Assuria VERZEKERINGEN

APPLICATION FORM AZPAS INTERNATIONAL DIAMOND

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

Marital Status : ❑ M-married ❑ S-single ❑ D-divorced ❑ W-widow/er

Home Address : Place of residence:

Correspondence address :

Country of residence : ❑ Suriname ❑ Guyana

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

Relationship to policyholder:

If the person is older than 19 years of age: Are they full-time students in a college or university? ❑ Yes ❑ No

Name and telephone number of college or university:
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 deductible*

Individual:

❑ USD 1.000,-/ USD 2.500,-

❑ USD 5.000,-

❑ USD 10.000,-

❑ USD 20.000,-

Group:

❑ USD 1.000,-

b. Rider:

❑ Maternity

❑ Private Pilot

c. Student / Employee Rider ❑ Yes ❑ No

Country Region

Period of stay

**) All deductibles have a maximum coverage of USD 2.000.000,-*

c. Select desired date of inception of the insurance (1st or 15th of the month):

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

d. Has a claim ever been filed for benefits under insurance policy for yourself or any proposed insured? ❑ Yes ❑ No

If yes, explain

****) 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?		
5	Do you have to cough regularly? Do you regularly have a shortness of breath? Do you have bronchitis, asthma or tuberculosis?		

Nr	Tick that which is applicable	Yes	No
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?		
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		

Nr	Tick that which is applicable	Yes	No
12	- 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	☐	☐
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?	☐	☐

Nr	Tick that which is applicable	Yes	No
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		
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		

Nr	Tick that which is applicable	Yes	No
31	At which company are you currently insured? ❑ Assuria ❑ SZF ❑ Self Reliance ❑ Parasco ❑ 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?		
32	Who is your current or most recent family doctor? Name: Address clinic:		

If the person is a employee, the following must be completed:

1. Date of Full-Time employee:

2. Hours worked per week: ❑ <30 hours ❑ >30 hours

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.

Beneficiaries:

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 hereby authorizes Assuria Medische Verzekering N.V. to consult with the reinsurer(s), within the process of acceptance of this request for medical insurance, with the understanding that personal data of the applicant or insured person(s) can be exchanged between parties.

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 :