Assuria △△
VERZEKERINGEN

APPLICATION FORM AZPAS INSURANCE

PARTICULARS POLICYHOLDER: (Applicant and premium payer)

Last name : _____

First names (in full) : _____

Date of birth : _____ Sex: ❑ M ❑ F

ID-card / passport number : _____ *(Compulsory to attach copy)*

Mobile number *(compulsory)* : _____

E-mailadress : _____

Correspondence address : _____

Bank / Account No : _____

PERSON TO BE INSURED:

Last name : _____

First names (in full) : _____

Date of birth : _____ Sex: ❑M ❑F

Adress : _____ Place of residence

ID-card / passport number : _____ *(Compulsory to attach copy)*

Telephone numbers : _____

Mobile number *(compulsory)* : _____

E-mailadress : _____

Relationship to policyholder: _____

Name of the mother *(for newborn)*: _____

Date of birth of the mother : _____

Relationnumber of the mother : _____

Whom do you prefer to be the family doctor if you
are AZPAS-insured?　　　　　Name: _____ Address clinic: _____

*Who is your current or most recent family doctor? Name: _____ Address clinic: _____

*Note:
The family doctor is the doctor who knows which conditions you have and from whom medical information may be retrieved by Assuria Medische Verzekering N.V.

PRODUCTINFORMATION

			Choose additional coverage(s):	
❑ **AZPAS BASIC**	❑ **SRD**	❑ **USD**	❑ Silver Medicines Assortment	❑ Optical Care Extra
❑ **AZPAS PLUS**	❑ **SRD**	❑ **USD**	❑ Gold Medicines Assortment	❑ Optical Care Extra+
❑ **AZPAS SUPRÊME**	❑ **SRD**	❑ **USD**	❑ Second Medical Opinion	❑ Optical Care Extra++

Select the hospital coverage

❏ 1st class

❏ 2nd class

❏ 3rd class

* For children up to 12 years old the children's class applies is equal to the 3rd class

Select premium payment

❏ per month

❏ per 3 months

❏ per 6 months

❏ per year

Select desired date of inception of the insurance:

(The insurance can only become effective after acceptance by Assuria)

Questions as regards the person to be insured

Nr	Fill in/Tick where appropriate	Yes	No
1	Length in cm: Weight in kg: Date of measuring:		
2	Do you exercise regularly? How many hours a week?		
3	Have you ever been diagnosed or treated for: (if multiple conditions are listed with 1 answer, **circle** which applies to you) Cataract (stare, lens clouding) Glaucoma (increased eye pressure) Ear complaints Asthma Heart disease High blood pressure Increased cholesterol level Diabetes Do you use insulin? "Low Sahli" (anaemia) Increased bleeding tendency or trombosis? Sickle cells Thyroid gland disorder / another hormone disease Epilepsy Rheumatism, gout Degeneration of the joints Stroke (CVA, TIA), paralysis Prostate, uterus, fallopain tubes or genitals Skin complaints ❏ Eczema ❏ Psoriasis ❏ Other, namely Cancer or tumours If so, what type / body part? Congenital defects If so, which one? Other diseases or disorders? If so, which one? HIV Alcohol- or drug use Kidney function disorders Are you being dialyzed? Are you being treated to prevent or postpone kidney dialysis?		

Nr	Fill in/Tick where appropriate	Yes	No
	Do you suffer from an illness or are you currently under medical treatment for another illnes which not mentioned before? Which disease?		
4	Do you smoke? If so, how many cigarettes or rolling tobacco per day? ❏ Less than 10 ❏ 10 or more		
5	Do you drink alcoholic beverages? If so, how many glasses per month: ❏ Less than 25 ❏ 25 or more		
6	Do you use drugs? If so, which?		
7	Do you use medicines? If so, which? How often? per day / week / month Since when? Who prescribes these?		
8	Have you had surgery in the past 5 years? Name specialist and hospital Have you been hospitalized in the past 5 years for anything other than surgery? Reason for hospitalization? In which year? Do you still have complaints thereof? Who do you consult for these complaints?		
9	Are you now in a hospital or is there an admission in prospect? If so, why? Within how many days/ weeks/ months?		
10	Have you visited a medical specialist in the past 5 years? Reason of treatment? Are you still being treated?		
11	**For women:** Are you pregnant?		

Statement of Consent

Name: *(name of the person to be insured)*	Date of birth: *(date of birth of the person to be insured)*
....	....
Firstname(s): *(name of the person to be insured)*	Place of birth: *(place of birth of the person to be insured)*
....	....
Adress: *(adress of the person to be insured)*	Place of residence: *(place of residence of the person to be insured)*
....	
Product type: *(requested product type)*	....
………………………………………….......…	

This statement/authorization is an integral part of the application form and health declaration of the prospective insured person.

- I hereby declare that I have provided the following information to Assuria Medische verzekering N.V. (hereinafter referred to as: Assuria) for the application of an insurance:
- I have answered all questions on the application form and health declaration truthfully and to the best of my knowledge.
- I have not withheld any information or circumstances that may be relevant to Assuria for the conclusion of the insurance contract.
- I am aware that any concealment and/or incorrect answers to the aforementioned application form and health declaration may lead to the i invalidation of the insurance contract. In the event of invalidation of the insurance contract, the premiums already paid will not be refunded.
- I am aware that Assuria may request an additional medical examination if necessary. This is dependent on the medical information already obtained. I hereby agree to an additional medical examination.
- I hereby authorize the Medical Advisors of Assuria to request my personal medical information from all physicians, hospitals, clinics, or any other medical institution that has treated me or will treat me in the future. The medical information may include documentation about my health status or the cause of my death.

This authorization remains in effect until Assuria terminates this insurance.

Place and date,　　　　　　　　　　　　　　　　Place and date,

Signature of the person to be insured　　　　　　　　*Signature of the policyholder (if other than person to be insured)*
(in case of a minor, the signature of the parents or guardian)

SMS/E-MAIL SERVICES

Tick that which applies to you:

❑ Yes, I give Assuria N.V. permission to send information about insurance policies and promotions via SMS/e-mail free of charge.
❑ No, I do not give Assuria N.V. permission to send information about insurance policies and promotions via SMS/e-mail free of charge.

TIPS AND INFORMATION

✓ Please check that you have filled in, circled or explained everything where necessary. If the form has not been filled out completely and signed, unfortunately your application cannot be processed.

✓ The Application is taken into consideration by Assuria Medische Verzekering N.V. if received within one month of signing.

✓ The duration of processing an application may be influenced, if:
  - Assuria Medische Verzekering N.V. deems necessary an extra exam / lab investigation of the prospective insured.
  - Medical information is necessary of a family doctor or specialist who in the past treated / currently treats the prospective insured.

✓ Go through the **policy conditions** thoroughly and if necessary ask for any further explanation, so that if you use your Azpas card in the future, you know what your rights and obligations are.

Name agent:

IP number agent: