

International Healthcare Plans

Application Form

Please read the following carefully, completing all relevant information in **BLOCK CAPITALS** and ticking the relevant boxes

Allianz 
Allianz Worldwide Care

If you are already insured with us and this form is being used to add a new dependant, please state your existing policy number

1 Applicant details.

Please enter the details of all persons to be covered under this contract, including the principal member and any dependants.

Dependants can include your spouse/partner and any children financially dependant on the principal member 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 college/university confirming student status or a copy of the student's ID. Please note that we will only consider applicants for cover up to the day before their 70th birthday.

Principal member

It is important that you notify us of any change of contact details so we can ensure that correspondence reaches you.

Mr. Mrs. Ms. Miss Other First name
Other initials Surname
Date of birth Gender: Male Female
Correspondence address

Home telephone COUNTRY CODE AREA CODE
Office telephone COUNTRY CODE AREA CODE
Mobile telephone COUNTRY CODE NETWORK CODE
Fax COUNTRY CODE AREA CODE
Email address (mandatory)
Occupation
Home country
(A country for which you hold a current passport and to which you would want to be repatriated)
Country of residence
(The country in which you occupy the majority of your time for the period of your insurance cover)
Nationality
Please indicate the language in which you wish to receive your policy documentation: English German French Spanish Italian

Next of kin:

Name
Address

Home telephone COUNTRY CODE AREA CODE
Mobile telephone COUNTRY CODE NETWORK CODE
Email address

Details of any current domestic or international health insurance:

Name of insurer
Policy number Start date

The following details are only to be completed if you are applying to join an existing group scheme:

Group name
Group number

Dependant 1

Mr. Mrs. Ms. Miss Other _____ First name _____
Surname _____
Date of birth Gender: Male Female Relationship to principal member: Spouse Child
Occupation _____
Home country _____
(A country for which you hold a current passport and to which you would want to be repatriated)
Country of residence _____
(The country in which you occupy the majority of your time for the period of your insurance cover)
Nationality _____
Details of any current domestic or international health insurance:
Name of insurer _____
Policy number _____ Start date

Dependant 2

Mr. Mrs. Ms. Miss Other _____ First name _____
Surname _____
Date of birth Gender: Male Female Relationship to principal member: Spouse Child
Occupation _____
Home country _____
(A country for which you hold a current passport and to which you would want to be repatriated)
Country of residence _____
(The country in which you occupy the majority of your time for the period of your insurance cover)
Nationality _____
Details of any current domestic or international health insurance:
Name of insurer _____
Policy number _____ Start date

Dependant 3

Mr. Mrs. Ms. Miss Other _____ First name _____
Surname _____
Date of birth Gender: Male Female Relationship to principal member: Spouse Child
Occupation _____
Home country _____
(A country for which you hold a current passport and to which you would want to be repatriated)
Country of residence _____
(The country in which you occupy the majority of your time for the period of your insurance cover)
Nationality _____
Details of any current domestic or international health insurance:
Name of insurer _____
Policy number _____ Start date

Dependant 4

Mr. Mrs. Ms. Miss Other _____ First name _____
Surname _____
Date of birth Gender: Male Female Relationship to principal member: Spouse Child
Occupation _____
Home country _____
(A country for which you hold a current passport and to which you would want to be repatriated)
Country of residence _____
(The country in which you occupy the majority of your time for the period of your insurance cover)
Nationality _____
Details of any current domestic or international health insurance:
Name of insurer _____
Policy number _____ Start date

If there is not sufficient space for all dependants, please use another Application Form.

2 Policy commencement date.

Please indicate the month and year on which you wish your cover to commence

(individual policies must commence on the first day of the month):

However, if you are applying to join a group scheme, you can specify the date you require cover from:

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

3 Plan details.

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

International Healthcare Plans

Please tick to indicate the type of plan(s) and deductible you require

Core Plan	Out-patient Plan	Out-patient deductible	Maternity Plan	Dental Plan	Repatriation Plan
Premier Individual <input type="checkbox"/>	Gold Individual <input type="checkbox"/>	0 <input type="checkbox"/>	Premier Maternity <input type="checkbox"/>	Dental 1 <input type="checkbox"/>	Repatriation Plan <input type="checkbox"/>
Club Individual <input type="checkbox"/>	Silver Individual <input type="checkbox"/>	£75/€100/\$140 <input type="checkbox"/>	Club Maternity <input type="checkbox"/>	Dental 2 <input type="checkbox"/>	
Classic Individual <input type="checkbox"/>	Bronze Individual <input type="checkbox"/>	£150/€200/\$280 <input type="checkbox"/>			
Essential Individual <input type="checkbox"/>	Crystal Individual <input type="checkbox"/>				

Out-patient, Dental and Repatriation Plans can only be purchased in conjunction with a Core Plan. Please note that Dental Plan 1 can only be purchased in conjunction with the Premier Individual Core Plan and Gold Individual Out-patient Plan.

Premier Maternity can only be purchased with the Premier Individual Core Plan. Club Maternity can only be purchased with the Club Individual Core Plan. Please note that an Out-patient Plan must be selected in conjunction with a Maternity Plan. Maternity Plans are available to couples and families i.e. a spouse/partner must also be insured on the policy. Your plan selection can only be amended at policy renewal.

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

Please tick to indicate the area of cover you require

Worldwide

Worldwide excluding USA

Africa

4 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.

4.1 Payment currency

Please tick to indicate your preferred payment currency

Euro

UK Sterling

US Dollars

4.2 Payment frequency and method

Please tick to indicate your preferred payment frequency and method

	Annual	Half yearly	Quarterly	Monthly
Credit card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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

4.3 Credit card payment details

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

Type of credit card MasterCard VISA

Card number

CVC code*

Expiry date

Credit card authorisation

I authorise Allianz Worldwide Care to charge my credit card account with my healthcare premiums (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 name

Cardholder's signature Date

*CVC Code: The last 3 digits after the card number on the back of the card or the last 3 digits in the signature field.

Payment charges and details

Payments are subject to the following administration surcharges:
3% for half yearly payments,
4% for quarterly payments and
5% for monthly payments.
There is no administration charge for annual payment.

- Cheques must be made payable to Allianz Worldwide Care, with the policyholder's name and policy number marked clearly on the back of the cheque
- Bank transfers must be clearly marked with the policyholder's name and policy number
- If you have chosen to pay by cheque or bank transfer, please ensure that payments are received in time, based on your chosen payment frequency, to avoid any possible delays to claims processing
- We will only accept payment by credit card via MasterCard or VISA
- Allianz Worldwide Care does not accept liability for any payment which does not clearly identify the policyholder
- If Insurance Premium Tax and other Government Levies apply, these will be stated on your Invoice/Payment Details

5 Pre-existing conditions.

Pre-existing conditions are covered under the policy, unless otherwise advised by us in writing. Conditions arising between signing the Application Form and confirmation of acceptance by the Underwriting Department of Allianz Worldwide Care will equally be deemed to be pre-existing. 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.

Pre-existing conditions are medical conditions or any related conditions, for which symptom(s) have been shown at some point during the 5 years prior to commencement of cover, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition about which you or your dependants know, knew or could reasonably have been assumed to have known, will be deemed to be pre-existing.

You are hereby obliged on request to provide any further information that we might require.

6 Health declaration.

Please answer the following questions. Your answers should be based on your complete medical past, where relevant, unless otherwise requested. All information supplied will be treated in strict confidence. All material facts including those relating to these questions must be disclosed. Failure to do so may invalidate the policy. A material fact is any information that would be likely to influence the insurer's assessment and acceptance of this Application Form. If you are in any doubt whether a fact is material then it should be disclosed.

	Principal member	Dependant 1	Dependant 2	Dependant 3	Dependant 4
1. What is your height/weight?	cm <input type="text"/> kg <input type="text"/>	cm <input type="text"/> kg <input type="text"/>	cm <input type="text"/> kg <input type="text"/>	cm <input type="text"/> kg <input type="text"/>	cm <input type="text"/> kg <input type="text"/>
2. Have you consumed any form of tobacco in the past year? Type Daily consumption/amount	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/>
3. How many units of alcohol do you drink per week? (1 short = 1 unit, 250ml beer = 1 unit, 1 glass wine = 1 unit)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4. Are you currently suffering from any complaints, illnesses, after-effects of an accident, mental or physical disabilities, psychiatric disorders or chronic/long term medical or dental conditions?	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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Have you ever suffered from, been in hospital with, or received treatment, tests or investigations for:					
a) Rheumatism, gout, arthritis or disease of the muscles or joints including the back?	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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Epilepsy or other neurological disorders?	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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c) Any digestive disorder including stomach and/or bowel problems?	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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
d) Anxiety, depression, psychiatric or mental illness?	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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
e) Gynaecological disorders?	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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
f) Any disorder of the kidneys, bladder or liver/pancreas including diabetes?	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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
g) Any lump, cyst, mole or cancer?	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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
h) Any eye, ear, nose or skin disorder?	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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
i) Any heart condition, stroke or raised blood pressure/cholesterol?	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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
j) Asthma, chronic bronchitis or any other respiratory condition?	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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
k) Any other illness or injury requiring medical attention (excluding colds and influenza)?	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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Have you ever been advised to consult a doctor for a recurrent complaint, or been advised to have any diagnostic test or treatment which has not been completed or that you still await the results of?	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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Have you ever tested positive for HIV, Hepatitis B or C? Are you awaiting the results of such a test?	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"/>	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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>

If the result is negative, having an HIV test will not, in itself, have any effect on your acceptance terms for insurance.

8. Have you ever suffered from or been in hospital for any other disorder or as a result of an accident which required that you:

- a) Received more than 14 days treatment? Yes No Yes No Yes No Yes No Yes No
- b) Were off work for more than one week? Yes No Yes No Yes No Yes No Yes No
- c) Had specialised treatment? Yes No Yes No Yes No Yes No Yes No

9. Are you pregnant? Yes No Yes No Yes No Yes No Yes No
 If yes, please state expected date of childbirth dd/mm/yy dd/mm/yy dd/mm/yy dd/mm/yy dd/mm/yy

10. Have either of your parents or any of your brothers or sisters, living or deceased, suffered (before the age of 65) from diabetes, heart disease, high blood pressure, cancer, kidney disease, raised cholesterol, nervous or brain disorders such as Alzheimer's, Parkinson's, or M.S., eye, hearing or speech disorders or any family disorder? Yes No Yes No Yes No Yes No Yes No

11. Have you had cancer screenings or general check-ups within the last 5 years? Yes No Yes No Yes No Yes No Yes No

Additional information.

If you answered "YES" to any of the questions from 4 to 11, please provide details in the box below (in BLOCK CAPITALS). Failure to provide complete information may delay the processing of your application. **If in doubt whether a fact or information is material then it must be disclosed.**

Name	Question number	Where applicable, please provide the date of first diagnosis/consultation, name and address of treating physician, frequency and severity of symptoms, date of last episode as well as details of any past, current or known future treatment

If there is not sufficient space for your additional information, please use another Application Form.

Name	Question number	Where applicable, please provide the date of first diagnosis/consultation, name and address of treating physician, frequency and severity of symptoms, date of last episode as well as details of any past, current or known future treatment

If there is not sufficient space for your additional information, please use another Application Form.

Additional information (continued).

Please state the name, address and telephone number of your family doctor:

Mr. Mrs. Ms. Miss Other First name

Surname

Address

Telephone number COUNTRY CODE — AREA CODE —

Date of last visit d | d | m | m | y | y |

Please state the date that you first became a patient of this doctor d | d | m | m | y | y |

7 Dental declaration.

(Should only be completed if you are purchasing dental cover)

	Principal member	Dependant 1	Dependant 2	Dependant 3	Dependant 4
a) Are you currently undergoing or been advised to undergo any treatment?	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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Do you have missing teeth which have not been replaced (excluding wisdom teeth)? If yes, how many?	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>
c) Have you denture sets (crowns, inlays, implants, bridges, fillings, etc.)? If yes, how many?	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>
d) Do you suffer from parodontosis?	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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
e) Have you had a dental check up within the last 5 years? If yes, please state the: Date Outcome	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>

Please state the name, address and telephone number of your family dentist:

Mr. Mrs. Ms. Miss Other First name

Surname

Address

Telephone number COUNTRY CODE — AREA CODE —

8 Data protection legislation.

All personal information and medical data provided will be dealt with in strict confidence and in accordance with the European Union Data Protection Directives; Data Protection Directive 95/46/EC and Electronic Privacy Directive 2002/58/EC. We require personal data for the purposes of preparing a quotation, underwriting, making policy documents available, collecting premiums, paying claims and anything else that is required for the performance and execution of the health insurance contract between you/your employer and Allianz Worldwide Care. Personal data may be given to hospitals and/or medical providers in relation to medical insurance claim services provided by us to you. You have a right to access the personal data that is held about you. You also have the right to amend or delete any information we hold about you if you believe that it is inaccurate or out of date. Allianz Worldwide Care, any of the Allianz Group companies or an organisation appointed by us, might contact you in the future in relation to other products/services that you might be interested in.

If you wish to receive information on other products or services from us, please tick this box.

9 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 may render this insurance null and void.
- (b) I consent to the processing and disclosure of the information I have provided in this form and any information which arises as part of my health insurance contract for the purposes of the Data Protection Directives as explained above.
- (c) I undertake to inform Allianz Worldwide Care immediately in writing of any changes in my or my dependants' state of health occurring after the Application Form has been signed and before the start date of my policy.
- (d) I understand that I can withdraw my application in writing by letter, email or fax, within 14 days from the policy start date, and provided that I have not submitted a claim, I am entitled to a full refund of the premium.
- (e) I accept that 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 14 days following the issue date of the Insurance Certificate.
- (f) 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 authorize 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.
- (g) I accept that this policy will be subject to the standard policy terms and conditions effective at the time of policy commencement contained within the Benefit Guide. I confirm that I have read and understand the full definitions, benefits, exclusions and conditions of this policy including the exclusion relating to pre-existing conditions.

As the principal member, I sign this declaration on behalf of all persons included in this Application Form.

Principal member's signature

Date

[d | d] [m | m] [y | y]

Please return this form fully completed to the address below:

Allianz Worldwide Care
18B Beckett Way
Park West Business Campus
Nangor Road
Dublin 12
Ireland

Helpline: +353 1 630 1301
Fax: +353 1 629 7117
Email: underwriting@allianzworldwidecare.com
Website: www.allianzworldwidecare.com

For office use only - agent details

April Medibroker Ltd
Fax: +44 (0)191 257 6272
Agency ID: 490862

Thank you for completing this Application Form. Prior to submission, please ensure that:

- Your contact details are correct, as we will use these to communicate with you in the future
- The information provided in section 6 (health declaration) is complete and correct
- Payment method and details have been completed in full
- You have signed and dated the declaration in section 9