AFFILIATION FORM
Collective Insurance Health Care

☐ **Affiliation of new insured person**
☐ **Addition of a family member**
☐ **Desaffiliation of an insured person**
☐ **Change of the policy of an insured person**

Effect date of the demand:
Policy number:

Identification employer:
Employer number:

Identification of policyholder (staff member)
Name:
First name:
Sex:
Date of birth:
Marital status:
Starting date of employment:
Language group:
Staffcategory:
Address:
No/Box:
Post code:
Place:

Affiliation/changement to the insurance health care

Partner	Name: Date of birth:	First name:	☐ Add	☐ Delete
Child	Name: Date of birth:	First name:	☐ Add	☐ Delete
Child	Name: Date of birth:	First name:	☐ Add	☐ Delete
Child	Name: Date of birth:	First name:	☐ Add	☐ Delete
Child	Name: Date of birth:	First name:	☐ Add	☐ Delete
Child	Name: Date of birth:	First name:	☐ Add	☐ Delete

Leaving of policyholder

Leaving date:

Comments:

The insured and the policy holder declare that the above data are correct and true in all details, despite the fact that they have not written them themselves. They declare to understand that the intentional omission of incorrect sharing of data under the Act on the Country Insurance Agreement of 25/06/1992 with limited boundaries, could lead to the nullity of the contract or the non-payment of the insurance sums.

The undersigned declare(s) to have taken note of the provisions regarding the protection of the personal privacy.

At: , on

The insured (signature preceded by “agreed and accepted”)
The policy-holder,

AXA Belgium, S.A. d’assurances agréée sous le n° 0039 pour pratiquer les branches vie et non-vie (A.R. 04-07-1979, M.B. 14-07-1979)
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