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:

PRODUCTINFORMATION

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

Choose additional coverage(s):
❑ Optical Care Extra
❑ Optical Care Extra $^{+}$
❑ Optical Care Extra $^{++}$
❑ Azpas Medicines Index Gold

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?		

***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.

If during the application procedure your health condition changes, you are obliged to report this to Assuria Medische Verzekering N.V. Non-compliance with this obligation may lead to nullification of the insurance.

Undersigned declares to have truthfully answered all questions and undertakes to accept the policy to be drawn up in pursuance of this application at payment of the premium and costs due. The applicant is aware that the insurance only becomes effective after the acceptance by the company. Article 320 of the Commercial Code**.

The undersigned herewith authorizes all physicians that have treated or will treat him/her to provide the information about his/her health situation to Assuria Medische Verzekering N.V. if so requested.

Place: Date:

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

Place: Date:

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

** Article 320 of the Commercial Code reads: any wrong or false statement or any concealment of circumstances that are known to the insured (read policyholder), no matter whether this was done in good faith, which is of such nature that the agreement would not have been entered into or not on the same conditions had the insurer known about the true state of affairs, shall render void the insurance.

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.
- ✓ Application is taken into consideration by Assuria Medische Verzekering 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: