Assuria VERZEKERINGEN

AZPAS INSURANCE APPLICATION FORM

1. PARTICULARS POLICYHOLDER (Applicant and premium payer)

If the application concerns groups (businesses)*:

Registration number Chamber of Commerce (KKF) :

Company name/ stamp :

Name managing director/ owner :

Mobile number managing director/ owner *(compulsory)*:

Name contact person : *(If different from managing director/ owner)*

Mobile number *(compulsory)*:

E-mail address : Fax number:

Correspondence address :

Bank / Account No. :

If the application concerns individuals (family)*:

Last name :

First names *(in full)* :

Date of birth : Sex: ❑M ❑F

Nationality :

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

Mobile number *(compulsory)*:

E-mail address : Fax number:

Correspondence address :

Bank / Account No. :

2. PERSON TO BE INSURED

Last name :

First names *(in full)* :

Date of birth : Sex: ❑M ❑F

Address : Place of residence:

ID-card number : Passport number: *(Compulsory to attach copy)*

Relationship to policyholder:

Name and date of birth of the mother *(for children <5 years)*:

Telephone number:

Home: Mobile *(compulsory)*: Work:

E-mail address: Fax number:

* You are required to notify us of any changes to your contact particulars

3. PRODUCT INFORMATION

a. Select the product

	b. Select the hospital coverage	c. Select premium payment
❑ AZPAS Plus	❑ 1st class ❑ 2nd class ❑ 3rd class*	❑ per month ❑ per 3 months ❑ per 6 months ❑ per year
❑ AZPAS Basis	❑ 1st class ❑ 2nd class ❑ 3rd class*	❑ per month ❑ per 3 months ❑ per 6 months ❑ per year

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

d. Select supplementary coverage:

❑ Optical care Supreme (Only possible in combination with AZPAS Plus, will replace the Classic coverage)
❑ Optical care Supreme+ (Only possible in combination with AZPAS Plus, will replace the Classic coverage)
❑ Optical care Extra (Only possible in combination with AZPAS Basis as an extra coverage)
❑ Optical care Extra+ (Only possible in combination with AZPAS Basis as an extra coverage)
❑ Alternative medicine Basic
❑ Alternative medicine Classic
❑ TandPas (dental care). *Submit the completed Tandpas application form and dental record certificate.*
❑ Azpas Medicines Index GOLD

e. Select desired date of inception of the insurance:
(The insurance can only become effective after acceptance by Assuria)

****) These questions do not apply to children < 5 years.**

4. QUESTIONS AS REGARDS THE PERSON TO BE INSURED

Nr	Tick where appropriate	Yes	No
1a	Length in cm : Weight in kg : Date of measuring:		
1b	**Only for children up to 5 years** Has your child been / will your child be vaccinated? If so, most recent vaccination date: Type of vaccination on that date :	☐	☐
2	What is your profession/occupation/engagement? If retired: what was your most recent profession/occupation? If unfit for work: what is the reason? Do you regularly physically exert yourself? Which sport do you practice and how often a week? Have you, during **the past 5 years**, been treated for 1 or more of the diseases or disorders mentioned below? *(tick where appropriate. If more diseases are mentioned circumscribe the one(s) applicable)*	☐	☐
3	Cataract (stare, lens clouding) Glaucoma (increased eye pressure) Another condition or illness Please explain: Do you use glasses or contact lenses? *(If so, circumscribe)*	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
4	Do you have ear complaints? Do you have complaints of ringing in the ears? Do you have running ears? Do you have eardrum tubes? Do you have a hearing aid? If so, ❑ left ❑ right?	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐

Nr	Tick that which is applicable	Yes	No
5	Do you have to cough regularly? Do you regularly have a shortness of breath? Do you have bronchitis, asthma or tuberculosis?	☐ ☐ ☐	☐ ☐ ☐
6	Do you have heart murmurs? Do you sometimes have a pain or an oppressed feeling in the chest or the heart region? Do you have high blood pressure? Do you have varicose veins? Do you have haemorrhoids? Do you experience pain in the calves while walking? Do you have increased cholesterol level in the blood? Do you have "Low Sahli" (anaemia)? Do you have another blood disorder? Do you have increased bleeding tendency or trombosis? Please explain:	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
7	Do you have diabetes? Do you use insulin? Do you often have symptoms of hunger or thirst? Do you have to pee often?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
8	Do you have sickle cell disorder? If so, which type? ❑ SS ❑ AS (carrier)	☐	☐
9	Thyroid gland disorder / another hormone disease?	☐	☐
10	Do you often have stomach region complaints? Do you have stomach ache? Do you have heartburn? Do you regularly have to burp/ belch?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
11	Do you regularly have problems with your bowels? Do you regularly have constipation? Do you regularly have diarrhoea? Do you regularly have blood in the stools?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

Nr	Tick that which is applicable	Yes	No

12 Have you, during **the past 5 years**, been treated for 1 or more of the diseases or disorders mentioned below? *(tick where appropriate. If more diseases are mentioned circumscribe the one(s) applicable)*

- Heart disease
- Overstrained, dizziness, chronic headaches or migraine
- Allergy for dust, food, medicine or something else, namely
- Epilepsy
- Rheumatism, gout
- Arthrosis (degeneration of the joints)
- Neck / back complaints
- Spinal anomalies or often backache
- Other muscle or joint complaints

If so, which part of the body?

- Gallbladder, liver (e.g. jaundice)
- Stroke (CVA, TIA), paralysis
- Nervous disorder
- Kidneys or bladder
- Prostate, uterus, fallopain tubes or genitals (penis/vagina)
- Skin complaints

If so, which?

❑ Eczema ❑ Psoriasis ❑ Other, namely

- Nerve inflammation, bone diseases, bone fractures
- Cancer or tumours

If so, what type / body part?

- Congenital defects

If so, which one?

- Other diseases or disorders?

If so, which one?

- Mental illness?

If so, which one?

13 Do you have a venereal disease or sexually transmitted disease?
A condition of the genitals?
Please explain:

14 Do you have HIV?

15 Did you have any routine medical, pediatric or gynecological checkups, mammograms, pap smears, etc.
If yes, indicate date and results:

16 Are you being treated for Leishmaniasis ("Bos Yaws")?
Are you being treated for tuberculosis?

17** Do you smoke?
If so, how many cigarettes or rolling tobacco **per day**?
❑ Less than 10 ❑ 10 or more

18** Do you drink alcoholic beverages?
If so, how many glasses **per month**:
❑ Less than 25 ❑ 25 or more

Nr	Tick that which is applicable	Yes	No

19** Do you use drugs? If so, which?

Have you ever been medically treated for the use of alcohol or drugs?

20 Are you being dialyzed?
Are you being treated to prevent or postpone kidney dialysis?

21 Do you use medicines?
If so, which?
How often? per day / week / month
Since when?
Who prescribes these?

22 Have you ever undergone surgery?
Were you hospitalised other than for surgery?
Name specialist and hospital

Reason of hospitalization

Do you still have complaints thereof?
Who do you consult for these complaints?

23 Is there a prospect of hospitalization?
If so, why?
Within how many days/ weeks/ months?

24 Are you currently under medical treatment for another illness which has not been mentioned above?
If so which illness?

25 Have you ever had an accident which resulted in physical injury?
In what year?
Describe the injury

If you are a male, please continue with question 28

26** Are you currently pregnant?
Are you being treated for an irregular menstruation?
Are you being treated for a desire to have children?

27** Did you have pregnancies?
If so, during your pregnancy did you have
- High blood pressure?
- Diabetes?

28 Have you visited a medical specialist in the past 5 years?
Name specialist and hospital

Reason of visit?
Are you still being treated?

29 Do you have any remarks about your health that have not been mentioned above?
Place them here

Nr	Tick that which is applicable	Yes	No
30	Has a life-, a medical- or accident insurance ever been: - rejected - declaimed - postponed - accepted at an increased premium - accepted at special conditions? If so, give details		
31	At which company were you insured last year? ❑ Assuria ❑ SZF ❑ Self Reliance ❑ Parsasco ❑ Somewhere else, namely ❑ Not insured Policy number: At which company are you currently insured? ❑ Assuria ❑ SZF ❑ Self Reliance ❑ Parsasco ❑ Somewhere else, namely ❑ Not insured Expiration date: You are required to attach a copy of your insurance card		

Nr	Tick that which is applicable	Yes	No
	Will the insurance applied for have to replace the current insurance? If so, why?		
32a	Whom do you prefer to be the family doctor if you are AZPAS-insured? Name: Address clinic:		
32b	Who is your current or most recent family doctor? Name: Address clinic:		

Note: The family doctor(s) is (are) the doctor(s) you visit when you are ill and from whom medical information may be retrieved by Assuria Medische Verzekering N.V.

If during the application procedure your health condition changes, you are obliged to report this to Assuria Medische Verzekering N.V. Non-compliance with this obligation may lead to nullification of the insurance.

Undersigned declares to have truthfully answered all questions and undertakes to accept the policy to be drawn up in pursuance of this application at payment of the premium and costs due. The applicant is aware that the insurance only becomes effective after the acceptance by the company. Article 320 of the Commercial Code*.

The undersigned herewith authorizes all physicians that have treated or will treat him/her to provide the information about his/her health situation to Assuria Medische Verzekering N.V. if so requested.

Place: Date: Place: Date:

(signature of the person to be insured)
(in case of a minor, the signature of the parents or guardian)

(signature of the policyholder)

*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 is 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, shall render void the insurance.

SMS/E-MAIL SERVICES

Tick that which applies to you
❑ Yes, I give Assuria NV permission to send information about insurance policies and promotions via SMS / e-mail, free of charge.
❑ No, I do not give Assuria NV permission to send information about insurance policies and promotions via SMS / e-mail, free of charge.

TIPS AND INFORMATION

- ✓ Please check whether you have filled out everything. If the form has not been filled out completely and signed, unfortunately your application cannot be processed.
- ✓ Application is taken into consideration by Assuria Medische Verzekering 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 :