MEDICAL QUESTIONNAIRE

Please complete this form in **BLOCK CAPITALS**. A separate Medical Questionnaire is required for each person applying for cover.

1 APPLICANT DETAILS

Please indicate if this form is being completed for or on behalf of (please tick one): Applicant/policyholder ☐ Dependant ☐

Applicant/policyholder:

Surname

First name

Full address in country of residence (mandatory)

Dependant to be insured (please also complete the applicant details):

Surname

First name

Date of birth D D / M M / Y Y Y Y Gender: Male ☐ Female ☐

Address if different than above

2 PRE-EXISTING CONDITIONS

Pre-existing conditions are medical conditions or any related conditions for which one or more symptoms have been displayed at some point during your lifetime, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition, about which you or your dependants could reasonably have been assumed to have known, will be deemed to be pre-existing. Pre-existing conditions are covered under the policy, unless otherwise advised by us in writing. Conditions arising between completing the Medical Questionnaire and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered. **Therefore, it is necessary that you advise us of any material changes to the information provided, between submission of this questionnaire and acceptance by us**. You are hereby obliged on request to provide any further information that we might require. Full and accurate completion of this Medical Questionnaire and disclosure of all relevant information is a condition precedent to cover.

3 HEALTH DECLARATION

3.1 Please provide the following information: Height (cm) Weight (kg)

3.2 Does your present state of health prevent you from fulfilling your professional duties? Yes ☐ No ☐

If Yes, please provide further details

3.3 Do you suffer from any Mental, Physical or Chronic disability either from birth or as a result of illness or accident? Yes ☐ No ☐

If Yes, please provide further details

3.4 Have you undergone a surgical intervention or medical treatment (medicinal or otherwise) in the last 10 years? Yes ☐ No ☐

If Yes, please provide further details (including date and surgery/treatment type)

3.5 Are you currently receiving or have you been advised to receive any of the following treatments in the next six months?

Hospitalisation Yes ☐ No ☐ Please specify type:

Surgical Intervention Yes ☐ No ☐ Please specify type:

Out-patient treatment Yes ☐ No ☐ Please specify type:

Dental treatment Yes ☐ No ☐ Please specify type:

3.6 Do you qualify for a 100% reimbursement from the JSIS? Yes ☐ No ☐

If yes, please specify for which medical condition

Allianz Care

4 WE CARE ABOUT YOUR PERSONAL DATA PROTECTION

Our Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process your personal data and should be read by you before the submission of any personal data to us. To read our Data Protection Notice visit: **www.allianzworldwidecare.com/en/privacy**

Alternatively, you can contact us on + 32 2 210 6501 to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, you can always contact us by e-mail at: **AWC.DataPrivacyOfficer@allianz.com**

5 DECLARATION

Please read the following declarations carefully and only sign below if you understand and accept them.

(a) I declare that all information supplied above is true and complete, including those answers that are not in my own handwriting. I also declare that I have not suppressed, misrepresented or misstated any material fact. I understand that this application shall be the basis of the contract between Allianz Care and myself, and that any false, incorrect or misleading statement or non disclosure of material medical information may render this contract null and void.

(b) I undertake to inform Allianz Care immediately in writing of any changes in my or my dependants' state of health occurring between completing the Medical Questionnaire and the start date of the contract.

(c) I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information and I consent to the fact that Allianz Care, if it considers it appropriate, will check statements concerning my health condition and will check with other healthcare insurers, all statements concerning previous, or existing contracts applied for. I authorise all such practitioners, physicians, dentists, members of medical professions, employees of hospitals and health authorities as well as medical facilities to provide relevant medical information relating to me, if requested by Allianz Care, its medical advisers, its appointed representatives, or to any third party expert(s) in case of disputes, subject to any legal restrictions which may apply. I also make this statement for my co-insured dependants, including those who cannot assess the meaning of this statement.

(d) I confirm that I have read and understood the full definitions, benefits, exclusions and conditions of this policy including the details relating to pre-existing conditions.

(e) I understand:

- That this Medical Questionnaire is valid for two months from the date of completing and signing it.
- That I can withdraw my Medical Questionnaire in writing by letter, email or fax, within 30 days from the date I receive the full terms and conditions of my policy, and provided that I have not submitted a claim, I am entitled to a full refund of the premium.

(f) I accept that:

- It is my responsibility to check the accuracy of the information contained within the Insurance Certificate, once issued. If the content is not in accordance with the Medical Questionnaire, the situation will be considered accepted if I enter no protest within 30 days following the issue date of the Insurance Certificate.
- This policy will be subject to the standard policy terms and conditions effective at the time of policy commencement contained within the Benefit Guide.

(g) I accept that it is my responsibility to check whether I am subject to any local compulsory health insurance requirements and I have satisfied myself that my insurance cover is legally appropriate.

As the applicant, I sign this declaration and Medical Questionnaire for and on behalf of all persons included in this Medical Questionnaire.

Applicant's signature _____ Date D D / M M / Y Y Y Y

Applicant's printed name

PLEASE RETURN YOUR FULLY COMPLETED FORM BY:

Email to: underwriting@allianzworldwidecare.com
Fax to: +353 1 629 7117
Post to: Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland

If you have any questions regarding this Medical Questionnaire or the application process, please contact our Helpline on: +353 1 630 1301