



International Healthcare Plans

APPLICATION form

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

Allianz  **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 or is your principal country of residence.

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 / / 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 / /

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 <input type="checkbox"/> Child <input type="checkbox"/>	Spouse <input type="checkbox"/> Child <input type="checkbox"/>	Spouse <input type="checkbox"/> Child <input type="checkbox"/>
First name	<input type="text"/>	<input type="text"/>	<input type="text"/>
Surname	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
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)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address (mandatory for dependants over 18)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Home country	<input type="text"/>	<input type="text"/>	<input type="text"/>
Principal country of residence	<input type="text"/>	<input type="text"/>	<input type="text"/>
Nationality	<input type="text"/>	<input type="text"/>	<input type="text"/>

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 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.

Select your Area of Cover	<input type="checkbox"/> Worldwide	<input type="checkbox"/> Worldwide excluding USA	<input type="checkbox"/> Africa		
Select your Core Plan	<input type="checkbox"/> Premier Individual	<input type="checkbox"/> Club Individual	<input type="checkbox"/> Classic Individual	<input type="checkbox"/> Essential Individual	
Select your Core Plan deductible <small>(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)</small>	<input type="checkbox"/> No deductible	<input type="checkbox"/> € 450/£374/ CHF585/\$610	<input type="checkbox"/> € 750/£625/ CHF975/\$1,015	<input type="checkbox"/> € 1,500/£1,245/ CHF1,950/\$2,025	<input type="checkbox"/> € 3,000/£2,490/ CHF3,900/\$4,050
	<input type="checkbox"/> €6,000/£4,980/ CHF7,800/\$8,100	<input type="checkbox"/> €10,000/£8,300/ CHF13,000/\$13,500			
Select your Optional Plans <small>(Please note that Optional Plans can only be purchased in conjunction with a Core Plan)</small>	Out-patient Plan	<input type="checkbox"/> Gold Individual	<input type="checkbox"/> Silver Individual	<input type="checkbox"/> Bronze Individual	<input type="checkbox"/> Crystal Individual
	Select your Out-patient Plan deductible <small>(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)</small>	<input type="checkbox"/> No deductible	<input type="checkbox"/> €100/£83/ CHF130/\$135	<input type="checkbox"/> €200/£165/ CHF260/\$270	
	Maternity Plan <small>(Maternity Plans are available to couples and families i.e. a spouse/partner must also be insured on the policy)</small>	<input type="checkbox"/> Premier Maternity <small>(Only available if you selected the Premier Individual Core Plan and any Out-patient Plan)</small>	<input type="checkbox"/> Club Maternity <small>(Only available if you selected the Club Individual Core Plan and any Out-patient Plan)</small>		
	Dental Plan	<input type="checkbox"/> Dental 1 <small>(Only available if you selected the Premier Individual Core Plan and the Gold Individual Out-patient Plan)</small>	<input type="checkbox"/> Dental 2		
Repatriation Plan	<input type="checkbox"/> Repatriation Plan				

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

<input style="width: 100%; height: 100%;" type="text"/>

<input style="width: 100%; height: 100%;" type="text"/>

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. If you are an existing client, please also include details of any conditions for which you have claimed for since joining.

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	<input type="text"/> <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> cm
Weight	<input type="text"/> <input type="text"/> <input type="text"/> kg	<input type="text"/> <input type="text"/> <input type="text"/> kg	<input type="text"/> <input type="text"/> <input type="text"/> kg	<input type="text"/> <input type="text"/> <input type="text"/> kg
Have you consumed any form of tobacco in the past year?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, please state amount per day	<input type="text"/> <input type="text"/> <input type="text"/> /day	<input type="text"/> <input type="text"/> <input type="text"/> /day	<input type="text"/> <input type="text"/> <input type="text"/> /day	<input type="text"/> <input type="text"/> <input type="text"/> /day
Do you drink alcohol?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, how many units of alcohol do you drink per week? <small>(1 short = 1 unit, 250ml beer = 1 unit, 1 glass wine = 1 unit, if none state "zero")</small>	<input type="text"/> <input type="text"/> <input type="text"/> /week	<input type="text"/> <input type="text"/> <input type="text"/> /week	<input type="text"/> <input type="text"/> <input type="text"/> /week	<input type="text"/> <input type="text"/> <input type="text"/> /week
Do you wear glasses or contact lenses? If Yes, please state:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
• Condition				
• Number of dioptres for each eye (This appears on the prescription from the optician)				

1. Has any person included in this application ever suffered from, been in hospital with, or received treatment of any kind, tests or investigations for:

- (a) Any heart or circulatory disease or disorders such as, but not limited to heart attack, coronary artery disease, irregular heart beat, murmur, chest pain, clots, blood disorder, abnormal blood pressure or high cholesterol? Yes No
- (b) Any dermatological disease or disorders such as, but not limited to psoriasis, dermatitis, eczema, allergy or acne? Yes No
- (c) Any endocrine disease or disorders such as, but not limited to diabetes, weight problems, gout or thyroid problems, or other hormonal imbalances? Yes No
- (d) Any eye, ear, nose and throat disease or disorders such as, but not limited to cataract, glaucoma, hearing loss, sinus problems or tonsils and adenoids? Yes No
- (e) Any gastrointestinal disease or disorders such as, but not limited to stomach problems, hernia, haemorrhoids, gall stones, colon polyps, Crohn's disease, colitis or liver problems? Yes No
- (f) Any infectious disease or disorders such as, but not limited to: hepatitis A-B-C, herpes, HIV, malaria, meningitis, blood infections or sexually transmitted disease? Yes No
- (g) Any muscular and skeletal disease or disorders such as, but not limited to back, neck or joint pain, arthritis, paralysis, joint replacement or any cartilage and ligament problems? Yes No
- (h) Any neurological disease or disorders such as, but not limited to stroke, multiple sclerosis, epilepsy, neurodegenerative disorders or seizures, migraine, sciatica or nerve pain? Yes No
- (i) Any oncological disease or disorders such as, but not limited to any cancer, leukaemia, lymphomas, tumour, skin lesions, growth, lump, cyst, mole, polyp or naevus? Yes No
- (j) Any psychiatric or psychological disorders such as, but not limited to depression, anxiety, chronic fatigue syndrome, eating disorders or alcohol/drug problem, Alzheimers or other Dementias? Yes No
- (k) Any respiratory disease or disorders such as, but not limited to Chronic Obstructive Pulmonary Disorder, asthma, bronchitis, sinusitis, or shortness of breath. Yes No
- (l) Any urological or reproductive organs disease or disorders such as, but not limited to kidneys or urinary tract problems, menstrual impairments, fertility problem, fibroids, endometriosis, testicular or prostate enlargement? Yes No
- (m) Any other accident, injury, disease or disorder not already disclosed? Yes No

2. Please indicate if any person included in this application:

- (a) Is currently taking any prescribed drugs, medication (including over the counter), tablets or any other treatment. Yes No
- (b) Is expecting to have a medical review, has been referred for further tests/investigations, is awaiting results or any treatment due to accident, injury, disease or disorder not already mentioned. Yes No
- (c) Has undergone any non routine tests or investigations such as, but not limited to biopsy, colonoscopy, colposcopy, computed tomography (CT), mammogram, magnetic resonance imaging (MRI), Papanicolaou test (PAP), prostate specific antigen test (PSA). Yes No

Please do NOT disclose results of any genetic (DNA or RNA) tests, as these are not required for the medical underwriting process.

QUESTIONS 3 AND 4 SHOULD ONLY BE COMPLETED IF YOU ARE PURCHASING DENTAL COVER.

- 3. 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/en/international-individual-health-insurance/paper-applications/

4. Does any person included in this application:

- (a) Suffer from periodontitis (extensive disorder of the gum and the tooth-supporting structures)? 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.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



8 DATA CONSENT

We need your consent to collect and process your health and other data for the insurance policy that you would like to subscribe to. If you do not provide your explicit consent for the processing of your personal data as outlined below, we will not be able to provide you with the policy that you would like to purchase or process any claims that may be owed to you. If you agree, your data will be processed for the following reasons and activities.

A parent or guardian should complete the consent for any dependant that is under the age of 18.

I, the Applicant, Dependant 1, Dependant 2 and Dependant 3 agree with the following:

NAME OF APPLICANT	NAME OF DEPENDANT 1	NAME OF DEPENDANT 2	NAME OF DEPENDANT 3

- 1. Permission to collect, store and use my health data:** The insurer may collect, store and use my health data in order 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. The insurer may store my health data in accordance with the Consumer Code of the law applying to my policy with the insurer or any other applicable law requiring its retention.
- 2. Permission to obtain my data from third parties:** The insurer 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 to provide me with insurance cover, underwrite the risks to be insured or process any claims. I agree to release all individuals at these institutions and the insurer from their respective confidentiality obligations relating to my health data or other data that they are required to share and use for these aforementioned stated purposes.
- 3. Sharing my data outside of the insurer:** The insurer may share my health and other data with the institutions set out below for them to use to the same extent, and for the same purposes as the insurer. I understand that the insurer has put in place contractual arrangements with these institutions to protect my data. I agree to release all individuals at these institutions and the insurer from their respective confidentiality obligations relating to my health data or other data that they are required to share and use for the purposes set out below:
 - With independent medical experts if this is necessary 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 policy.
 - With service providers outside of the Allianz Group of companies that perform certain services on behalf of the insurer, such as risk assessments and claims handling that involve the collection and use of my health and other data, without which the insurer would not be able to administer my policy or pay any claims due to me.
 - With coinsurers to distribute the coverage of the insurance risk jointly with other companies to which the insurer issue 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 to 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 the insurer know by emailing: AP.EU1DataPrivacyOfficer@allianz.com

POLICYHOLDER APPOINTMENT

In order to assist with the administration of the policy you can nominate the policyholder as the main person of contact for the insurance. To do this, simply select "Yes" below.

I hereby authorise

INSERT NAME OF POLICYHOLDER

to act for and on my behalf 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 Care to revoke it.

Yes No

Yes No

Yes No

INTERMEDIARY APPOINTMENT

I hereby authorise

INSERT NAME OF BROKER

to act for and on my behalf 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 Care to revoke it.

For office use only — Agent details and stamp

Applicant's signature

/ /

Dependant 1 signature

/ /

Dependant 2 signature

/ /

Dependant 3 signature

/ /

9 MARKETING PREFERENCES

I, the Applicant, Dependant 1, Dependant 2 and Dependant 3 agree that the insurer may collect, use and disclose my personal data to provide me with marketing information, and I understand that my personal data will only be processed for the following reasons and activities that I have expressly agreed to by indicating below.

NAME OF APPLICANT	NAME OF DEPENDANT 1	NAME OF DEPENDANT 2	NAME OF DEPENDANT 3

- Information that the insurer 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 shall 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 the insurer on their products and services. I understand that you shall 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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9 MARKETING PREFERENCES (CONTINUED)

APPLICANT	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3
Such communications should be sent to me via the following channels:			
<input type="checkbox"/> Email	<input type="checkbox"/> Email	<input type="checkbox"/> Email	<input type="checkbox"/> Email
<input type="checkbox"/> In-App Notifications	<input type="checkbox"/> In-App Notifications	<input type="checkbox"/> In-App Notifications	<input type="checkbox"/> In-App Notifications
<input type="checkbox"/> Telephone	<input type="checkbox"/> Telephone	<input type="checkbox"/> Telephone	<input type="checkbox"/> Telephone
<input type="checkbox"/> Post	<input type="checkbox"/> Post	<input type="checkbox"/> Post	<input type="checkbox"/> Post

10 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: www.allianzworldwidecare.com/en/privacy.

Alternatively, you can contact us on + 353 1 630 1301 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: AP.EU1DataPrivacyOfficer@allianz.com

11 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.

Payment currency		Payment frequency and method				
Please tick to indicate your preferred payment currency:		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.				
Euro <input type="checkbox"/>		Please tick to indicate your preferred payment frequency and method:				
Sterling (GBP) <input type="checkbox"/>			Annual	Half-yearly	Quarterly	Monthly
Swiss Franc (CHF) <input type="checkbox"/>		Direct Debit* (For payments in Euro, Sterling and Swiss Franc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
US Dollars <input type="checkbox"/>		Credit card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Please note that the Direct Debit facility is available for payments in Euro, Sterling (GBP) and Swiss Franc (CHF), but not US Dollars (USD).</i>		Cheque	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Not available
		Bank transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Not available
*If you choose to pay by Direct Debit, please complete and submit the relevant Direct Debit Mandate available from: www.allianzworldwidecare.com/en/international-individual-health-insurance/paper-applications/ . Please note that if you are a member of a group scheme and wish to pay by Direct Debit, the monthly payment frequency option must be selected.						

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 Application Form 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 Care and Allianz Partners are registered business names of AWP Health & Life SA.

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CREDIT CARD PAYMENT

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

Card type Mastercard Visa American Express

Cardholder's name

Card number - - - Expiry date / / /

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 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 Care. I understand I will be given one month's notice of any annual premium rate increase.

Cardholder's signature _____ Date / / /

