Assuria VERZEKERINGEN

APPLICATION FORM AZPAS INSURANCE

PARTICULARS POLICYHOLDER: (Applicant and premium payer)

Last name :

First names (in full) :

Date of birth : Sex: ❑ M ❑ F

ID-card / passport number : *(Compulsory to attach copy)*

Mobile number *(compulsory)*:

E-mailadress :

Correspondence address :

Bank / Account No :

PERSON TO BE INSURED:

Last name :

First names (in full) :

Date of birth : Sex: ❑M ❑F

Adress : Place of residence

ID-card / passport number : *(Compulsory to attach copy)*

Telephone numbers :

Mobile number *(compulsory)* :

E-mailadress :

Relationship to policyholder:

Name of the mother *(for newborn)*:

Date of birth of the mother :

Relationnumber of the mother :

Whom do you prefer to be the family doctor if you are AZPAS-insured? Name: Address clinic:

*Who is your current or most recent family doctor? Name: Address clinic:

***Note:**
The family doctor is the doctor who knows which conditions you have and from whom medical information may be retrieved by Assuria Medische Verzekering N.V.

PRODUCTINFORMATION

❑ **AZPAS BASIC**	❑ **SRD**	❑ **USD**
❑ **AZPAS PLUS**	❑ **SRD**	❑ **USD**
❑ **AZPAS SUPRÊME**	❑ **SRD**	❑ **USD**

Choose additional coverage(s):

❑ Silver Medicines Assortment
❑ Gold Medicines Assortment
❑ Second Medical Opinion

Select the hospital coverage

❑ 1st class

❑ 2nd class

❑ 3rd class

** For children up to 12 years old the children's class applies is equal to the 3rd class*

Select premium payment

❑ per month

❑ per 3 months

❑ per 6 months

❑ per year

Select desired date of inception of the insurance:

(The insurance can only become effective after acceptance by Assuria)

Questions as regards the person to be insured

Nr	Fill in/Tick where appropriate	Yes	No
1	Length in cm: Weight in kg: Date of measuring:		
2	Do you exercise regularly? How many hours a week?		
3	Have you ever been diagnosed or treated for: (if multiple conditions are listed with 1 answer, **circle** which applies to you)		
	Cataract (stare, lens clouding)		
	Glaucoma (increased eye pressure)		
	Ear complaints		
	Asthma		
	Heart disease		
	High blood pressure		
	Increased cholesterol level		
	Diabetes		
	Do you use insulin?		
	"Low Sahli" (anaemia)		
	Increased bleeding tendency or trombosis?		
	Sickle cells		
	Thyroid gland disorder / another hormone disease		
	Epilepsy		
	Rheumatism, gout		
	Degeneration of the joints		
	Stroke (CVA, TIA), paralysis		
	Prostate, uterus, fallopain tubes or genitals		
	Skin complaints ❑ Eczema ❑ Psoriasis ❑ Other, namely		
	Cancer or tumours If so, what type / body part?		
	Congenital defects If so, which one?		
	Other diseases or disorders? If so, which one?		
	HIV		
	Alcohol- or drug use		
	Kidney function disorders		
	Are you being dialyzed?		
	Are you being treated to prevent or postpone kidney dialysis?		

Nr	Fill in/Tick where appropriate	Yes	No
	Do you suffer from an illness or are you currently under medical treatment for another illnes which not mentioned before? Which disease?		
4	Do you smoke? If so, how many cigarettes or rolling tobacco per day? ❑ Less than 10 ❑ 10 or more		
5	Do you drink alcoholic beverages? If so, how many glasses per month: ❑ Less than 25 ❑ 25 or more		
6	Do you use drugs? If so, which?		
7	Do you use medicines? If so, which? How often? per day / week / month Since when? Who prescribes these?		
8	Have you had surgery in the past 5 years? Name specialist and hospital Have you been hospitalized in the past 5 years for anything other than surgery? Reason for hospitalization? In which year? Do you still have complaints thereof? Who do you consult for these complaints?		
9	Are you now in a hospital or is there an admission in prospect? If so, why? Within how many days/ weeks/ months?		
10	Have you visited a medical specialist in the past 5 years? Reason of treatment? Are you still being treated?		
11	**For women:** Are you pregnant?		

Statement of Consent

Name: *(name of the person to be insured)* ..... Firstname(s): *(name of the person to be insured)* ..... Adress: *(adress of the person to be insured)* ..... Product type: *(requested product type)* …….....…	Date of birth: *(date of birth of the person to be insured)* ..... Place of birth: *(place of birth of the person to be insured)* ..... Place of residence: *(place of residence of the person to be insured)* .....

This statement/authorization is an integral part of the application form and health declaration of the prospective insured person.

- I hereby declare that I have provided the following information to Assuria Medische verzekering N.V. (hereinafter referred to as: Assuria) for the application of an insurance:
- I have answered all questions on the application form and health declaration truthfully and to the best of my knowledge.
- I have not withheld any information or circumstances that may be relevant to Assuria for the conclusion of the insurance contract.
- I am aware that any concealment and/or incorrect answers to the aforementioned application form and health declaration may lead to the i invalidation of the insurance contract. In the event of invalidation of the insurance contract, the premiums already paid will not be refunded.
- I am aware that Assuria may request an additional medical examination if necessary. This is dependent on the medical information already obtained. I hereby agree to an additional medical examination.
- I hereby authorize the Medical Advisors of Assuria to request my personal medical information from all physicians, hospitals, clinics, or any other medical institution that has treated me or will treat me in the future. The medical information may include documentation about my health status or the cause of my death.

This authorization remains in effect until Assuria terminates this insurance.

Place and date,

Signature of the person to be insured
(in case of a minor, the signature of the parents or guardian)

Place and date,

Signature of the policyholder (if other than person to be insured)

SMS/E-MAIL SERVICES

Tick that which applies to you:

❑ Yes, I give Assuria N.V. permission to send information about insurance policies and promotions via SMS/e-mail free of charge.
❑ No, I do not give Assuria N.V. permission to send information about insurance policies and promotions via SMS/e-mail free of charge.

TIPS AND INFORMATION

- ✓ Please check that you have filled in, circled or explained everything where necessary. If the form has not been filled out completely and signed, unfortunately your application cannot be processed.
- ✓ The Application is taken into consideration by Assuria Medische Verzekering N.V. if received within one month of signing.
- ✓ The duration of processing an application may be influenced, if:
  - Assuria Medische Verzekering N.V. deems necessary an extra exam / lab investigation of the prospective insured.
  - Medical information is necessary of a family doctor or specialist who in the past treated / currently treats the prospective insured.
- ✓ Go through the **policy conditions** thoroughly and if necessary ask for any further explanation, so that if you use your Azpas card in the future, you know what your rights and obligations are.

Name agent:

IP number agent: