FULL MEDICAL UNDERWRITING (FMU) APPLICATION FORM

IMPORTANT INFORMATION: Please use this form to tell us about your medical history and the medical history of anyone else you want to add to your cover (dependant). We need this information to confirm your cover, process future claims and pay for treatment. As the policy you are applying for is fully medical underwritten, any symptoms or medical conditions that you or any of your dependants had before the start date may not be covered. You must tell us if you or any dependant to be covered under the policy experience any symptoms between the time you complete this application form and when the policy is issued. This may be different from the requested policy start date on this form. If you do not provide this information you (and your dependants') cover may be affected. Please provide complete and accurate information. Without it, we may be unable to pay all or part of a claim or need to treat your (and your dependants') policy as if it had not existed.

1. YOUR PERSONAL DETAILS (PLEASE KEEP US INFORMED OF ANY CHANGE OF YOUR ADDRESS) ABOUT THE MAIN APPLICANT (POLICYHOLDER)

POLICYHOLDER (name of company / employer / family and first name)

CORRESPONDENCE ADDRESS (To be completed only if you wish to receive your correspondence in a different address from that of the Residence Address)

PERMANENT RESIDENCE ADDRESS

DATE OF BIRTH (dd/mm/yyyy)

COMPANY/ PERSONAL ID/ PASSPORT NO

NATIONALITY (If you have dual citizenship, please state the countries)

COUNTRY WHERE YOU ARE RESIDING FOR MOST OF THE YEAR (at least 6 months)

OCCUPATION

EMAIL

MOBILE NUMBER

2. YOUR CHOICE OF PLAN & DEDUCTIBLE

Cover will commence from the date shown on your Insurance Certificate/Membership Certificate provided your application has been received and accepted by us. Choose **ONE** level of cover, deductible and area of cover that you require and tick (√) the relevant boxes. Your choice applies to your dependents insured under the policy.

CHOICE OF LEVEL OF COVER: BLUE ☐ ADMIRAL ☐ ROYAL ☐

DEDUCTIBLE OPTION: BLUE / Annual deductible on all benefits, per person, per policy year:

NIL ☐ €75 ☐ €150 ☐ €250 ☐ €500 ☐ €1000 ☐ €2500 ☐ €4500 ☐

DEDUCTIBLE OPTION: ADMIRAL, ROYAL / Annual deductible on all In-patient benefits, per person, per policy year:

NIL ☐ €150 ☐ €300 ☐ €625 ☐ €1250 ☐ €2500 ☐ €6250 ☐

AREA OF COVER

WORLWIDE EXCLUDING U.S.A. ☐ WORLDWIDE ☐

OPTIONAL PLAN (valid only on ADMIRAL and ROYAL) DENTAL + OPTICAL ☐

3. EXISTING OR ANY PREVIOUS INSURANCE MEMBERSHIP

HAVE YOU EVER BEEN INSURED OR APPLIED FOR MEMBERSHIP UNDER ANY HEALTH INSURANCE? IF YES, PLEASE PROVIDE US WITH THE DETAILS BELOW.

YES ☐ NO ☐

NAME OF INSURER(S) AND PLAN(S)

DATE OF POLICY EXPIRY

4. CURRENCY & PAYING YOUR PREMIUM

CURRENCY: € / CHOOSE ONE PAYMENT MODE:

ANNUAL ☐ SEMI-ANNUAL ☐ QUARTERLY ☐

PREFERRED DATE OF ENTRY (dd/mm/yyyy)

5. MEMBERS TO BE COVERED*

1.

TITLE

FAMILY AND FIRST NAME

RELATIONSHIP TO YOU (spouse, partner, son / daughter)

DATE OF BIRTH (dd/mm/yyyy)

ID/PASSPORT NO

NATIONALITY

OCCUPATION

RESIDING IN

2

TITLE

FAMILY AND FIRST NAME

RELATIONSHIP TO YOU (spouse, partner, son / daughter)

DATE OF BIRTH (dd/mm/yyyy)

ID/PASSPORT NO

NATIONALITY

OCCUPATION

RESIDING IN

3

TITLE

FAMILY AND FIRST NAME

RELATIONSHIP TO YOU (spouse, partner, son / daughter)

DATE OF BIRTH (dd/mm/yyyy)

ID/PASSPORT NO

NATIONALITY

OCCUPATION

RESIDING IN

4

TITLE

FAMILY AND FIRST NAME

RELATIONSHIP TO YOU (spouse, partner, son / daughter)

DATE OF BIRTH (dd/mm/yyyy)

ID/PASSPORT NO

NATIONALITY

OCCUPATION

RESIDING IN

*For more family members please continue and use another separate Application Form, if necessary.

6. MEDICAL HISTORY

Please tell us about yours and your dependants' health and medical details, past and present.
If you are an existing customer upgrading your cover you must complete this section in full, so that we have an up to date record of your (and your dependants') health.
Please tick yes or no to every question for every person. If you tick yes to a question, please give full details in section 7.
If you do not provide us with full details we may lapse your cover or it may stop us from paying your claims, and/or cause us to review the terms and conditions of your policy.
You must also tell us immediately if you or any dependants experience any symptoms between the time you complete this application form and the date the policy is issued. Failure to do so may also result in cancellation, rejection of claims and/or changes to the terms and conditions of your policy.

	MAIN APPLICANT	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3
1. In the last 5 years, has any applicant seen a doctor or other healthcare professional for any recurrent or persistent medical condition or symptoms? (persistent means has continued for 2 weeks or more)	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
2. In the last 5 years, has any applicant been advised by doctor to take any medications (such as to be taken daily, once per week, as needed as directed by doctor) for a continuous period of more than 1 month?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
3. In the last 5 years, has any applicant to be covered ever had or been advised to have any regular or ongoing follow-up consultations or medical care with a healthcare professional (such as a doctor, physiotherapist, psychiatrist) for any disease or other medical condition?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
4. In the last 10 years, has any applicant ever had or been advised to undergo investigations (such as blood or urine test, colonoscopy, mammogram, ECG, X-ray, ultrasound, CT scan, MRI, PET scan, HIV test, Hepatitis B or Hepatitis C test)?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
5. In the last 10 years, has any applicant been admitted to hospital?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
6. In the last 3 months, has any applicant experienced any signs or symptoms of a medical problem, illness or injury not yet diagnosed or treated?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
7. Does any applicant have any chronic conditions e.g. a disease, illness or injury that has one or more of the below characteristics?				
Continues indefinitely, symptoms or condition may recur or likely to recur?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Needs ongoing or long-term monitoring through consultation, examination, check-ups, and tests	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Needs ongoing or long-term relief of symptoms	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Needs daily or regular medication	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Needs rehabilitation	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
8. Has any applicant ever had a history of the following?				
Liquid or solid Cancer	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Heart condition e.g. angina, heart attack, heart failure, abnormal heartbeat	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Stroke	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Prosthetic implants and appliances in their body e.g. shunts, pacemakers, joint replacements	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Congenital/hereditary conditions	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

9. Does any applicant have any ongoing or planned treatment, investigations or tests?	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Further details (for over 16's only):				
How tall are you (metres/centimetres)?				
How much do you weigh (kilograms)?				

10. To be filled in by Moratorium applicants:

Has anybody to be covered on this plan suffered from any chronic condition which has required treatment or medication within the last 24 months? If yes, please provide details.	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Has anybody to be covered on this plan been diagnosed with having cancer or is currently under investigation relating to a potential cancer diagnosis? If yes, please provide details.	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐
Has anybody to be covered on this plan received treatment for any degenerative condition or has a history of joint replacement treatment? If yes, please provide details.	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

7. MEDICAL HISTORY: ADDITIONAL INFORMATION

This section applies if any applicant has indicated yes to any medical questions in section 6. If you are unsure whether any details are relevant, you must include them. Please attach medical reports or test results relating to the medical conditions you have declared if these are available.

	THE RELEVANT QUESTION NUMBER FROM SECTION 6	PLEASE SPECIFY AS ACCURATELY AS POSSIBLE THE NAME OF THE ILLNESS OR MEDICAL PROBLEM. WHERE APPLICABLE, PLEASE STATE THE AREA OF THE BODY AFFECTED (E.G. RIGHT LEG, LEFT EYE).	WHEN WERE SYMPTOMS FIRST EXPERIENCED AND WHEN WAS TREATMENT COMPLETED (IF APPLICABLE)?	WHAT TREATMENT DID YOU RECEIVE AND WHEN (PLEASE INCLUDE DATES, NAMES AND DETAILS OF MEDICATIONS)?	WHAT WAS THE OUTCOME OF THE TREATMENT (E.G. ONGOING, COMPLETE RECOVERY, RECURRENT OR LIKELY TO RECUR)?
Main applicant					
Dependant 1					
Dependant 2					
Dependant 3					

8. CONSENT FOR PROCESSING OF PERSONAL DATA

Your application and policy membership are through MediHelp International, insured by AWP Health & Life SA, an insurance company governed by the French Insurance Code, hereafter referred to as "the Insurer":

Certain administrative aspects of your policy are handled by AWP Hellas Insurance Brokers, Roadside Assistance and Services Providers S.A (part of the Allianz Group) and MediHelp Customer Care SRL.

Please make sure that everyone covered by this policy reads this summary and the full data privacy policies on our website. We want to reassure you that we will never sell personal member information to third parties. We will only use your information in ways we are allowed by law, which includes only collecting as much information as we need. We will obtain your consent to process information such as your medical information when it's necessary to do so.

We collect information about you and the family members who are covered by your plan from you, those family members, your healthcare providers, your employer (if you are on a company scheme), your insurance broker if you have one and third-party suppliers of information.

We process your information mainly for managing your membership and claims, including investigating fraud. We also have a legal obligation to do things such as report suspected crime to law enforcement agencies. We also do some processing because it helps us run our business, such as research, finding out more about you, statistical analysis for example to help us decide on premiums and marketing.

We may disclose your information to other people or organisations. For example, we'll do this to:

- Manage your claims, e.g. to deal with your doctors;
- Facilitate the provision of benefits or otherwise manage your policy; and
- Help us prevent and detect crime and medical malpractice by talking to other insurers and relevant agencies; and
- Allow other Alianz companies to contact you if you have agreed.

In order to be able to manage your policy, we may transfer and access your information from countries anywhere in the world. Before doing so we will ensure that your data is protected and disclosed only to authorised individuals solely for servicing your policy or claim. Any internal transfer of your data will be undertaken only in accordance with the relevant data protection laws and regulations. Where our using your information relies on your consent you can withdraw your consent, but if you do we may not be able to process claims or manage your plan properly.

We will inform you if a data breach occurs and your personal and medical information are disclosed to unauthorised parties. The notification will be provided within 72 hours of the confirmation of the incident. In some cases, you have the right to ask us to stop processing your information or tell us that you don't want to receive certain information from us, such as marketing communications. You can also ask us for a copy of information we hold about you and ask us to correct information that is wrong.

If you want to ask to exercise any of your rights just write to us.

1. In compliance with the European General Data Protection Regulation (EU Regulation 2016/679, "GDPR") applicable since May 25th 2018, I expressly give my consent for the Insurer and MediHelp to process MY PERSONAL DATA REGARDING MY HEALTH, data which is absolutely necessary for the provision of the insurance service corresponding to the insurance policy I concluded or, as applicable, whose effects apply to me.

I (we) agree to empower the Insurer to perform any investigations, to request documents to treating physicians, which can help with the complete assessment of my (our) health. I (we) authorise any physician, hospital, policlinic or any other health facility that holds data or information and/or documents regarding my (our) health to provide, upon the Insurer's written request, complete information regarding any disease, accident, treatment, examination, consultation or hospitalisation I (we) have undertaken.

In the event an insured Event/Risk occurs, I (we) empower the Insurer/MediHelp to undertake all actions for obtaining the documents necessary for establishing the extension of the obligation to pay the Insurance Benefit, exempting from the professional secrecy obligation both the physicians who have examined / treated me (us), as well as any public or private institution holding information regarding my (our) health and my (our) health history, both during my (our) lifetime and subsequently, in case of death, regardless of the causes.

I (we) have understood that, should I (we) refuse to expressly give my (our) consent on health data processing, the Insurer will not be able to execute the insurance contract to which I am (we are) a part of or whose effects apply to me (us), including, but not limited to, the payment of compensation.

YES	NO	NAME AND SURNAME	
			SIGNATURE

2. I (we) expressly give my (our) consent for the Insurer and MediHelp to send me (us) newsletters about their products and services, including for the improvement of these, benefits that I (we) could access, promotional offers or insurance opportunities (MARKETING PURPOSE).

YES	NO	NAME AND SURNAME	
			SIGNATURE

3. I (we) expressly give my (our) consent to receive electronic correspondence using my (our) contact data given in this form, for the closing of the contract and/or by running it, reminders of due invoices, this type of correspondence producing the same effects as the correspondence on paper.

YES	NO	NAME AND SURNAME	
			SIGNATURE

9. DECLARATION AND SIGNATURE

a. I declare that:

- to the best of my knowledge and belief the statements on this application form are full, true and correct;
- I shall read the General Terms, Conditions and Agreement when received and that I agree to be bound by it unless I cancel the enrolment within 30 days of acceptance of my application.

b. I agree that the acceptance of my application shall be on the basis of these statements.

c. I understand that if there are changes in the information I have given before the start date of my/our policy, I must inform you in writing immediately.

d. I understand that once the policy has started, you will not pay for treatment of any medical condition (or related medical condition) which the member(s) already had when they joined unless fully disclosed on this application and accepted by you. This includes any such medical condition(s) or symptoms, whether or not being treated and any previous medical condition(s) which recurs, or which I should reasonably have known about even if I/We had not consulted a doctor.

e. I understand that as the legal holder of this insurance policy, all correspondence about this application, including claims correspondence, will be sent to me unless I write to tell you otherwise. I also understand that policy documents, written communications and membership details will be issued in English/Greek.

f. I understand that some countries require residents, whether expatriates or otherwise, to take out health cover through a local provider or to hold cover which meets certain compulsory requirements and that the cover provided by you may not meet these country specific requirements and therefore additional cover may be necessary. I further understand that in some situations there may be consequences in the form of tax penalties or otherwise where a resident does not hold the required local cover in addition to their international medical insurance policy. If I have any concerns about any additional cover requirements in my principal country of residence (as defined in 1 About the Policyholder), I understand that it will be my responsibility to check with the local authorities to determine whether there are any further healthcare requirements with which I am expected to comply.

g. By signing and returning this form:

- I confirm that the declarations set out in this application are correct and that I have the authority to enter this policy on behalf of any family members.
- I understand the broker, agent, agency, or persons acting on my (our) behalf taking this application from me (us) is an independent representative and is acting on my (our) behalf and not the Plan administrator nor the Insurer offering this insurance. Neither the Plan Administrator nor the Insurer offering this insurance can be held liable for any circumstance if the broker, agent, agency, or persons acting on my (our) behalf, who is taking this application, fails now or in the future to transmit or communicate any documentation or modify or waive any portion of this application or coverage, restrictions, conditions contained in the General Terms and Conditions or any information requested by the Plan administrator or Insurer.

Please note: You are advised to keep a record of all information supplied in connection with this application, including any letters you send to us in connection with it. If you would like a copy of this application, please let us know within 90 (ninety) days. After completing this application form and signing the Declaration, please return to: **client@medihelp.ro**. The declaration is valid for 30 (thirty) days from the date of the signature. **I shall disclose to the Company any change in health and/or medical consultation and/or material facts of all applicants that occur after signing this application form but before the policy is issued. If a material fact is not disclosed in this Application, I understand any policy issued may not be valid.**

I acknowledge and confirm that:
a. I am fully satisfied with the information declared in this Application and includes the information I have provided,
b. I have received a copy of the General Terms and Conditions and Product Information Document,
c. I had the opportunity to review the General Terms and Conditions and Product Information Document, to formulate questions and request for clarifications in relation to such General Terms and Conditions and Product Information Document (all of which have been answered by the Insurer in a satisfactory manner),
d. I understand the General Terms and Conditions and Product Information Document,
e. I agree to them.

NAME OF POLICYHOLDER

DATE

SIGNATURE OF POLICYHOLDER

NAME OF INTERMEDIARY

INSURANCE INTERMEDIARY'S CODE

SIGNATURE OF INSURANCE INTERMEDIARY