Allianz

Care

International healthcare plans for you and your family

Application form

For policies with full medical underwriting

Before you start, please consider that:

- If you choose to complete a printed version of this form, PLEASE COMPLETE IT IN BLOCK CAPITALS.
- 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.
- If you already have one of our healthcare plans and you are applying for a cover upgrade or for a new plan, please tell us about any medical conditions you have claimed for since joining us.
- On page 15, for the 'Approvals' section;
  - The applicant and each named dependant above 18 need to sign this section.
  - All adult applicants must provide consent as detailed in Sections 8 and 11. In line with the General Data Protection Regulations, 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.
  - All adult applicants wishing to appoint a broker as the main point of contact for this policy must provide consent as detailed in Section 9.

Are you completing this form to join an existing company policy? Please state:

Group name

Group number

If you are already included in your company policy and you want to add a new dependant, please state your policy number:

Policy number

Allianz Medical Expert (AME) - our automated underwriting tool:

We may use an automated medical underwriting tool to determine whether we can provide cover to you and if so, on what terms. This tool is used to process personal and medical information you provide us in order to calculate the cost of your International Healthcare cover. Without this information we are unable to calculate the premium for your insurance which is relevant to your needs.

We regularly assess the way our automated underwriting tool works to ensure we continue to offer a fair assessment. This assessment is based on the plans you select and on the personal and medical information you provide to us on this application.

Permission to automate the underwriting decision

☐ By ticking this box you accept and agree that Allianz may use an automated medical underwriting tool to evaluate your personal and health data in order to make the underwriting decision on the risks to be insured. This is performed in accordance with GDPR guidelines on the processing of data using an automated underwriting tool.

Once the automated underwriting decision has been made, you have the right to request that we reconsider our decision which will involve a review by our medical underwriting team. If you wish to invoke this right please contact us at **individual.joining@e.allianz.com**.

Just for clarity...

You will see that we often refer to the following phrases in this form. This is what we mean:

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's details (The applicant will be the policyholder)

Your contact details will also be used to communicate with you on important things regarding your policy. You must tell us if your contact details change over time, so we can ensure that correspondence reaches you.

We will consider applicants for cover up to the day before their 76th birthday.

Applicant's details

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ ☐ Other

First name

Surname

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

Home country Nationality

Principal country of residence

Tax ID (mandatory for people residing in Spain, Italy and Portugal)

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 it)		

Details of any current domestic or international health insurance:

Name of insurer	
Policy number	
Start date	D D / M M / Y Y Y Y

In what language do you wish to receive your policy documents?

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

2. Your dependants' details

You can add dependants to your policy. Dependants are 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 26th birthday if they are in full-time education. If they are aged 18 to 25 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 and ensure that all relevant Declaration(s) and Consent(s) are signed and dated.

	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 at birth	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐

	Dependant 1	Dependant 2	Dependant 3
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 current insurer (if applicable)			
Current policy number (if applicable)			

3. Start date of your cover

From what date do you require cover?

Start date D D / M M / Y Y Y Y

You will have confirmation that your application for cover has been accepted when we issue you the Insurance Certificate. Your cover will be 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 ☐ Europe ☐

Next, please select the Core Plan and any optional plans that you require for your policy. Optional plans can only be purchased with a Core Plan; they can't be bought separately. You can find all details of the plans listed below in the Table of Benefits and Benefit Guide.

Select your Core Plan

	Care Base	Care Enhanced	Care Signature
Policyholder	☐	☐	☐
Each member can choose a different Core Plan, it does not need to match the one chosen by the policyholder.			
Dependant 1	☐	☐	☐
Dependant 2	☐	☐	☐
Dependant 3	☐	☐	☐

Select your optional plans

Out-patient Plans

You can select an Out-patient Plan together with the corresponding Core Plan. For example, if you chose the Care Signature Core Plan, you can only select the Care Signature Out-patient Plan. **You can't buy an Out-patient Plan separately.**

	Care Base	Care Enhanced	Care Signature
Policyholder	☐	☐	☐
Dependant 1	☐	☐	☐
Dependant 2	☐	☐	☐
Dependant 3	☐	☐	☐

Dental Plans

You can select a Dental Plan together with the corresponding Core Plan. For example, if you chose the Care Signature Core Plan, you can only select the Care Signature Dental Plan. **You can't buy a Dental Plan separately.**

	Care Base	Care Enhanced	Care Signature
Policyholder	☐	☐	☐
Dependant 1	☐	☐	☐
Dependant 2	☐	☐	☐
Dependant 3	☐	☐	☐

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. You can choose either a Core Plan deductible AND/OR an Out-patient Plan deductible. 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	Premium discount
☐ No deductible	0%
☐ £ 830 / € 1,000 / US$ 1,350 / CHF 1,300	10%
☐ £ 2,490 / € 3,000 / US$ 4,050 / CHF 3,900	20%
☐ £ 4,980 / € 6,000 / US$ 8,100 / CHF 7,800	30%

Select your Out-patient Plan deductible

To reduce your Out-patient Plan premium, simply select an optional deductible from the list below and read across to find the relevant premium discount. You can choose either an Out-patient Plan deductible AND/OR a Core Plan deductible. 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 cent), therefore, percentages may be slightly higher or lower than those stated below.

Optional Out-patient Plan deductibles	Premium discount
☐ No deductible	0%
☐ £ 208 / € 250 / US$ 338 / CHF 325	10%
☐ £ 457 / € 550 / US$ 743 / CHF 715	20%
☐ £ 705 / € 850 / US$ 1,148 / CHF 1,105	30%

5. Medical Underwriting terms available

Full medical underwriting

This means we assess your health history when considering your insurance application and likely terms of cover. If you have a pre-existing condition (as defined below), **you must declare this accurately, honestly and completely ensuring you answer all questions asked in the 'Your Health' section below for all applicants.**

Pre-existing conditions

Pre-existing conditions are medical conditions where one or more symptoms presented 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 will consider any medical condition to be pre-existing if we can determine that you or your dependants would have known about it.

Any medical conditions that arise between the date you completed the Application Form and the later of the following we will also treat as pre-existing:

- the date we issued your Insurance Certificate, or
- the start date of your policy.

Please note that you/your dependants must provide any further information that we might request. Full and accurate completion of this Application Form and disclosure of all relevant information is a requirement for cover. You need to disclose all material facts likely to influence our assessment and acceptance of this application. Failure to do so will invalidate the policy. If there is any doubt as to whether a fact is relevant, then it must be disclosed. If any pre-existing medical conditions are not disclosed, they will not be covered.

6. Your health

Please answer the following questions based on your own and your dependants' full medical history. **You must disclose all material facts (i.e. facts likely to influence our assessment and acceptance of this application). 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? 1 cigarette = 1 unit, 1 medium cigar = 2 units, 1 gram roll-your-own tobacco = 2 units, 1 pipe bowl tobacco = 2.5 units, 10mg e-cigarette nicotine = 1 unit, if none state NO	/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 NO	/week	/week	/week	/week

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, vascular disease, irregular heartbeat, murmur, chest pain, clots, blood disorder, abnormal blood pressure or high cholesterol.	Yes ☐ No ☐
b)	**Any dermatological disease or disorder,** such as, but not limited to, psoriasis, dermatitis, eczema, allergy or acne.	Yes ☐ No ☐
c)	**Any endocrine disease or disorder,** such as, but not limited to, diabetes, pancreatitis, weight problems, gout or thyroid problems or other hormonal imbalances.	Yes ☐ No ☐
d)	**Any eye, ear, nose and throat disease or disorder,** such as, but not limited to, cataract, glaucoma, detached retina, hearing loss, ear infections, sinus problems, tonsillitis, adenoiditis or myopia with levels greater than -6.	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 or liver problems.	Yes ☐ No ☐
f)	**Any infectious or viral disease or disorder,** such as, but not limited to, hepatitis A/B/C, herpes, HIV, SARS-CoV-2 / COVID-19, malaria, meningitis, blood infection or sexually transmitted disease.	Yes ☐ No ☐
g)	**Any muscular or skeletal disease or disorder,** such as, but not limited to back, neck or joint pain, arthritis, fibromyalgia, joint replacement, any cartilage and/or ligament problem or carpal tunnel syndrome.	Yes ☐ No ☐
h)	**Any neurological disease or disorder,** such as, but not limited to stroke, multiple sclerosis, epilepsy, neurodegenerative disorder, paralysis, seizures, migraine, Alzheimer's or other form of dementia.	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 or naevus.	Yes ☐ No ☐
j)	**Any psychiatric or psychological disorder,** such as, but not limited to attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, depression, anxiety, chronic fatigue syndrome, eating disorder, obsessive-compulsive disorders, phobic disorders or alcohol/drug problems.	Yes ☐ No ☐
k)	**Any respiratory or lung disease or disorder,** such as, but not limited to chronic obstructive pulmonary disorder, sarcoidosis, asthma, bronchitis, sinusitis, shortness of breath or allergy.	Yes ☐ No ☐
l)	**Any urological or reproductive organs disease or disorder,** such as, but not limited to kidney or urinary tract problems, menstrual impairment, fertility problems, fibroids, endometriosis, testicular or prostate problems.	Yes ☐ No ☐
m)	**Any congenital disease or disorder present at or before birth,** such as but not limited to, adrenal hyperplasia, cystic fibrosis, Down syndrome, haemophilia, heart defects, Huntington's disease, Klinefelter's syndrome, Marfan syndrome, malformations and spina bifida. **Please do NOT disclose results of any genetic (DNA or RNA) tests as these are not required for the underwriting process.**	Yes ☐ No ☐

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

Please tell us whether you or your dependants:

o)	Are currently taking any prescribed or over-the-counter drugs, medication, tablets or other treatment.	Yes ☐ No ☐
p)	Are expecting to have a medical review, have been referred for further tests/investigations, or are awaiting results or any treatment due to accident, injury, disease or disorder.	Yes ☐ No ☐
q)	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), echocardiogram (Echo) or ultrasound (US). **Please do NOT disclose results of any genetic (DNA or RNA) tests, as these are not required for medical underwriting.**	Yes ☐ No ☐
r)	Have experienced, within the past two years, any recurrent or ongoing symptoms or medical complaints NOT related to a condition already disclosed such as, but not limited to: • Fever (103°F/39.4°C or above) and/or continuous cough • Shortness of breath • Hoarseness • 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 • Joint pain/stiffness	Yes ☐ No ☐
s)	Have been recommended or decided to self isolate within the past 30 days?	Yes ☐ No ☐

Please complete the following question only if you are purchasing dental cover.

t)	Is any person included in this application currently undergoing or have they been advised to undergo any dental treatment, dental surgery, dental prosthesis, orthodontics or periodontics?	Yes ☐ No ☐

Additional information for 'Yes' answers

If you answered **Yes** to any part of the questions from a) to t) above, 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 or tooth affected)
Exact date of onset of the condition
Frequency and severity of symptoms
Date of last symptoms
Investigations, blood tests or readings (please include the dates, results and any diagnosis)
Past and current treatment (please include name, dosage and frequency of usage of medication and provide dates of when treatment started, how often it was required and when it ended)
Current status (e.g. any complications, complete recovery, recurrent or ongoing).Please also indicate if you continue to see a dentist for an ongoing issue, or have stopped attending recommended routine dental checkups

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.

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

7. Declaration

Please read the following declarations carefully. You will need to sign below in the '**Approvals**' section to confirm 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 and myself, and that **any false, incorrect or misleading statement or non-disclosure of material information may make this insurance null and void, in accordance with the applicable legislation.**
- I undertake to inform Allianz 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, 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 (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, the Benefit Guide and Table of Benefits and I accept the terms and conditions as summarised there.
  - 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 or email 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.
  - 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 may not be suitable if my dependants and I are or become resident in countries where local compulsory health insurance restrictions are in place.
  - 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.

8. Policyholder appointment

This section must be completed by all dependants wishing to appoint the policyholder 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 consent to this in the '**Approvals**' section below.

The policyholder will be authorised to act on behalf of all dependants in the administration of this policy. This may include the disclosure of sensitive medical information. This authorisation will remain in place until I or any dependant on cover request from Allianz in writing to revoke it.

9. Broker appointment (if applicable)

By consenting below in the '**Approvals**' section, I authorise the named 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 in writing to revoke it.

10. Your personal data

Our Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. 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, please email us 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

- **Permission to collect, store and use my health data.** Allianz 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 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.
- **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 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 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.
- **Sharing my data outside of Allianz.** Allianz 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. I understand that Allianz has put in place arrangements with these institutions to protect my data. I agree to release all individuals at these institutions and Allianz 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, such as risk assessments and claims handling, where:
    - these services involve the collection and use of my health and other data, and
    - Allianz 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 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 know by emailing AP.EU1DataPrivacyOfficer@allianz.com

12. Marketing preferences

I (the applicant) and my dependants agree that Allianz 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 ticking the boxes below.

	Applicant	Dependant 1	Dependant 2	Dependant 3
Name				
Information that Allianz 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 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. Approvals

Please indicate the section you're providing consent for

7	Declaration**	☐	
8	Policyholder appointment**	☐	
9	Broker appointment (if applicable)	☐	Broker name
10	Your personal data**	☐	
11	Data consent**	☐	
12	Marketing preferences	☐	

Signatures

The applicant and each named dependant above 18 need to sign this Application here. By signing, you are consenting to the relevant sections ticked above.

Applicant's signature	Dependant 1's signature	Dependant 2's signature	Dependant 3's signature
D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y

** Please note that we won't be able to process your application if you have not provided consent for the marked sections in the Approvals' box above.

14. 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 (EUR)	☐
Sterling (GBP)	☐
Swiss Franc (CHF)	☐
US Dollars (USD)	☐

You can use direct debit for payments from EU accounts in Euro but not Sterling (GBP), Swiss Franc (CHF) or US dollars (USD)

Payment frequency and method

Payments are subject to the following administration surcharges: 0% for annual payments, 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	Quartly	Monthly
Direct Debit* (For payments from EU accounts in Euro)	☐	☐	☐	☐
Card	☐	☐	☐	☐
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.

Card payment

If you choose to pay by 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 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 card details from the application form and destroy them.

Card authorisation

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

Signature

Date D D / M M / Y Y Y Y

Please return your fully completed form by:

Email: **individual.joining@e.allianz.com**

Post: Allianz
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/

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