

# APPLICATION FORM

## HEALTH CARE

Alfonso X El Sabio, 14 - Entlo. 03004 Alicante

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**ASSSA**  
INSURANCE

### POLICYHOLDER

|  |  |                |                    |                 |        |
|--|--|----------------|--------------------|-----------------|--------|
| SURNAME & FIRST NAME/S                                 |  |                | NIE OR PASSPORT N° |                 |        |
| RESIDENTIAL ADDRESS                                    |  |                |                    |                 |        |
| TOWN   |  | POST CODE      |                    | PROVINCE        |        |
| POSTAL ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRESS) |  |                | TELEPHONE NUMBER   |                 | MOBILE |
| FAX NUMBER   |  | E-MAIL ADDRESS |                    | NATIONALITY     |        |
| CIVIL STATUS   |  | GENDER         |                    | POLICY LANGUAGE |        |
| FORMER COMPANY   |  |                | REPLACED POLICY    |                 |        |

### DETAILS OF PERSONS TO BE COVERED

| N° | SURNAME & FIRST NAME/S | GENDER | RELATIONSHIP TO POLICYHOLDER | DATE OF BIRTH |       |      | ACTUARIAL AGE | OCCUPATION |
|----|------------------------|--------|------------------------------|---------------|-------|------|---------------|------------|
|    |                        |        |                              | DAY           | MONTH | YEAR |               |            |
| 1  |                        |        |                              |               |       |      |               |            |
| 2  |                        |        |                              |               |       |      |               |            |
| 3  |                        |        |                              |               |       |      |               |            |
| 4  |                        |        |                              |               |       |      |               |            |
| 5  |                        |        |                              |               |       |      |               |            |
| 6  |                        |        |                              |               |       |      |               |            |

### ECONOMIC DETAILS

|                           |  |                                     |                       |                             |        |                                |              |               |  |                    |
|---------------------------|--|-------------------------------------|-----------------------|-----------------------------|--------|--------------------------------|--------------|---------------|--|--------------------|
| POLICY LEVEL              |  | COMMENCEMENT DATE                   |                       | METHOD OF PAYMENT           |        | AGENCY                         |              | CODE          |  |                    |
| ACCIDENT INSURANCE POLICY |  | <input checked="" type="checkbox"/> | INSURED OLDER THAN 14 |                             | YEARLY |                                | BENEFICIARY* |               |  |                    |
| DENTAL                    |  | EXTRADENTAL                         |                       | INSURED OLDER THAN 7        |        | YEARLY                         |              | OBSERVATIONS  |  |                    |
| NET PREMIUM               |  | RECEIPTS AMOUNT                     |                       |                             |        | TO BE COMPLETED BY THE COMPANY |              |               |  |                    |
|                           |  | FIRST PAYMENT UNTIL                 |                       | SUBSEQUENT PAYMENTS AS FROM |        | HEALTH                         |              | POLICY NUMBER |  | YEARLY NET PREMIUM |
|                           |  |                                     |                       |                             |        | ACCIDENT                       |              |               |  |                    |
|                           |  | TOTAL                               |                       |                             |        | DENTAL                         |              |               |  |                    |

\* IF BENEFICIARIES ARE NOT ASSIGNED, LEGAL HEIRS WILL BE AS SUCH CONSIDERED

IN ACCORDANCE WITH PROVISIONS OF ACT 15/1999 OF 13 DECEMBER ON DATA PROTECTION, THE HOLDER IS INFORMED THAT HIS/HER SIGNATURE ON THIS DOCUMENT EXPRESSLY AUTHORISES ASSSA TO INCLUDE HIS/HER PERSONAL DATA IN THE COMPANY'S FILES, REQUIRED FOR THE MAINTENANCE OF THE RELATIONSHIPS BETWEEN COMPANY AND CLIENTS, AND TO TRANSFER THEM TO THE BANK MANAGING PAYMENT BY STANDING ORDERS. AGRUPACIÓN SANITARIA SEGUROS, S.A. IS THE RESPONSIBLE ENTITY FOR THE TREATMENT OF THESE DATA, AND THE HOLDER MAY EXERCISE HIS/HER RIGHTS OF ACCESS, RECTIFICATION, CANCELLATION AND OPPOSITION AT THE FOLLOWING ADDRESS: AVDA. ALFONSO X EL SABIO, 14 - ENTLO. ALICANTE. FURTHERMORE, THE HOLDER AUTHORISES ASSSA TO SEND HIM/HER INFORMATION AND ADVERTISING ON THE COMPANY'S PRODUCTS AND SERVICES AND THOSE OF ITS PARTNERS THAT ARE RELATED TO THE INSURANCE FIELD.

IF YOU DO NOT WISH TO RECEIVE INFORMATION ABOUT OUR PRODUCTS AND SERVICES, PLEASE TICK THIS BOX

AGENCY **April Medibroker** POLICYHOLDER, DATE

Unit 4, Rake House Farm  
Rake Lane  
North Shields  
Tyne & Wear  
NE29 8EQ, UK  
Fax: +44 (0)191 257 6272

**AGRUPACIÓN SANITARIA SEGUROS S.A.**  
C.I.F. A-28005312

### DIRECT DEBIT MANDATE

|   |           |          |                         |        |      |                |
|---|-----------|----------|-------------------------|--------|------|----------------|
| DATE  |           |          | ASSSA POLICY NUMBER     |        |      |                |
| SURNAME & FIRST NAME/S OF BANK ACCOUNT HOLDER   |           |          |                         |        |      |                |
| BANK OR SAVINGS BANK  |           |          | CURRENT ACCOUNT DETAILS |        |      |                |
| ADDRESS OF BANK OR SAVINGS BANK   |           |          | BANK                    | OFFICE | D.C. | ACCOUNT NUMBER |
| TOWN  | POST CODE | PROVINCE |                         |        |      |                |
| DEAR SIR: WE KINDLY ASK YOU TO DEBIT THE ABOVE MEMBERED ACCOUNT WITH THE PREMIUM RECEIPTS PRESENTED BY ASSSA (AGRUPACIÓN SANITARIA SEGUROS, S.A.) UNTIL FURTHER NOTICE. |           |          |                         |        |      | SIGNATURE      |