

PARTICULARS POLICYHOLDER: (Applicant and premium payer)

Last name	:			
First names (in full)	:			
Date of birth	:		Sex:	<input type="checkbox"/> M <input type="checkbox"/> F
ID-card / passport number	:		(Compulsory to attach copy)	
Mobile number (compulsory):	:			
E-mailaddress	:			
Correspondence address	:			
Bank / Account No	:			

PERSON TO BE INSURED:

Last name	:			
First names (in full)	:			
Date of birth	:		Sex:	<input type="checkbox"/> M <input type="checkbox"/> F
Adress	:		Place of residence	
ID-card / passport number	:		(Compulsory to attach copy)	
Telephone numbers	:			
Mobile number (compulsory) :	:			
E-mailaddress	:			
Relationship to policyholder:	:			
Name of the mother (for newborn):	:			
Date of birth of the mother	:			
Relationnumber of the mother	:			

Whom do you prefer to be the family doctor if you are AZPAS-insured?	Name:		Address clinic:	
*Who is your current or most recent family doctor?	Name:		Address clinic:	

***Note:**
The family doctor is the doctor who knows which conditions you have and from whom medical information may be retrieved by Assuria Medische Verzekering N.V.

PRODUCTINFORMATION

- | | | |
|--|------------------------------|------------------------------|
| <input type="checkbox"/> AZPAS BASIC | <input type="checkbox"/> SRD | <input type="checkbox"/> USD |
| <input type="checkbox"/> AZPAS PLUS | <input type="checkbox"/> SRD | <input type="checkbox"/> USD |
| <input type="checkbox"/> AZPAS SUPRÊME | <input type="checkbox"/> SRD | <input type="checkbox"/> USD |

Choose additional coverage(s):

- ☐ Silver Medicines Assortment
- ☐ Gold Medicines Assortment
- ☐ Second Medical Opinion

- ☐ 1st class
- ☐ 2nd class
- ☐ 3rd class

Select desired date of inception of the insurance:

Questions as regards the person to be insured

☐ per month

☐ per 3 months

☐ per 6 months

☐ per year

Nr	Fill in/Tick where appropriate	Yes	No
	Do you suffer from an illness or are you currently under medical treatment for another illness which not mentioned before? Which disease? _____	<input type="text"/>	<input type="text"/>
4	Do you smoke? If so, how many cigarettes or rolling tobacco per day? <input type="checkbox"/> Less than 10 <input type="checkbox"/> 10 or more	<input type="text"/>	<input type="text"/>
5	Do you drink alcoholic beverages? If so, how many glasses per month: <input type="checkbox"/> Less than 25 <input type="checkbox"/> 25 or more	<input type="text"/>	<input type="text"/>
6	Do you use drugs? If so, which? _____	<input type="text"/>	<input type="text"/>
7	Do you use medicines? If so, which? _____ How often? _____ per day / week / month Since when? _____ Who prescribes these? _____	<input type="text"/>	<input type="text"/>
8	Have you had surgery in the past 5 years? Name specialist and hospital _____ Have you been hospitalized in the past 5 years for anything other than surgery? Reason for hospitalization? _____ In which year? _____ Do you still have complaints thereof? Who do you consult for these complaints? _____	<input type="text"/>	<input type="text"/>
9	Are you now in a hospital or is there an admission in prospect? If so, why? _____ Within how many days/ weeks/ months? _____	<input type="text"/>	<input type="text"/>
10	Have you visited a medical specialist in the past 5 years? _____ Reason of treatment? _____ Are you still being treated?	<input type="text"/>	<input type="text"/>
11	For women: Are you pregnant?	<input type="text"/>	<input type="text"/>

Statement of Consent

Name: <i>(name of the person to be insured)</i>	Date of birth: <i>(date of birth of the person to be insured)</i>
Firstname(s): <i>(name of the person to be insured)</i>	Place of birth: <i>(place of birth of the person to be insured)</i>
Adress: <i>(adress of the person to be insured)</i>	Place of residence: <i>(place of residence of the person to be insured)</i>
Product type: <i>(requested product type)</i>

This statement/authorization is an integral part of the application form and health declaration of the prospective insured person.

- I hereby declare that I have provided the following information to Assuria Medische verzekering N.V. (hereinafter referred to as: Assuria) for the application of an insurance:
- I have answered all questions on the application form and health declaration truthfully and to the best of my knowledge.
- I have not withheld any information or circumstances that may be relevant to Assuria for the conclusion of the insurance contract.
- I am aware that any concealment and/or incorrect answers to the aforementioned application form and health declaration may lead to the i invalidation of the insurance contract. In the event of invalidation of the insurance contract, the premiums already paid will not be refunded.
- I am aware that Assuria may request an additional medical examination if necessary. This is dependent on the medical information already obtained. I hereby agree to an additional medical examination.
- I hereby authorize the Medical Advisors of Assuria to request my personal medical information from all physicians, hospitals, clinics, or any other medical institution that has treated me or will treat me in the future. The medical information may include documentation about my health status or the cause of my death.

This authorization remains in effect until Assuria terminates this insurance.

Place and date,

*Signature of the person to be insured
(in case of a minor, the signature of the parents or guardian)*

Place and date,

Signature of the policyholder (if other than person to be insured)

SMS/E-MAIL SERVICES

Tick that which applies to you:

- ☐ Yes, I give Assuria N.V. permission to send information about insurance policies and promotions via SMS/e-mail free of charge.
- ☐ No, I do not give Assuria N.V. permission to send information about insurance policies and promotions via SMS/e-mail free of charge.

TIPS AND INFORMATION

- ✓ Please check that you have filled in, circled or explained everything where necessary. If the form has not been filled out completely and signed, unfortunately your application cannot be processed.
- ✓ The Application is taken into consideration by Assuria Medische Verzekering N.V. 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: