International Healthcare Plans for you and your family

APPLICATION FORM

Please note that you can apply online for one of our International Healthcare Plans at **www.allianzcare.com**

PLEASE COMPLETE THIS FORM IN BLOCK CAPITALS

If you are adding a new dependant to an existing policy, please state your policy number:

If you are applying to join an existing group scheme, please state:

Group name

Group number

Guidelines on how to complete this Application Form

1. You must complete the Application form in full and tell us all relevant information. Once you have sent us your application, our Medical Underwriting Team will review the details. If you have told us about any medical conditions we may ask you for more information. We will then assess the information and get back to you with our decision as quickly as possible.
2. If you already have one of our healthcare plans, please tell us about any medical conditions you have claimed for since joining us.
3. Section 7 must be signed by the policyholder. Sections 8 and 11 must be signed by all adult applicants. In line with the European General Data Protection Regulation (GDPR), we won't be able to process your application without these signatures. A parent or guardian should complete these sections for any applicants under the age of 18. Section 9 needs to be signed by all adult applicants wishing to appoint a broker as the main point of contact for this policy.
4. If any person applying for cover is undergoing dental treatment, please ensure that a dental questionnaire is completed. This can be downloaded from our website: **https://www.allianzcare.com/en/personal-international-health-insurance/paper-applications.html**

Wherever the following words and phrases appear in this form, they will have the meanings as defined below.
Home country: A country for which you (or your dependants, if applicable) hold a current passport or which is your principal country of residence.
Principal country of residence: The country where you and your dependants (if applicable) live for more than six months of the year.

1 APPLICANT DETAILS (please note that the applicant will be the policyholder)

You must tell us if your contact details change so we can ensure that correspondence reaches you. We will consider applicants for cover up to the day before their 76th birthday.

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other First name

Surname

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

Home country

Nationality

Principal country of residence

Full address in principal country of residence (mandatory)

Primary phone number COUNTRY CODE AREA CODE

Secondary phone number COUNTRY CODE AREA CODE

Email address (mandatory, please print)

Occupation (mandatory. If you are a student, please state this here)

Please indicate the language in which you wish to receive your policy documents:

English ☐ German ☐ French ☐ Spanish ☐ Italian ☐ Portuguese ☐

Details of any current domestic or international health insurance:

Name of insurer

Policy number Start date D D / M M / Y Y Y Y

Allianz Care

2 DEPENDANTS TO BE COVERED UNDER THE CONTRACT

Dependants can include your spouse/partner and any children financially dependent on you up to the day before their 18th birthday, or up to the day before their 24th birthday if they are in full-time education. If they are aged 18 to 23 and in full-time education, please attach either a letter from the college/university confirming their student status or a copy of their student ID. We will consider adult dependants for cover up to the day before their 76th birthday. If there is insufficient space for all dependants, please use another Application Form.

	Dependant 1	Dependant 2	Dependant 3
Relationship to applicant	Spouse/Partner ☐ Child ☐	Spouse/Partner ☐ Child ☐	Spouse/Partner ☐ Child ☐
First name			
Surname			
Date of birth	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
Gender	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Occupation (mandatory, please state if student)			
Email address (mandatory for dependants over 18)			
Home country			
Principal country of residence			
Nationality			

Details of any current domestic or international health insurance

Name of insurer (if applicable)			
Policy number (if applicable)			

3 START DATE OF COVER

Please indicate the date you require cover from: D D / M M / Y Y Y Y

Our acceptance of your application for cover is confirmed when we issue your Insurance Certificate and your cover is valid from the start date shown on the certificate.

4 PLAN DETAILS (this section does not need to be completed if you are applying as part of a group scheme)

Select your Area of Cover

The area of cover is subject to full terms and conditions as stated in the Benefit Guide.

☐ Worldwide ☐ Worldwide excluding USA ☐ Africa

You can choose different plans for each family member under the policy subject to the guidelines outlined below. Please make sure to select the appropriate cover for each person to be insured, in a way that best suits your needs and the needs of your family.

Core Plans

Please refer to the Benefit Guide and Table of Benefits for details of the various plans listed below.
If you select Care Pro plan for anyone under the policy, then you must select Care Pro or Care Plus for the remaining applicants - you can't select the Care Plan.

	Policyholder	Dependant 1	Dependant 2	Dependant 3
Care Pro	☐	☐	☐	☐
Care Plus	☐	☐	☐	☐
Care	☐	☐	☐	☐

4 PLAN DETAILS (CONTINUED)

Select your Core Plan deductible

To reduce your Core Plan premium, simply select an optional deductible from the list below and read across to find the relevant premium discount. The level of discount will depend on whether you have selected a Maternity Plan. Please note that either a Core Plan deductible OR an Out-patient Plan deductible can be chosen (details follow). Where a deductible is selected it is payable per person, per Insurance Year. Also, our premiums are expressed in whole numbers (i.e. without any cents or pence etc.), therefore, percentages may be slightly higher or lower than those stated below.

Optional Core Plan Deductibles	Discount if a Maternity Plan is not included on your policy	Discount if a Maternity Plan is included on your policy
☐ No deductible	0% premium discount	0% premium discount
☐ £374/€450/$610/CHF 585 deductible	5% premium discount	2.5% premium discount
☐ £625/€750/$1,015/CHF 975 deductible	10% premium discount	5% premium discount
☐ £1,245/€1,500/$2,025/CHF 1,950 deductible	20% premium discount	10% premium discount
☐ £2,490/€3,000/$4,050/CHF 3,900 deductible	35% premium discount	17.5% premium discount
☐ £4,980/€6,000/$8,100/CHF 7,800 deductible	50% premium discount	25% premium discount
☐ £8,300/€10,000/$13,500/CHF 13,000 deductible	60% premium discount	30% premium discount

Select your Optional Plans (Optional Plans can only be purchased with a Core Plan)

Maternity Plans

One of the following Maternity Plans can only be purchased with the Care Pro or Care Plus Core Plans. They cannot be purchased with the Care core plan. Our Maternity Plans offer cover for Routine Delivery, Newborn Care and Complications of Childbirth. You can also supplement your maternity cover by selecting our 'Active Family' Out-patient plan to include pre and post-natal care and other maternity benefits. For more details please refer to the Benefit Guide and Table of Benefits.

	Policyholder	Dependant 1	Dependant 2	Dependant 3
Bloom Plus	☐	☐	☐	☐
Bloom	☐	☐	☐	☐

Out-patient Plans

If you select Active Pro out-patient plan for anyone on the policy, then you must select an out-patient plan for all applicants and in this circumstance, you must select either Active Family, Active Pro or Active Plus for the remaining applicants, but you may not select the Active plan.

	Policyholder	Dependant 1	Dependant 2	Dependant 3
Active Family	☐	☐	☐	☐
Active Pro	☐	☐	☐	☐
Active Plus	☐	☐	☐	☐
Active	☐	☐	☐	☐

Select your Out-patient Plan deductible

(Please note that either an Out-Patient Plan deductible OR a Core Plan deductible can be chosen. Where a deductible is selected it is payable per person, per Insurance Year.)

☐ No deductible ☐ €100/£83/CHF130/$135 ☐ €200/£165/CHF260/$270

Dental Plans

If you select Smile Plus plan for anyone under the policy, then you must select one of the dental plans below for the remaining applicants.

	Policyholder	Dependant 1	Dependant 2	Dependant 3
Smile Plus	☐	☐	☐	☐
Smile	☐	☐	☐	☐

Repatriation Plan

	Policyholder	Dependant 1	Dependant 2	Dependant 3
Repatriation Plan	☐	☐	☐	☐

If your plan is not listed in the sections above, please state your chosen Core Plan and any supplementary plans:

5 PRE-EXISTING MEDICAL CONDITIONS

Pre-existing conditions are medical conditions for which one or more symptoms have appeared at some point during your or your dependants' lifetime. This applies regardless of whether you or your dependants sought any medical advice or treatment.

We would deem any such condition to be pre-existing if we could reasonably assume you or your dependants have known about it. Your policy will cover pre-existing conditions unless we tell you otherwise in writing.

We will also treat as pre-existing any medical conditions that arise between the date you complete the application form and the later of the following:

- The date we issue your Insurance Certificate or
- The start date of your policy

Pre-existing conditions will be subject to full medical underwriting and if they are not disclosed, they will not be covered. **Therefore, it is important that in the periods outlined above, you inform us if there is any change to your and your dependants' health status or to any material facts (facts likely to influence our assessment and acceptance of this application). In addition**, you will need to provide further information, if requested.

6 HEALTH DECLARATION

Please answer the following questions based on your own and your dependants' full medical history. **All material facts (facts likely to influence our assessment and acceptance of this application) must be disclosed. If you are in any doubt about whether a fact is material, then you should disclose it to us. Failure to disclose all material facts may invalidate the policy. This health declaration is valid for two months from the date you complete and sign the form.**

	Applicant	Dependant 1	Dependant 2	Dependant 3
Height	cm	cm	cm	cm
Weight	kg	kg	kg	kg
Have you used any form of tobacco in the past year?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If yes, how much per day on average?	/day	/day	/day	/day
Do you drink alcohol?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If Yes, how many units of alcohol do you drink per week? (1 short = 1 unit, 250ml beer = 1 unit, 1 glass wine = 1 unit, if none state "zero")	/week	/week	/week	/week
Do you wear glasses or contact lenses? If yes, please state:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
• Condition				
• Number of dioptres for each eye (this appears on the prescription from the optician)	Right eye	Right eye	Right eye	Right eye
	Left eye	Left eye	Left eye	Left eye

1. Has any person included in this application ever suffered from, been in hospital with, or had tests, investigations or treatment of any kind, for the following conditions?

(a) **Any heart or circulatory disease or disorder,** such as, but not limited to heart attack, coronary artery disease, irregular heartbeat, murmur, chest pain, clots, blood disorder, abnormal blood pressure, high cholesterol, etc. Yes ☐ No ☐

(b) **Any dermatological disease or disorder,** such as, but not limited to psoriasis, dermatitis, eczema, allergy, acne, etc. Yes ☐ No ☐

(c) **Any endocrine disease or disorder,** such as, but not limited to diabetes, weight problems, gout or thyroid problems or other hormonal imbalances, etc. Yes ☐ No ☐

(d) **Any eye, ear, nose and throat disease or disorder,** such as, but not limited to cataract, glaucoma, hearing loss, sinus problems, tonsils, adenoids, etc. Yes ☐ No ☐

(e) **Any gastrointestinal disease or disorder,** such as, but not limited to stomach problems, hernia, haemorrhoids, gall stones, colon polyps, Crohn's disease, colitis, liver problems, etc. Yes ☐ No ☐

(f) **Any infectious or viral disease or disorder,** such as, but not limited to: hepatitis A/B/C, herpes, HIV, malaria, meningitis, blood infection, sexually transmitted disease, etc. Yes ☐ No ☐

(g) **Any muscular or skeletal disease or disorder,** such as, but not limited to back, neck or joint pain, arthritis, paralysis, joint replacement, any cartilage and ligament problem, etc. Yes ☐ No ☐

(h) **Any neurological disease or disorder,** such as, but not limited to stroke, multiple sclerosis, epilepsy, neurodegenerative disorder, seizures, migraine, Alzheimer's or other form of dementia, etc. Yes ☐ No ☐

(i) **Any oncological disease or disorder,** such as, but not limited to any cancer, leukaemia, lymphoma, tumour, skin lesion, growth, lump, cyst, mole, polyp, naevus, etc. Yes ☐ No ☐

(j) **Any psychiatric or psychological disorder,** such as, but not limited to depression, anxiety, chronic fatigue syndrome, eating disorder, alcohol/drug problem, etc. Yes ☐ No ☐

(k) **Any respiratory disease or disorder,** such as, but not limited to chronic obstructive pulmonary disorder, asthma, bronchitis, sinusitis, shortness of breath, etc. Yes ☐ No ☐

(l) **Any urological or reproductive organs disease or disorder,** such as, but not limited to kidney or urinary tract problem, menstrual impairment, fertility problem, fibroids, endometriosis, testicular or prostate problem, etc. Yes ☐ No ☐

(m) **Any other accident, injury, disease or disorder** not already disclosed. Yes ☐ No ☐

2. Please tell us whether you or your dependants:

(a) Are currently taking any prescribed or over-the-counter drugs, medication, tablets or other treatment. Yes ☐ No ☐

(b) Are expecting to have a medical review, has been referred for further tests/investigations, or is awaiting results or any treatment due to accident, injury, disease or disorder. Yes ☐ No ☐

(c) Have undergone any tests or investigations within the last 10 years which resulted in referral for further medical advice or treatment, such as, but not limited to biopsy, colonoscopy, colposcopy, computed tomography (CT), mammogram, magnetic resonance imaging (MRI), Papanicolaou test (PAP), or prostate-specific antigen test (PSA), etc. Yes ☐ No ☐

Please do NOT disclose results of any genetic (DNA or RNA) tests, as these are not required for medical underwriting.

(d) Within the past 2 years have you experienced any symptoms or medical complaints such as, but not limited to: Yes ☐ No ☐

- Fever and continuous cough (within the last 2 weeks)
- Shortness of breath
- Severe/ongoing headache
- Mole or skin marking that has bled, changed or become painful
- Tingling, blurred or double vision
- Unexpected weight loss
- Bleeding per rectum, change in bowel habit or urine frequency
- Loss of sensation, seizures, loss of consciousness
- Abnormal bleeding, etc.

(e) Have you been recommended or decided to self-isolate? Yes ☐ No ☐

PLEASE COMPLETE QUESTIONS 3 AND 4 ONLY IF YOU ARE PURCHASING DENTAL COVER

3. Is any person included in this application currently undergoing or have they been advised to undergo any dental treatment? Yes ☐ No ☐

If yes, please complete a Dental Questionnaire, which you can download from our website:
www.allianzcare.com/en/international-individual-health-insurance/paper-applications/

4. Does any person included in this application:

(a) Suffer from periodontitis (extensive disorder of the gum and the tooth-supporting structures)? Yes ☐ No ☐

(b) Have any crowns, inlays, implants, fillings, bridges or missing teeth? Yes ☐ No ☐

If yes, please state in the table below the person's name and the type and quantity of each of the above, including how many teeth are affected by a bridge.

ADDITIONAL INFORMATION FOR "YES" ANSWERS

If you answered **Yes** to any part of the questions 1, 2, 3 or 4 within the previous Health Declaration section, please provide details in the table below.
Please tell us if a full recovery has been made or if you or your dependants have any medical condition or disease related to or arising from the original diagnosis.

Please enclose supporting up-to-date medical reports/test results if possible.

Question number	Name of the person affected by the medical condition	Diagnosis - where applicable state the area of the body affected (e.g. left arm, right foot)	Exact date of onset of the condition	Frequency and severity of symptoms and date of last symptoms	Investigations, blood tests or readings	Past and current treatment	Current status (e.g. any complications, complete recovery, recurrent)

If there is insufficient space in the table above, please use another Application Form

Please provide the name, address and telephone number of the regular/family doctor for everyone included in this application.
Please use a separate sheet if the space provided is not sufficient.

7 DECLARATION

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

- 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 will 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 make this insurance null and void.
- I undertake to inform Allianz Care immediately in writing of any changes in my or my dependants' state of health occurring between completing the Application Form and the start date of the policy.
- I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information in the context of this application for insurance. I consent to allow Allianz Care, if it considers it appropriate, to check statements concerning my health condition and to check with other healthcare insurers all statements concerning previous or existing contracts I may have applied for.
- Subject to legal restrictions, Allianz Care (or its medical advisers, appointed representatives or third-party experts in case of disputes) may request medical information about me from medical professionals. In these circumstances I authorise all such practitioners, physicians, dentists, members of medical professions, and employees of hospitals, health authorities and medical facilities to provide relevant medical information as requested. I also make this statement for my dependants under the age of 18 and for dependants who cannot assess the meaning of this statement.
- 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.
  - I have received, read and understood the Insurance Product Information Document and I accept the terms and conditions as summarised there and further explained in my Benefit Guide.
  - Based on the information provided within these documents and the plan selections that I have made, I believe the product I selected is most suited to my specific insurance needs.
- I understand that:
  - This Application Form is valid for two months from the date of completing and signing it.
  - I can withdraw my application in writing by letter, email or fax within 30 days from the date I receive the full terms and conditions of my policy. Provided that I have not submitted a claim, I am then entitled to a full refund of the premium.
- 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 Application Form but I enter no protest within 30 days following the issue date of the Insurance Certificate, I will be considered to have accepted the offer of cover.
  - Cover will be subject to the standard terms and conditions that apply at the start or renewal date of the policy and are set out in the Benefit Guide.
  - The cover provided by Allianz Care may not be suitable if my dependants and I are or become resident in countries where local compulsory health insurance restrictions are in place (e.g. Switzerland).
  - It is my responsibility to check if I am subject to any local compulsory health insurance requirements in my country of residence and I can confirm that my healthcare cover is legally appropriate.

As the applicant, I sign and date this form for and on behalf of everyone included in this application.

Applicant's signature _____

Applicant's printed name _____

Date D D / M M / Y Y Y Y

8 POLICYHOLDER APPOINTMENT

This section must be completed by all dependants wishing to appoint the policyholders as the main point of contact.

To help us administer the policy, you can nominate the policyholder as the main contact for the insurance. To do this, simply select 'Yes' and sign below.

I authorise INSERT NAME OF POLICYHOLDER

to act on my behalf in the administration of this policy. This may include the disclosure of sensitive medical information. This authorisation will remain in place until I ask Allianz Care in writing to revoke it.

Dependant 1's signature _____ D D / M M / Y Y Y Y

Dependant 2's signature _____ D D / M M / Y Y Y Y

Dependant 3's signature _____ D D / M M / Y Y Y Y

9 BROKER APPOINTMENT

This section must be completed by the applicant and their dependant(s) wishing to appoint a broker as the main point of contact)

I authorise INSERT NAME OF BROKER

to act on my behalf in relation to the administration of this policy. This may include the disclosure of sensitive medical information. This authorisation will remain in place until I ask Allianz Care in writing to revoke it.

For office use only — Agent details and stamp

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

Dependant 1's signature D D / M M / Y Y Y Y

Dependant 2's signature D D / M M / Y Y Y Y

Dependant 3's signature D D / M M / Y Y Y Y

10 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. You should read it before submitting any personal data to us. To read our Data Protection Notice, visit: **www.allianzcare.com/en/privacy.html**

Alternatively, you can contact us on + 353 1 630 1301 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 email at: **AP.EU1DataPrivacyOfficer@allianz.com**

11 DATA CONSENT

We need your consent to collect and process your health and other personal data . **If you do not give explicit consent, we may not be able to provide you with your policy or process any claims you may be entitled to make**. If you agree, we will process your data for the following reasons and activities.

A parent or guardian should complete the consent for any member under the age of 18.

I (the applicant), and the dependants named below agree with the following:

Name of applicant	Name of dependant 1	Name of dependant 2	Name of dependant 3

1. **Permission to collect, store and use my health data:** Allianz Care may collect, store and use my health data to administer the policy, for example to provide me with a quote for insurance cover, underwrite the risks to be insured or process any claims. Allianz Care may store my health data in accordance with the Consumer Code of the law applying to this insurance policy or with any other applicable law requiring the retention of the data.
2. **Permission to obtain my data from third parties.** To provide me with insurance cover, underwrite the risks to be insured or process any claims, Allianz Care may obtain my health and other data from physicians, nursing and hospital staff, other medical institutions, care homes, statutory health insurance funds, my plan sponsor, professional associations and public authorities. I agree to release all individuals at these institutions and Allianz Care from their respective confidentiality obligations relating to my health data or other data that they have to share and use for the purposes stated above.
3. **Sharing my data outside of Allianz Care.** Allianz Care may share my health and other data with the experts or institutions set out below. They will only use the data to the same extent and for the same purposes as Allianz Care. I understand that Allianz Care has put in place arrangements with these institutions to protect my data. I agree to release all individuals at these institutions and Allianz Care from their respective confidentiality obligations relating to my health data and other data that they have to share and use for the purposes set out below:
   - With independent medical experts to enable them to assess insurance risks and any benefits to be paid to me or to the third party providing treatment or service to me under my insurance policy.
   - With service providers outside of the Allianz Group of companies that perform certain services on behalf of Allianz Care, such as risk assessments and claims handling, where:
     - these services involve the collection and use of my health and other data, and
     - Allianz Care would not be able to administer my policy or pay any claims due to me without such data.
   - With co-insurers to distribute the coverage of the insurance risk jointly with other companies to which Allianz Care issues the policy, and to handle claims jointly.
   - With other insurers/reinsurers that may be covering the same insurance risk at the same time (multiple insurance) to:
     - distribute the payment of any compensation that may be owed to me, or
     - collaborate in the detection or prevention of fraud and financial crime.

If I change my mind about my preferences above, including withdrawing my consent to any of these items, I can let Allianz Care know by emailing AP.EU1DataPrivacyOfficer@allianz.com

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

Dependant 1's signature D D / M M / Y Y Y Y

Dependant 2's signature D D / M M / Y Y Y Y

Dependant 3's signature D D / M M / Y Y Y Y

12 MARKETING PREFERENCES

I (the applicant) and my dependants agree that Allianz Care may collect, use and disclose my personal data to provide me with marketing information. I understand that my personal data will only be used for the following reasons and activities, which I have expressly agreed to by indicating ☑ below.

	Name of applicant	Name of dependant 1	Name of dependant 2	Name of dependant 3
Information that Allianz Care sends about their products and services, including updates on their latest promotions and new products and services.	☐	☐	☐	☐
Information sent directly by other Allianz Group companies on their products and services. I understand that you will disclose my relevant contact information to them for that purpose.	☐	☐	☐	☐
Information sent directly by the business partners of Allianz Care on their products and services. I understand that you will disclose my relevant contact information to them for that purpose.	☐	☐	☐	☐
Such communications should be sent to me by the following methods:				
Email	☐	☐	☐	☐
In-app notifications	☐	☐	☐	☐
Phone	☐	☐	☐	☐
Post	☐	☐	☐	☐

13 PAYMENT DETAILS

You don't need to complete this section if you are applying as part of a group scheme and your employer is paying the premium.

Please don't make any payments until you receive your policy number.

Payment currency

Please tick to indicate your preferred payment currency:

Euro	☐
Sterling (GBP)	☐
Swiss Franc (CHF)	☐
US Dollars	☐

You can use direct debit for payments in euro, sterling (GBP) and Swiss franc (CHF), but not US dollars (USD)

Payment frequency and method

Payments are subject to the following administration surcharges: 0% for annual payment, 3% for half-yearly payments, 4% for quarterly payments and 5% for monthly payments.

Please tick to indicate your preferred payment frequency and method:

	Annual	Half-yearly	Quarterly	Monthly
Direct Debit* (For payments in Euro, Sterling and Swiss Franc)	☐	☐	☐	☐
Credit card	☐	☐	☐	☐
Cheque	☐	☐	☐	Not available
Bank transfer	☐	☐	☐	Not available

If you choose to pay by direct debit, please complete and submit the relevant direct debit mandate, available from: **www.allianzcare.com/en/international-individual-health-insurance/paper-applications/**
Please note that if you are a member of a group scheme and wish to pay by direct debit, you must select the monthly payment frequency option.

Please return your fully completed form by:

Email: underwriting@allianzworldwidecare.com

Fax : +353 1 629 7117

Post: Allianz Care
15 Joyce Way
Park West Business Campus
Nangor Road
Dublin 12, Ireland

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

www.facebook.com/AllianzCare/
www.linkedin.com/company/allianz-care
www.youtube.com/c/allianzcare
www.instagram.com/allianzcare/
twitter.com/AllianzCare

FRM-APP-EN-0819

AWP Health & Life SA, acting through its Irish Branch, is a limited company governed by the French Insurance Code. Registered in France No. 401 154 679 RCS Bobigny. Irish Branch registered in the Irish Companies Registration Office, registered No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. Allianz Care and Allianz Partners are registered business names of AWP Health & Life SA.

CREDIT CARD PAYMENT

If you choose to pay by credit card, please provide the following information:

Card type MasterCard ☐ VISA ☐ American Express ☐ JCB ☐ Diners Club ☐ Discover ☐

Cardholder's name

Card number Expiry date M M / Y Y

CVV code

VISA, MasterCard, Discover and Diners Club: the last three-digits on the signature panel on the back of the card.
American Express: four-digit number printed on the front of the card above the card number.

For security reasons, once we have transferred this information to our system, we will detach the credit card details from the application form and destroy them.

Credit card authorisation

I authorise Allianz Care to charge my credit card account with my healthcare premium. I understand I will be notified of the premium when my cover/renewal is accepted or if I make a request that affects the premium, such as adding a dependant. This payment will continue until I cancel the instruction by giving written notice to Allianz Care. I understand I will be given one month's notice of any annual premium rate increase.

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