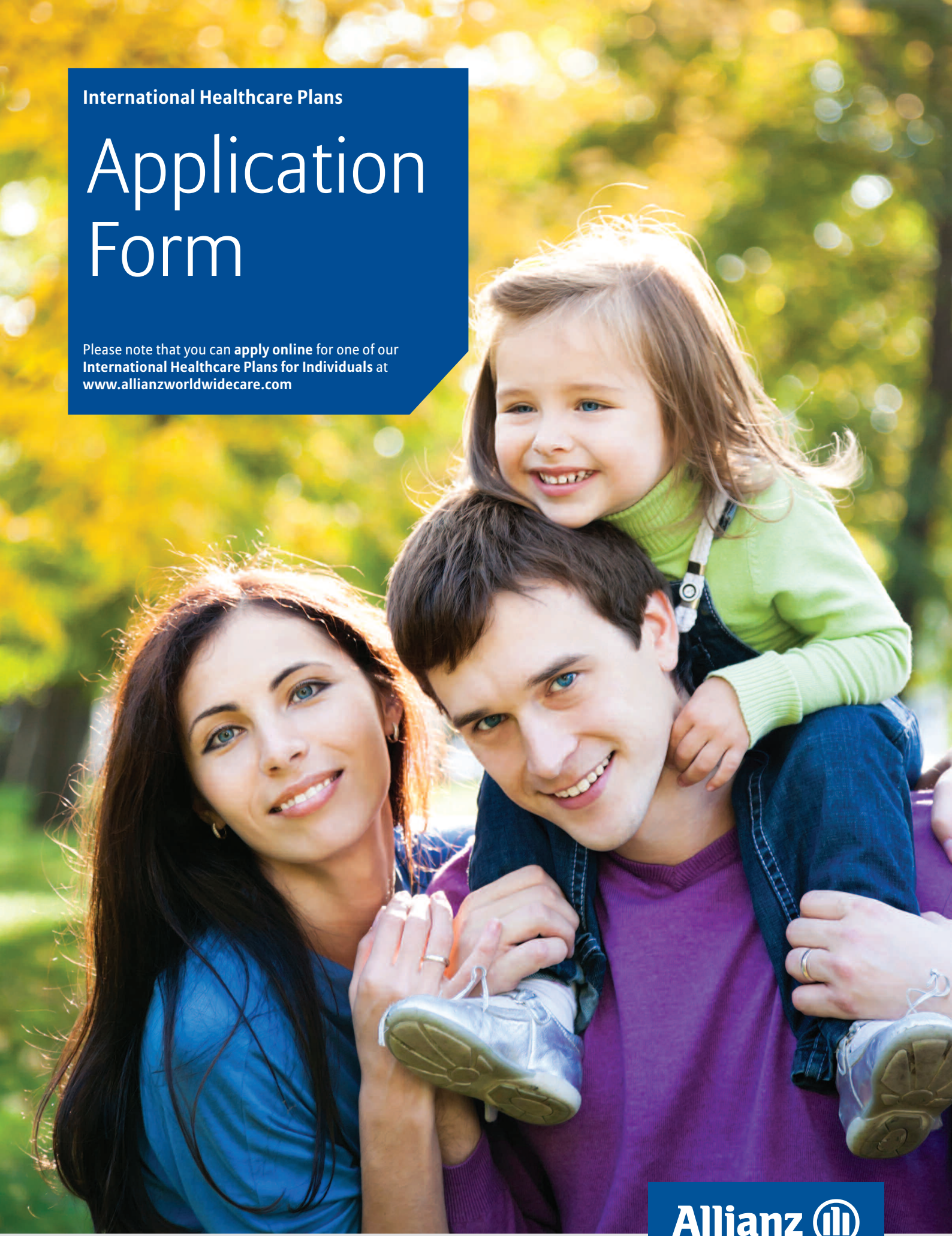

International Healthcare Plans

Application Form

Please note that you can **apply online** for one of our **International Healthcare Plans for Individuals** at **www.allianzworldwidecare.com**

Allianz

Allianz Worldwide Care

PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS

If you are adding a new dependant, please state your existing Policy Number:

If you are applying to join an existing group scheme, please state:

Group name

Group number

Wherever the following words and phrases appear in this form, they will always have the meanings as defined below:
Home country: A country for which you (or your dependants, if applicable) hold a current passport and/or to which you would want to be repatriated.
Principal country of residence: The country where you and your dependants (if applicable) live for more than 6 months of the year.

1 Applicant details *(Please note that the applicant will be the policyholder)*

You must notify us of any change of contact details so we can ensure that correspondence reaches you. We will consider applicants for cover up to the day before their 76th birthday.

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other First name

Surname

Date of birth D D M M Y Y 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), please state if student

Please indicate the language in which you wish to receive your policy documentation:

English ☐ German ☐ French ☐ Spanish ☐ Italian ☐ Portuguese ☐

Details of any current domestic or international health insurance:

Name of insurer

Policy number Start date D D M M Y Y

2 Dependants to be covered under the contract

Dependants can include your spouse/partner and any children financially dependant on the applicant up to the day before their 18th birthday, or up to the day before their 24th birthday if in full-time education. Where the child is 18 years of age or older, please attach a letter from the college/university confirming student status or a copy of the student's ID. We will consider adult dependants for cover up to the day before their 76th birthday. If there is insufficient space for all dependants, please use another Application Form.

	Dependant 1	Dependant 2	Dependant 3
Relationship to applicant	Spouse ☐ Child ☐	Spouse ☐ Child ☐	Spouse ☐ Child ☐
First name			
Surname			
Date of birth	D D / M M / Y Y	D D / M M / Y Y	D D / M M / Y Y
Gender	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Occupation (mandatory), please state if student			
Home country			
Principal country of residence			
Nationality			

Details of any current domestic or international health insurance

Name of insurer			
Policy number			

3 Commencement of cover

Please indicate the date you require cover from: D D M M Y Y

Cover is conditional upon acceptance of your application, which is only confirmed when an Insurance Certificate is issued to you.

4 Plan details *(This section does not need to be completed if you are applying as part of a group scheme)*

Please note that each plan chosen will apply to all policy members.

1 Select your Area of Cover

☐ Worldwide ☐ Worldwide excluding USA ☐ Africa

2 Select your Core Plan

☐ Premier Individual ☐ Classic Individual

☐ Club Individual ☐ Essential Individual

3 Select your Core Plan deductible *(Please note that either a Core Plan deductible OR an Out-patient Plan deductible can be chosen. The deductible option selected will apply to each policy member, per Insurance Year. Core Plan deductibles are not available to members applying as part of a group scheme.)*

☐ No deductible ☐ €3,000/£2,490/CHF3,900/$4,050

☐ €450/£374/CHF585/$610 ☐ €6,000/£4,980/CHF7,800/$8,100

☐ €750/£625/CHF975/$1,015 ☐ €10,000/£8,300/CHF13,000/$13,500

☐ €1,500/£1,245/CHF1,950/$2,025

4 Select your Optional Plans *(Please note that Optional Plans can only be purchased in conjunction with a Core Plan.)*

Out-patient Plan

☐ Gold Individual ☐ Silver Individual ☐ Bronze Individual ☐ Crystal Individual

Select your Out-patient Plan deductible *(Please note that either an Out-Patient Plan deductible OR a Core Plan deductible can be chosen. The deductible option selected will apply to each policy member, per Insurance Year.)*

☐ No deductible ☐ €100/£83/CHF130/$135 ☐ €200/£165/CHF260/$270

Maternity Plan *(Maternity Plans are available to couples and families i.e. a spouse/partner must also be insured on the policy.)*

☐ Premier Maternity
(Only available if you selected the Premier Individual Core Plan and any Out-patient Plan)

☐ Club Maternity
(Only available if you selected the Club Individual Core Plan and any Out-patient Plan)

Dental Plan

☐ Dental 1
(Only available if you selected the Premier Individual Core Plan and the Gold Individual Out-patient Plan)

☐ Dental 2

☐ **Repatriation Plan**

If your plan is not listed in the sections above, please state your chosen Core Plan and any supplementary plans:

5 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 Application Form 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 application 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 Application Form and disclosure of all relevant information is a condition precedent to cover.

6 Health Declaration

Please answer the following questions on the basis of your own and your dependant's (if applicable) complete medical past. **All material facts (facts likely to influence our assessment and acceptance of this application) must be disclosed.** Failure to do so may invalidate the policy. **If you are in any doubt as to whether a fact is material, then it should be disclosed. This Health Declaration is valid for two months from the date of completion and the form being signed by the applicant.**

	Applicant	Dependant 1	Dependant 2	Dependant 3
Height	_____ cm	_____ cm	_____ cm	_____ cm
Weight	_____ kg	_____ kg	_____ kg	_____ kg
Have you consumed any form of tobacco in the past year? *If Yes, please state amount per day*	Yes ☐ No ☐ _____ /day	Yes ☐ No ☐ _____ /day	Yes ☐ No ☐ _____ /day	Yes ☐ No ☐ _____ /day
How many units of alcohol do you drink per week? *(1 short = 1 unit, 250ml beer = 1 unit, 1 glass wine = 1 unit, if none state "zero")*	_____ /week	_____ /week	_____ /week	_____ /week
Do you wear glasses or contact lenses? *If Yes, please state:* • Condition • Number of dioptres for each eye *(This appears on the prescription from the optician)*	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Health Declaration (continued)

1. **Has any person included in this application ever suffered from, been in hospital with, or received treatment, tests or investigations for:**
   - (a) Rheumatism, gout, arthritis, paralysis, muscular or skeletal disorder or any form of neck or back disorder? Yes ☐ No ☐
   - (b) Epilepsy or other neurological disorders such as migraine, Multiple Sclerosis or nerve damage? Yes ☐ No ☐
   - (c) Any digestive disorder including oesophageal, stomach, liver or bowel/colon problems? Yes ☐ No ☐
   - (d) Anxiety, depression, ME, psychological, psychiatric or other mental illness? Yes ☐ No ☐
   - (e) Any reproductive, gynaecological or genital disorders? Yes ☐ No ☐
   - (f) Any disorder of the kidneys, urinary or gall bladder, or pancreas including diabetes? Yes ☐ No ☐
   - (g) Any growth, lump, cyst, mole or cancer? Yes ☐ No ☐
   - (h) Any eye, ear, nose, thyroid or skin disorder such as acne, eczema or dermatitis? Yes ☐ No ☐
   - (i) Any heart disease or disorder, murmur, chest pain, stroke, haemorrhage, clots, blood disorder, abnormal blood pressure or high cholesterol? Yes ☐ No ☐
   - (j) Asthma, bronchitis or any other respiratory condition such as rhinitis, sinusitis or allergy? Yes ☐ No ☐
   - (k) Alcohol excess or misuse of drugs? Yes ☐ No ☐
   - (l) Any other illness or injury requiring medical attention (excluding colds and influenza) not mentioned above? Yes ☐ No ☐

2. **Has any person included in this application:**
   - (a) Ever tested positive for HIV, Hepatitis B or C or are they currently awaiting the results of such a test? Yes ☐ No ☐
     If the result is negative, having an HIV test will not, in itself, have any effect on your acceptance terms for insurance.
   - (b) Been in hospital for any injury, disease or disorder which required treatment of any kind, or been off work for more than 14 days at any one time? Yes ☐ No ☐
   - (c) Undergone cancer screening or check-ups within the last five years? Yes ☐ No ☐

3. **Is any person included in this application:**
   - (a) Currently suffering from or been advised to seek medical advice or treatment or been referred for further tests due to accident, injury, disease or other disorder not mentioned above, or is any person included in this application still awaiting further investigation, tests or treatment? Yes ☐ No ☐
   - (b) Currently taking any medication (including over the counter medication) on a regular basis? Yes ☐ No ☐

4. **Have any of your parents, brothers or sisters (living or deceased) suffered from diabetes, heart disease, high blood pressure or cholesterol, cancer, kidney disease, polyposis of the colon, Motor Neurone Disease or any other hereditary disorder before the age of 65?** Yes ☐ No ☐

   If Yes, please state:

   Who was affected *(e.g. mother)* _____ of

   ☐ Applicant ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 Other _____

   Age at diagnosis _____ Condition _____

   Who was affected *(e.g. father)* _____ of

   ☐ Applicant ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 Other _____

   Age at diagnosis _____ Condition _____

   Who was affected *(e.g. brother)* _____ of

   ☐ Applicant ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 Other _____

   Age at diagnosis _____ Condition _____

   If there is insufficient space, please use an additional Application Form

5. **Is any person included in this application, currently pregnant?** Yes ☐ No ☐

   If Yes, please state:

   The name of the person who is pregnant _____

   Your/their due date D D M M Y Y

Questions 6 and 7 should only be completed if you are purchasing dental cover.

6. **Is any person included in this application currently undergoing or been advised to undergo any dental treatment?** Yes ☐ No ☐

   If Yes, please complete a Dental Questionnaire, which can be downloaded from our website: **www.allianzworldwidecare.com/members**

7. **Does any person included in this application:**
   - (a) Suffer from parodontosis? Yes ☐ No ☐
   - (b) Have any missing teeth, crowns, inlays, implants, fillings or bridges? Yes ☐ No ☐

     If Yes, please state name of person, type and quantity of each of the above, including number of teeth affected by bridge (if applicable)

   If there is insufficient space, please use an additional Application Form

Additional information for "Yes" answers

If you answered **Yes** to any part of questions 1, 2, 3 or 4 within the previous Health Declaration section, please provide details in the table below. **Please advise if a full recovery has been made and if you or your dependants (if applicable) have any condition or disease related to, or arising from, the original diagnosis. Please enclose supporting medical reports/test results if possible.**

Name of the person affected by the condition	Question number	Diagnosis	Date of onset	Frequency and severity of symptoms	Date of last episode	Test results	Past / current treatment or recovery

If there is insufficient space in the table above, please use another Application Form

Please provide the name, address and telephone number of the regular/family doctor for all persons included in this application. Please use a separate sheet if the space provided is not sufficient:

7 Data Protection Acts – Collection and use of personal information

In these statements, references to information include personal data and information given by you to us, whether in your application, any Claim Form and/or supporting documents or any information we may collect in connection with any product or service we provide. Allianz Worldwide Care, a member of the Allianz Group, is an Irish authorised non-life insurance company and shall be the data controller in respect of all such information.

Uses: Information you supply may be used for the purposes of insurance administration (including underwriting, processing, claims handling, reinsurance and fraud prevention) by us. Allianz Worldwide Care may use third parties to process data on its behalf. Such processing, which may be undertaken outside the European Economic Area (EEA), is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by the Data Protection Act.

Sensitive data: We need to collect sensitive data relating to you (such as medical and health details) in order to assess the terms of insurance we issue/arrange or to administer claims which arise.

Retention: We are obliged to retain your records for 6 years from the date the insurance relationship ends. We will not retain your data for longer than is necessary and we will hold it only for the purposes for which it was obtained.

Consent: By providing us with your information and by signing this Application Form, you consent to all of your information being used, processed, disclosed and retained as set out above.

Representation: By your signature you warrant and represent to us that you have authority to act on behalf of your dependants in respect of all personal information you provide to us, you have the authority of your dependants to disclose this personal information for the uses listed above and you are consenting to the processing, disclosure, use and retention of your dependants information on their behalf. In these statements, all references to "you" or "your" shall be deemed to include both you and your dependants.

Access: Under the Data Protection Acts 1988 and 2003, you have the right to request and receive a copy of your personal data held by us. Should you wish to exercise this right, you should send the request in writing and address it to the Data Protection Officer, Allianz Worldwide Care, 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland, or by email to: client.services@allianzworldwidecare.com. A fee of €6.35 is chargeable under the terms of the Data Protection Acts and cheques should be made payable to Allianz Worldwide Care.

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

8 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 Application Form and the start date of the policy.

(c) 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 release my medical records to Allianz Worldwide Care. 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:

(i) That this Application Form is valid for two months from the date of completing and signing it.

(ii) 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:

(i) 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 Application Form, the situation will be considered accepted if I enter no protest within 30 days following the issue date of the Insurance Certificate.

(ii) 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 Application Form for and on behalf of all persons included in this Application Form.

Applicant's signature

Applicant's printed name

Date D D M M Y Y

9 Intermediary appointment

As the applicant I hereby authorise INSERT NAME OF BROKER to act for and on behalf of all persons named in this Application Form in relation to the administration of this policy which may include the disclosure of sensitive medical information. This authorisation will remain in place until I provide a written request to Allianz Worldwide Care to revoke it.

Applicant's signature

Applicant's printed name

Date D D M M Y Y

ID 362761
For office use only — Agent details and stamp
Adelheid Helbich, Actuary,
BWV, Helbich GmbH
Breitscheidstrasse 2 A
63477 Maintal, Germany
Phone: 06181-43816-80
Fax: 06181-43816-81

10 Payment details

This section does not need to be completed if you are applying as part of a group scheme and your employer is paying the premium.

No payment should be made until you have been notified of your policy number.

(a) Payment currency

Please tick ☑ to indicate your preferred payment currency: Euro ☐ Sterling (GBP) ☐ Swiss Franc (CHF) ☐ US Dollars ☐

(b) Payment frequency and method

Payments are subject to the following administration surcharges: 0% for annual payment, 3% for half-yearly payments, 4% for quarterly payments and 5% for monthly payments.

Please tick ☑ to indicate your preferred payment frequency and method:

	Annual	Half-yearly	Quarterly	Monthly
Credit card	☐	☐	☐	☐
Cheque	☐	☐	☐	Not available
Bank transfer	☐	☐	☐	Not available

Credit card payment

If you choose to pay by credit card, please provide the following information:

Card type Mastercard ☐ Visa ☐

Cardholder's name

Card number — — — Expiry date M M Y Y

For security reasons, once this information is transferred to our system, the credit card details will be detached from the Application Form and destroyed.

Credit card authorisation

I authorise Allianz Worldwide Care to charge my credit card account with my healthcare premium (of which I will be notified at acceptance of cover/renewal or upon a request made by me which impacts my premium, such as adding a dependant). This will continue until the instruction is cancelled, by me giving written notice to Allianz Worldwide Care. I understand I will be given one month's notice of any annual premium rate increase.

Cardholder's signature Date D D M M Y Y

Please send the completed and signed application form to the following fax number: +49-6181-43816-81

BROKER ID: 362716

ADELHEID HELBICH, ACTUARY, BWV

E-MAIL: Adelheid.Helbich@GermanHealthPlans.com, SKYPE: adelheid.helbich

WEBSITE: WWW.GERMANHEALTHPLANS.COM, WEBSITE: WWW.STUDENTS-INTERNS.COM

HELBICH GMBH, G E R M A N H E A L T H P L A N S W O R L D W I D E

BREITSCHEIDSTRASSE 2 A, 63477 MAINTAL,GERMANY

PHONE: +49-6181-43816-80, FAX: +49-6181-43816-81

H A M B U R G - H R B 5 3 7 5 3, §34D ABS. 1 GEWO IHK HH:D-OFKI-WHE31-81

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, 18B Beckett 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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