & Specialty SE, Hong Kong Branch 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 Global Corporate & Specialty SE, Hong Kong Branch 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 Global Corporate & Specialty SE, Hong Kong Branch 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.** Allianz Global Corporate & Specialty SE, Hong Kong Branch 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 Global Corporate & Specialty SE, Hong Kong Branch. I understand that Allianz Global Corporate & Specialty SE, Hong Kong Branch has put in place arrangements with these institutions to protect my data. I agree to release all individuals at these institutions and Allianz Global Corporate & Specialty SE, Hong Kong Branch 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 Global Corporate & Specialty SE, Hong Kong Branch, such as risk assessments and claims handling, where:
 - these services involve the collection and use of my health and other data, and
 - Allianz Global Corporate & Specialty SE, Hong Kong Branch 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 Global Corporate & Specialty SE, Hong Kong Branch 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 Global Corporate & Specialty SE, Hong Kong Branch know by emailing AP.EU1DataPrivacyOfficer@allianz.com



Applicant's signature

DD / MM / YYYY



Dependant 1's signature

DD / MM / YYYY



Dependant 2's signature

DD / MM / YYYY



Dependant 3's signature

DD / MM / YYYY

8 Marketing preferences

I (the applicant) and my dependants agree that Allianz Global Corporate & Specialty SE, Hong Kong Branch 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.

Name of applicant	Name of dependant 1	Name of dependant 2	Name of dependant 3

Information that Allianz Global Corporate & Specialty SE, Hong Kong Branch sends about their products and services, including updates on their latest promotions and new products and services.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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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.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Information sent directly by the business partners of Allianz Global Corporate & Specialty SE, Hong Kong Branch on their products and services. I understand that you will disclose my relevant contact information to them for that purpose.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Such communications should be sent to me by the following methods:

Email	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-app notifications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please return your fully completed form by:

@ Email: underwriting@e.allianz.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 Group Member Declaration Form or the application process, please contact our Helpline on: + 852 3077 5486 (toll-free when calling from Hong Kong) or +353 1 630 1301 (international number to call from outside Hong Kong)

For our list of toll-free numbers to call from other countries, please visit:
www.allianzcare.com/toll-free-numbers

The insurer is Allianz Global Corporate & Specialty SE (incorporated in the Federal Republic of Germany with limited liabilities), Hong Kong Branch, address Suites 403-11, 4/F, 12 Tai Koo Wan Road, Tai Koo Shing Island East Hong Kong, Hong Kong. Company Registration No. F18771.

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