Health Insurance Application Form

This form should be filled out by the applicant or the applicant's legal representative. All applicable questions should be answered in full and singed form should then be sent promptly to the address on the last page of the form. If you have any question, contact us on 0844 000 000. Thank you in advance.

Client number

1 Personal details

Family number

Sex Female Male

First name

Last name

Street, Number

Address supplement

Postal code/ Town

P.O. Box

Date of birth

E-mail (non mandatory)

Legal residence, postal code

Phone number

2 Outpatient treatment

☐ Illness ☐ Accident ☐ Maternity

Cancer ☐ Skin cancer ☐ Blood cancer ☐ Breast cancer

HIV ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No

Blood or Protein in the urine ☐ Yes ☐ No

Treatment		**Treatment performed by**	**Town/ country**
From	to		

Reason/ diagnosis	currency	amount

What kind of treatment has been performed?

Treatment		Treatment performed by	Town/ country
From	to		

Reason/ diagnosis	currency	amount

Remarks

The signatory declares that he/she has answered all the questions on each page completely and truthfully.

By signing the application form the signatory authorizes us to share and obtain information at all times from doctors, other service providers, state and private insurers, authorities and company physicians and medical advisors of the foregoing as needed to assess the insurance cover while respecting the provisions of data privacy legislation. With respect to the foregoing the signatory releases all agencies from the obligation to maintain professional secrecy or patient confidentiality with respect to @@@ Insurance.

The signatory is entitled to request information about his or her data that is being processed. Permission to process data may be revoked at any time.

Legal entity: @@@ Insurance Ltd.

Town	Date

Signature