

Received by DKV Globality S.A.:

Date/ Person responsible



APRIL Medibroker
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Application for health insurance

Globality YouGenio®

DKV Globality S.A.

13, rue Edward Steichen · L-2540 Luxembourg
Phone: +352 270 444 3601, e-mail: service-yougenio@dkv-globality.com

DKV Globality S.A.

Board of Administration: Martin von Kiær, Wolfgang Diels, Horst Weber
R.C.S. Luxembourg (Commercial Register): B 134471

Application for health insurance (individual insurance)

I herewith apply for conclusion of a health insurance contract in accordance with Globality YouGenio® for the persons listed under Person 1, 2, 3, 4.

A. Particulars concerning the applicant

First name	Surname	Title	Date of birth (DD/MM/YYYY)	Start date of insurance
Gender <input type="checkbox"/> male <input type="checkbox"/> female	Nationality	Occupation	Professional status	
Building/floor	Street and house number	Postcode and town	Country and region	
Mobile phone (+ country code)	Fax (+ country code and local dialling code)	E-mail		
<input type="checkbox"/> New (not yet customer of DKV Globality S.A.)		<input type="checkbox"/> Existing customer of DKV Globality S.A./ Insurance No.		
Correspondence address <input type="checkbox"/> Same as above <input type="checkbox"/> Other:	Building/ floor	Street and house number	Postcode and town	Country and region

B. Particulars concerning the insured persons

Person	First name	Surname	Title	Husband/Wife	Non-marital partner	Child	Applicant	Date of birth	Gender m f	Nationality	Occupation	Start date of insurance
1				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>			
2				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>			
3				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>			
4				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>			

C. Further particulars concerning the insured persons

Country of location/ future location:

Home country:

Contractual language / language for communication:
 All the required information will be provided in this language.
 German English Dutch
 French Spanish

D. Plan levels and geographical areas for Globality YouGenio®

Person	Plan level	Deductible in €* <input type="checkbox"/> None <input type="checkbox"/> 250 <input type="checkbox"/> 500 <input type="checkbox"/> 1.000	Geographical area <input type="checkbox"/> None USA <input type="checkbox"/> Incl. USA	Premium (monthly) in €
1	<input type="checkbox"/> Classic <input type="checkbox"/> Plus <input type="checkbox"/> Top	<input type="checkbox"/> None <input type="checkbox"/> 250 <input type="checkbox"/> 500 <input type="checkbox"/> 1.000	<input type="checkbox"/> None USA <input type="checkbox"/> Incl. USA	
2	<input type="checkbox"/> Classic <input type="checkbox"/> Plus <input type="checkbox"/> Top	<input type="checkbox"/> None <input type="checkbox"/> 250 <input type="checkbox"/> 500 <input type="checkbox"/> 1.000	<input type="checkbox"/> None USA <input type="checkbox"/> Incl. USA	
3	<input type="checkbox"/> Classic <input type="checkbox"/> Plus <input type="checkbox"/> Top	<input type="checkbox"/> None <input type="checkbox"/> 250 <input type="checkbox"/> 500 <input type="checkbox"/> 1.000	<input type="checkbox"/> None USA <input type="checkbox"/> Incl. USA	
4	<input type="checkbox"/> Classic <input type="checkbox"/> Plus <input type="checkbox"/> Top	<input type="checkbox"/> None <input type="checkbox"/> 250 <input type="checkbox"/> 500 <input type="checkbox"/> 1.000	<input type="checkbox"/> None USA <input type="checkbox"/> Incl. USA	
*Classic level only with a deductible of € 250.				Total premium: <input type="text"/>

E. Miscellaneous information

Do you have or have you ever had health insurance cover elsewhere? (Including compulsory statutory/ private insurance)

Person	Insurer	Inpatient	Outpatient	Dental	Period (from - to/ month-year)
1	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

F. Information on your state of health

In order to get complete coverage including pre-existing conditions from the start date of the insurance, you must fill in the health questionnaire below. Based on the answers you provide, you will be informed whether you are eligible for insurance, and whether risk loadings have to be added to the premium or whether exclusions have to be applied to your insurance cover.

- I chose to get full insurance cover including pre-existing conditions. I fill in the health questionnaire below.
- I opt for the moratorium. I do not fill in the health questionnaire below. In that case, pre-existing conditions and their consequences will not be covered during a qualifying period of 24 months. Please refer to pages 4 and 5 for further information on the moratorium option.

Important: Please note the following (refer also to "Responsibility for the information provided in the application form", page 4): All questions must be answered in detail. Symptoms, illnesses and the consequences of an accident should be mentioned even if you consider them to be unimportant. Dashes do not qualify as an answer. **If you need more space:** continue on a separate sheet, specifying the number of the person concerned, and refer to that sheet in your application form. If you do not wish to reveal certain information to the intermediary, this information must be provided directly to DKV Globality S.A. **in writing within three days.** In this case, you must indicate in the application form that the information is to be provided separately. If the questions on this page, where of relevance for acceptance of the risk, are answered incorrectly or incompletely, we may – if the duty to provide information has not been wilfully violated – terminate the contract within one month of being informed of the violation, insofar as we can prove that we would not have insured the risk in any case. The contract shall be null and void if our assessment of the risk is affected by wilful violation of your duty to provide information. In this case, you are obliged to repay the insurance benefits already received. We will not refund the paid premiums. **If insurance cover already exists with DKV Globality S.A.,** it is not necessary to specify any disorders or courses of treatment during the last five years which are already fully known to DKV Globality S.A. on account of the invoices or medical certificates presented to DKV Globality S.A. in conjunction with the previously existing insurance contract.

	Person 1		Person 2		Person 3		Person 4	
Height and weight	in cm / in kg							
	No	Yes	No	Yes	No	Yes	No	Yes
1. Have you been admitted to a hospital, therapy centre, health cure or sanatorium during the last five years? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you undergone surgery (including outpatient surgery) at any time during the last five years? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you received psychotherapy or treatment of an addiction during the last five years? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you suffered any illnesses, disorders, consequences of an accident or other impairments of your health _____ or have you undergone any examinations / treatment either during the last three years or at present?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you require any kind of medication (e.g. tablets, ointments)? If yes, please specify which and what for. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you been advised, or are you planning, to undergo any kind of outpatient / inpatient treatment or examination? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has an HIV infection ever been established (e.g. through an AIDS test)? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have impaired vision with 8 diopters or more? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have any physical / organic defect, a chronic illness, an illness or injury due to military service, any reduction in your ability to work / degree of disability? If yes, please enclose a copy of the official notice. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you pregnant? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you visited a dentist during the last three years? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you currently receiving dental treatment, are dentures being produced or renewed, are you receiving treatment for periodontitis or orthodontic treatment, or has such treatment been recommended or planned? (If yes, an up-to-date plan of treatment and costs must be enclosed.) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have any missing teeth which have not yet been replaced (other than milk and wisdom teeth, as well as teeth for which the gaps have been filled by adjacent teeth)? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If yes: number of missing teeth _____							

Further details concerning questions 1 – 9 and 12 if answered with "yes":					
Person	Question	Type of illness, drugs, injury, symptoms, examination (what was diagnosed?); diopter grade? Question 12: which treatment?	Treatment / symptoms from – to	Name and address of doctors, hospitals; who can provide further information?	When did treatment / symptoms cease?

Please specify the name and address of your family doctor or other doctor best able to provide further information concerning your health:

G. Special agreements* and remarks

* Subject to written confirmation by DKV Globality S.A.

H. Payment of premiums

Premiums to be paid monthly
 quarterly
 half-yearly
 yearly

Bank transfer **Premium to be remitted to DKV Globality S.A.**
 BGL BNP Paribas · IBAN: LU090030309301020000 · WL BIC Code BGLLLULL

Visa MasterCard American Express

Card No. _____ Valid thru (month/ year) _____

Card check code _____ Name of card holder as stated on credit card _____

Credit card
Direct debit order
 I herewith authorize DKV Globality S.A., 13, rue Edward Steichen, L-2540 Luxembourg, to debit the premiums when due in conjunction with my health insurance via my credit card account until further notice. I will inform DKV Globality S.A. of the new credit card number and/ or new validity period, as well as of any changes in the card check code, in good time before expiry of the aforementioned credit card. I am aware that the following surcharges are due on the premium for the respective intervals: 0% for yearly payment, 2% for half-yearly payment, 3% for quarterly payment and 4% for monthly payment. If I have any doubts, objections or queries concerning the reason for or amount of a premium to be debited, I must contact DKV Globality S.A. at the following service number/ e-mail address to clarify the matter:
Tel.: +352 / 270 444 3601, service-yougenio@dkv-globality.com

Consent clause / Payment by credit card
 By signing below, I authorize DKV Globality S.A. to forward to the relevant banks and credit card processors my insurance contract number (Policy No.), the name of the credit card company, my credit card No. with card check code, month and year of expiry, as well as the amount of premium to be debited and the corresponding currency, for the purposes of debiting premiums – in conjunction with my existing insurance contract – by credit card. This authorization may be revoked at any time. I confirm that the information I have provided is true and correct.

 Place, date, signature of the card holder (first name and surname, unless identical with the insured person)

One account must be specified for reimbursements by the insurer if available.

Account holder	Name of bank
Account No.	Branch No. (BLZ)
Postcode / Town	Country
Swift (BIC)	IBAN

I. Final provisions

Please check that the information provided in this application form is correct and complete.

- By signing this form, I also give my consent to the receipt, storage, processing and transmission of personal data and to the release from the professional confidentiality duty as detailed on page 4. I give this consent for myself, for my insured children and for the co-insured persons I represent by law.
- I do not consent to the receipt, storage, processing and transmission of personal data and to the release from the professional confidentiality duty as detailed on page 4. I wish to be informed by the insurer of the persons and institutions requiring information. I will then decide in each instance whether or not I will release the specified persons or institutions from their duty to maintain professional confidentiality.
 If I choose this alternative,
 1. conclusion of the insurance contract which I have requested may at least be delayed, if the remaining sources of information do not make it possible to investigate and assess the risk.
 2. it may take longer to investigate my claims, benefits may be reduced or the insurer relieved from its obligation to pay benefits if the obligation to pay benefits cannot be established or can only be partially established on the basis of the remaining sources of information.

To be completed by the intermediary:
 When answering the questions in this form, did the applicant provide information which has not been recorded in this application form? No Yes

If yes, which?

I herewith agree that information on special offers by DKV Globality S.A. may be sent to me in writing and by telephone.

Yes No This consent may be revoked at any time.

By signing this form, I also give my consent to all declarations printed on pages 4 and 5 (including the declaration concerning my right of withdrawal).

_____ Place and date	_____ Signature of the applicant	_____ Signature of intermediary
_____ Intermediary name and No.	_____ Sub-intermediary 1 name and No.	_____ Sub-intermediary 2 name and No.

Signature(s) of the co-insured person(s) or their legal representative(s)

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

Declarations by the applicant and person(s) to be co-insured

The following points are known to me:

Right of withdrawal

You may withdraw your application of health insurance in writing within 14 days without stating any reasons. The time-limit begins to run on the day on which you receive your insurance policy and the General Conditions of Insurance. It is sufficient to send off your withdrawal in time by surface mail, e-mail or fax in order to comply with the deadline for withdrawal. Your withdrawal should be addressed to DKV Globality S.A., 13, rue Edward Steichen, L-2540 Luxembourg. If you send your withdrawal by e-mail or fax, please send it to: service-yougenio@dkv-globality.com +352 / 270 444 3699.

Consequences of withdrawal

If you validly exercise your right of withdrawal, the premiums and benefits received must be returned by the respective parties. If you have agreed to inception of the insurance cover before expiry of the period for withdrawal, we are only obliged to refund the premium corresponding to the period following the receipt of your notice of withdrawal.

Acceptation of your application for health insurance

The application for health insurance does not commit the applicant or the insurer to conclude the insurance contract. The insurer is obliged, subject to payment of damages, to notify the applicant, within thirty days from the receipt of the application, an offer for insurance, the conditioning of the insurance to a further enquiry, or a refusal.

Responsibility for the information provided in the application

Before declaring my intention to conclude a contract, I must inform the insurer of all circumstances known to me and requested by the insurer, which are of importance for the insurer's decision to provide the agreed insurance cover.

Attention is drawn to the information given on page 2 with regard to the legal consequences of incorrectly answering the questions concerning your state of health.

Applicable law

Unless the application of a different law is required by national legislation, the insurance contract shall be governed by the law of the Grand Duchy of Luxembourg.

Supervisory authority

Complaints may be addressed to DKV Globality S.A. or to the ombudsman for insurance companies (A.C.A. – Association des Compagnies d'Assurance – in collaboration with the U.L.C. – Union Luxembourgeoise des Consommateurs) or to the supervisory authority for the insurance sector in Luxembourg, the Commissariat aux Assurances.

Consent to the receipt, storage, processing and transmission of personal data

By signing this application for health insurance, I explicitly agree to the receipt, storage and processing of my personal, insurance, health data and bank details by DKV Globality S.A., and to the transmission thereof to other companies in the Munich Re Group and to partners cooperating with DKV Globality S.A.. This consent is revocable at any time. DKV Globality S.A. undertakes to collect, store, process and transmit such data and details to third parties exclusively for the purpose of the performance of the insurance contract, the granting of the insurance cover and the provision of assistance services, advice and support.

Information concerning the identity and registered office of third parties processing my data is available from DKV Globality S.A. on request at any time.

This consent shall continue to apply after my death, and be valid for my insured children and any other insured persons whom I represent by law.

I have a right of access and rectification to my personal data on request at any time.

Release from the professional confidentiality duty

By signing this application for health insurance, I release from their professional confidentiality duty and give appropriate mandate to allow doctors, nurses and other medical staff, as well as employees of hospitals, clinics, nursing homes, personal insurance companies, statutory health insurance institutions, employers' liability insurance associations and public authorities who are named in the documents presented to DKV Globality S.A. or were

involved in the medical treatment, to provide DKV Globality S.A. with information on my health and treatment in order to permit assessment of the medical risk when concluding the contract and verification of my rights under the insurance contract.

By signing this application for health insurance, I also release the employees of DKV Globality S.A. from their professional confidentiality duty and give appropriate mandate to allow DKV Globality S.A. to provide information on my health and treatment or on my insurance cover to other companies in the Munich Re Group and to partners cooperating with DKV Globality S.A.. This mandate is revocable at any time. DKV Globality S.A. undertakes to provide such information to third parties exclusively for the purpose of the performance of the insurance contract, the granting of the insurance cover and the provision of assistance services, advice and support.

The release from the professional confidentiality duty as defined above shall continue to apply after my death, and be valid for my insured children and any other insured persons whom I represent by law.

I also agree, subject to revocation at any time, that DKV Globality S.A. may obtain information from the Register of Companies, the Register of Debtors and the Register of Private Insolvencies, either directly or through credit reporting agencies, in order to assess my creditworthiness.

Start date of insurance cover

Insurance cover commences on the date specified in the insurance policy (start date of insurance), but not before payment of the first premium and not before expiry of any qualifying periods. Insured events occurring before the start date of the insurance will not be indemnified. Insured events occurring after conclusion of the insurance contract but before the start date of the insurance are excluded. If the contract is amended, the provisions of this paragraph will apply to the new, additional part of the insurance cover.

Governing documents

The insurance contract will be governed by the General Conditions of Insurance for Globality YouGenio®.

A copy of the application form will be handed over to me as soon as I have signed it.

Validity of the contract

The insurance contract is only valid when the application has been accepted by the insurer in writing and the insurance policy has been issued. Payment of the first premium to the intermediary does not constitute acceptance of the application.

Due payment of the first premium

The first premium or premium instalment is due as soon as we have accepted your application for insurance. The premium is owed by you; it is your responsibility to ensure punctual payments.

Term of the contract

The insurance contract is concluded for a term of one year which is automatically renewed for further periods of 12 months each on expiry of each year, unless you object to the renewal not less than three months before expiry of the insurance year.

Moratorium

The moratorium is defined as a qualifying period of 24 months during which pre-existing medical conditions and their consequences will not be covered. After a continuous insurance period of 24 months, we will reimburse the eligible expenses incurred for pre-existing medical conditions and their consequences if the insured person did not suffer any symptoms and did not require treatment, did not consult a doctor and did not receive or require any medication for pre-existing medical conditions during this 24-month period. The moratorium may be extended beyond the 24 months for those disorders which were not without symptoms or treatment during the first 24 months.

Conversion:

- General Conditions of Insurance for Globality YouGenio®

In cases of conversion of a health insurance contract (e.g. change of plan levels), the plan features specified in the General Conditions of Insurance for the Globality YouGenio® shall apply for the new plan level as from the date of conversion specified in the endorsement to the insurance policy. Depending on the agreed plan level, the qualifying periods will also apply accordingly for the additional insurance cover.

- **Right of withdrawal**

The previous insurance cover shall continue to apply if a requested conversion does not become effective because the right of withdrawal has been exercised.

- **Crediting of the prior term**

The term of the prior insurance shall be credited to the new insurance following conversion.

Insurance cover may be increased during an insurance year; reductions in insurance cover are only possible with effect from the beginning of the next insurance year.

- **Insurance year**

The insurance year shall remain unchanged following conversion.

- **Surcharges for substandard risk, restrictions, exclusions**

If surcharges were payable for substandard risk prior to conversion of the insurance, these surcharges shall also be levied on the new plan premiums at the same percentage rates unless agreed otherwise. The surcharges will change to the same extent that premiums change (e.g. due to adjustment except when changing to the next age group).

Any restrictions on insurance cover and exclusions from benefits applicable in the past will continue to apply after conversion of an insurance.

Illnesses and their consequences, as well as the consequences of accidents which have occurred during the previous insurance term and which constitute an increased risk according to medical findings may be excluded from the higher insurance cover.

This also includes the treatment and delivery associated with an existing pregnancy.

Persons eligible for insurance

As someone who is temporarily living abroad for at least three months, I am eligible for insurance or will be eligible on the start date of the insurance cover. I am aware that family members / my non-marital partner can only be co-insured to the extent that they are eligible for insurance under the provisions of the General Conditions of Insurance; they are not co-insured automatically.

Prior insurance

Insofar as one of the persons to be insured did not have private or statutory health insurance cover for outpatient, dental and inpatient treatment during the last five years before applying for insurance, that person must now undergo medical examination. For this purpose, DKV Globality S.A. will send me a form to be completed by the doctor, which I must return within 14 days of receiving the form. The costs incurred for this medical examination will be borne by the applicant. The examination report shall in all cases become the property of DKV Globality S.A..