Assuria VERZEKERINGEN

APPLICATION FORM
PERSONAL ACCIDENT INSURANCE

TO BE FILLED IN BY ASSURIA OR PRODUCER

1. INFORMATION POLICY HOLDER

Customer number :

Name :

First names (in full) :

Date of birth : Sex: ❑M ❑F

Correspondence address :

Home number : Place of residence :

Telephone number : Fax no. :

E-mail address :

ID number CBB
(Central Civil Registry) :

2. PROSPECTIVE INSURED

Customer number :

Name :

First names (in full) :

Date of birth : Sex: ❑M ❑F

Profession / Occupation :

3. RISK-INCREASING CIRCUMSTANCES

What does your daily profession / occupation consist of?
❑ Mainly administrative ❑ Mainly supervisory / managerial
❑ Executive

Does your profession / occupation involve travelling? ❑ No ❑ Yes
If so, within which area and how many days a year?

Which sport / hobby do you practice?

Do you wish to co-insure the risk below?
- motorcycling from 50 cc. through 125 cc. cylinder capacity ❑ No ❑ Yes
- motorcycling with more than 125 cc. cylinder capacity ❑ No ❑ Yes

4. HEALTH QUESTIONS

(answer only if the insured sum exceeds USD 15.000 or Euro 11.000 or SRD 50.000)

Has the prospective insured ever had an accident? ❑ No ❑ Yes
If so, when and what was the injury?

Does he/she still have lingering complaints or defects? ❑ No ❑ Yes

Was (is) he/she unfit for work? ❑ No ❑ Yes
If so, when and how long did this last?

Did you suffer from a disease, a condition, disorder or anomaly? ❑ No ❑ Yes
If so, please explain

Do you use medicines? ❑ No ❑ Yes
If so, which

5. COVER

a. Choice of currency: ❑SRD ❑USD ❑EUR

b.

Which sections do you wish to insure?	**Fill out insured sum**
❑ **Section A:** Payment (death benefit) when death is the result of an accident	
❑ **Section B:** Payment if as a result of an accident permanent disability is caused Do you want a progressive cover? ❑ No ❑ Yes (50% premiumsurcharge)	
❑ **Section C:** Payment if the insured is temporarily unfit for work as a result of an accident. ▪ Deductible period: ❑ 8 days (standard) Options: (at granting a discount) ❑ 16 days ❑ 20 days ❑ 30 days ❑ 90 days ❑ 180 days ▪ Maximum duration payment: ❑ 1 year (standard) Options: (at granting a discount) ❑ 9 months ❑ 6 months ❑ 3 months ❑ 2 months ❑ 1,5 month ❑ 1 month	per day
❑ **Section D:** Compensation of medical costs as a result of an accident.	

c. Who must be paid?

	Name beneficiary	
Section A: In case of death		per accident
Section B: In case of permanent disability		
Section C: In case of temporary occupational disability		
Section D: Due to medical costs		

6. INCEPTION DATE OF THE INSURANCE

Life of the insurance ❑ 1 consecutive year ❑ Short-term: what is the maturity date?

The policyholder or (as the case may be) the prospective insured declares to have truthfully answered all questions and that he/she is aware of the provisions as laid down in article 320 of the Commercial Code.*

The policyholder or (as the case may be) the prospective insured furthermore declare to agree with the policy conditions and is aware of the fact that the insurance can only be effectuated after acceptance by the company

The undersigned herewith also authorises all physicians that have treated him/her or will treat him/her to provide the information about his/her health situation to the Medical Advisor of Assuria Medische Verzekering N.V.
The prospective insured agrees that Assuria – if the company deems such necessary - inspects files of the insured which may exist with the insurer and to also take into consideration such information in assessing whether or not to accept a risk or a claim.

***) Article 320 of the Commercial Code reads:** *any wrong or false statement or any concealment of circumstances that are known to the insured (read policyholder), no matter whether this was done in good faith, which are of such nature that the agreement would not have been entered into or not on the same conditions, had the insurer known about the true state of affairs, makes the insurance null and void.*

Paramaribo

Signature policyholder:

Signature prospective insured:

Name and signature Assuria Agent:

TO BE COMPLETED BY ASSURIA OR AGENT

Name Agent

Agent number

Policy number

Object number

TO BE COMPLETED BY ASSURIA EMPLOYEE FOR RISK ACCEPTANCE

Hazard category	*Acceptance agreed*	*Remarks*