Assuria VERZEKERINGEN

APPLICATION FORM DENTAL HEALTH INSURANCE

(Please submit this form together with the dental record certificate)

PLEASE PRINT

Client number :

Policy number :

A. PARTICULARS OF THE POLICYHOLDER

Name :

First names :

Date of birth : ID-number: Sex: ❑ M ❑ F

Collection adress:

E-mail :

Telephone number: Mobile:

Bank and account number:

B. PARTICULARS OF THE PERSON TO BE INSURED

Name :

First names :

Date of birth : ID-number: Sex: ❑ M ❑ F

Place of birth :

Relationship to policyholder:

Adress :

E-mail :

Telephone number: Mobile:

Premium per : ❑ year / ❑ month

Profession / Occupation:

Age :

Your current dentist:

Which dental coverage do you wish to take out?

❑ Basic ❑ Classic ❑ Supreme ❑ Supreme+

Submission of bitewing X-rays is required when applying for a Tandpas Classic coverage or higher.

Questions to be answered upon applying for the TandPas dental health insurance

Tick where appropriate:

1. Do you, in your opinion have a good set of teeth? ❑ Yes ❑ No

2. Have teeth / molars been extracted from your permanent set of teeth? ❑ Yes ❑ No
   If so, how many? ❑1-2 ❑ 3-4 ❑ 5-6 ❑ more than 6

3. Have teeth / molars of your permanent set of teeth been filled or have you undergone root treatments? ❑ Yes ❑ No
   If so, how many? ❑1-2 ❑ 3-4 ❑ 5-6 ❑ more than 6

4. Do you have your set of teeth checked by the dentist? ❑ Yes ❑ No
   If so, how often and when was your last check-up?

   Number of times: Date last check-up:

5. Have your molars and teeth caused you any pain during the past 2 years? ❑ Yes ❑ No

   If so, describe the pain:

6. Have you undergone any surgery of your set of teeth, gums and/or jaw as a result of an accident/ cause? ❑ Yes ❑ No

   If so, how long ago? Date:

7. Do you wear a(n) (entire or partial) prosthesis? ❑ Yes ❑ No

   If so, since when? Date:

8. Do you have any further comments about your set of teeth? ❑ Yes ❑ No

   If so, state comment

9. Will the Insurance applied for replace another existing similar Insurance? ❑ Yes ❑ No

   If so, state comment

10. Whom do you prefer as your dentist? *(Your teeth will have to be seen to by this dentist)*

    Name dentist:

11. As of which date do you wish to have the insurance become effective?

    Date:

SMS / E-MAIL services

Tick where appropriate::
❑ Yes, I give permission to Assuria NV to forward information about policies and promotions via SMS / e-mail free of charge.
❑ No, I do not give permission to Assuria NV to forward information about policies and promotions via SMS / e-mail free of charge.

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 submitting a dental record certificate issued by a dentist with whom Assuria has an agreement and after acceptance by Assuria Medische Verzekering N.V*

Undersigned also authorizes all dentists that have treated him/her or will treat him/her to provide all relevant medical information to be asked by the Medical Advisor of Assuria N.V

Paramaribo

Signature of the prospective insured
(in case of minors, parents or guardian need to co-sign)

Paramaribo

Signature of the prospective policyholder
(in case of minors, parents or guardian need to co-sign)

* Article 320 of the Commercial Code reads: any wrong or true statement or any concealment of circumstances that are known to the insured (read policyholder), no matter whether this was done in good faith, which are 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, makes the insurance null and void.

Name agent: Number agent:

Paramaribo

(signature agent)

TO BE COMPLETED BY ASSURIA MEDISCHE VERZEKERING N.V.

Acceptance: ❑ YES / ❑ NO Notes:

Paramaribo

DENTAL RECORD CERTIFICATE DENTAL HEALTH INSURANCE

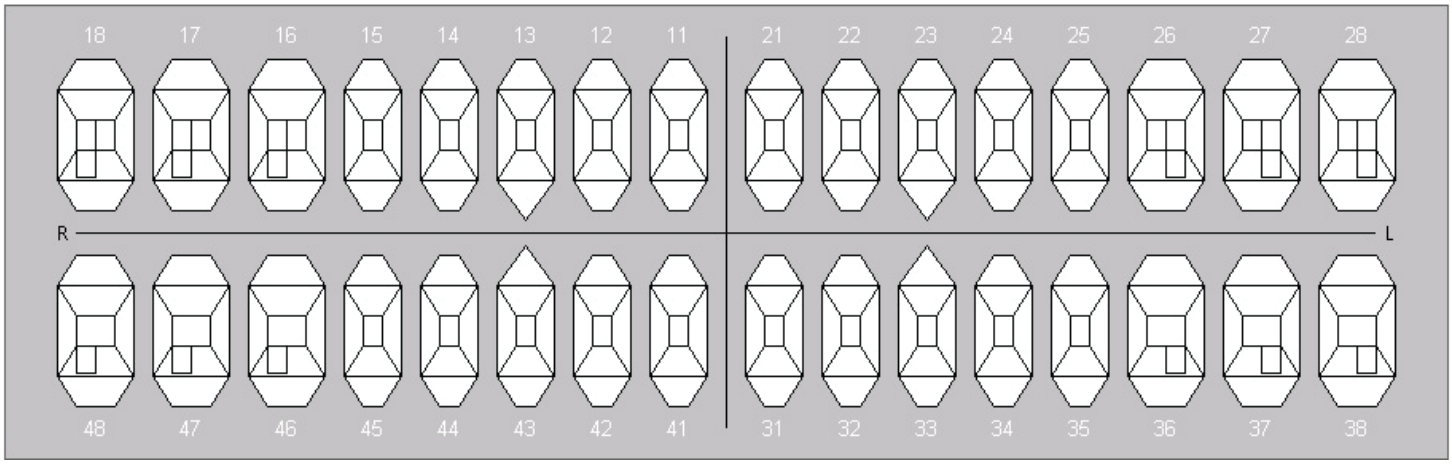
TO BE COMPLETED BY THE DENTIST

Name :

First names :

Date of birth : Sex: ❑ M ❑ F

Diagram set of teeth:



Comments / additions:

Undersigned declares that aforesaid patient has a set of teeth that is in order and well-maintained.

Paramaribo,

Stamp dentist Signature dentist