Henner™

JOH INSURANCES

INTERNATIONAL EXPAT INSURANCE PACKAGE

Application Form

INDIVIDUALS

Tips on how to fill out this application form

Completing insurance applications is no fun job so in order to speed up the process and prevent mistakes we have gathered all potential issues in the application form and wrote them down below to help you to complete this form correctly at once.

YOUR DETAILS

1. **Residential address / Country of Usual Residence**: if you have no fixed address (yet) please leave blank and fill in the country you will be living in / moving to.
2. **Mailing address**: the address where you can receive mail (post). This can be in the country of residence, or in your home-country.

PAYMENT

1. Fill out how you would like to pay (SEPA withdraw, Credit Card payment or bank transfer) If you choose SEPA withdraw, don't forget to fill out the SEPA mandate form which is added to this applicationform!

EFFECTIVE DATE OF COVERAGE

1. Please choose a date in the future. The actual startdate of the insurance is the date you will be accepted by Henner for the insurance, or your requested date of coverage, whichever is later.

CHOOSE YOUR CORE PLAN

1. The Core of the Plan is the healthcare insurance. You can choose between 3 different types of coverages and several deductibles.

CHOOSE YOUR ADDITIONAL INSURANCES

1. Dental: if chosen this cover applies on all family members
2. Life: Minimum amount: €50.000. Maximum amount: €500.000.
3. Accidental death + invalidity: Minimum €50.000. Maximum €500.000.
4. Temporary Incapacity (TI): waiting period 3 months – payment up to 21 months.
5. Permanent Disability (PD): payment max up to 65 years old.
    a. The covers TI+PD <u>combined</u> represent cover for disability with monthly payments up to max 65y. of age or until capable of working again.
    b. If you want to issue PD cover you need to issue TI cover as well.
    c. <u>You need to haven a quote for these covers before you can issue them.</u>
    d. Did you already receive a quote and do you want to issue the policy? Please fill out the amount you want to insure per month.
    e. The monthly amount for TI and PD need to be the same, they cannot exceed 80% of you gross income excl. bonuses and/ or allowances.
    f. Insured amount: minimum is €1.000/month, maximum is €10.000/month.

YOUR DECLARATION

1. Please read the text
2. Place the date of signing this declaration
3. Place your signature
4. Add the place you are when signing this declaration (city + country)
5. **<u>ADD THE WORDS 'READ AND AGREED' IN HANDWRITING. (IMPORTANT!)</u>**

Concerns

☐ New application
☐ Change of an existing policy with policy number: _____

Your details

Last name _____

First name _____

Date of birth ___ / ___ / ____ (dd/mm/yyyy) Nationality _____ Gender (M/F) ____

Residential address(1) _____

City _____ Country _____ Postcode _____

Mailing address _____

City _____ Country _____ Postcode _____

Phone number _____ Mobile _____ Email (2) _____

Occupation _____

Dependants to be included in the plan

Last name _____ First name _____
Relationship(3) _____ Gender (M/F) ___ Date of birth (dd/mm/yyyy) ___ / ___ / ____
Country of usual residence Nationality

Last name _____ First name _____
Relationship(3) _____ Gender (M/F) ___ Date of birth (dd/mm/yyyy) ___ / ___ / ____
Country of usual residence _____ Nationality _____

Last name _____ First name _____
Relationship(3) _____ Gender (M/F) ___ Date of birth (dd/mm/yyyy) ___ / ___ / ____
Country of usual residence _____ Nationality _____

Last name _____ First name _____
Relationship(3) _____ Gender (M/F) ___ Date of birth (dd/mm/yyyy) ___ / ___ / ____
Country of usual residence _____ Nationality _____

(1) Any country in which you and your dependants will reside for at least 6 months of the year is called Country of Usual Residence.
(2) An email address must be provided as we will send invoices and claim statements by email.
(3) E.g. spouse, child.

Payment

How would you like to pay your premium?

☐ Annually ☐ Semi-annually ☐ Quarterly ☐ Monthly**

***If you opt for monthly payment, direct debit of your credit card is mandatory.*

Select your method of payment:

☐ Visa / MasterCard / American Express
(For payment by credit card, upon receipt of your invoice, go to www.henner.com, log into your secure personal access page and register your credit card details online.)

☐ SEPA automatic withdrawal *(For EURO policies only)*

☐ Bank Transfer *(account details for transfer will be provided with your invoice. Bank transfer is not allowed for monthly payments.)*

Effective date of coverage

When would you like your cover to start?

_____ / _____ / _____
dd mm yyyy

Your membership and that of your dependants are effective on the date indicated on your Certificate of Enrolment, and that is at the earliest on the day we accepted you for the insurances you applied for, or: on the day that you agreed to accept our proposal for insurance.

▶Your Area of Coverage

☐ Worldwide excluding USA

You will be covered worldwide – also in the USA – for unexpected illnesses and accidents only and for a duration of up to 90 days per insurance year.

▶Choose your Currency

☐ Euro ☐ US Dollar

▶Choose your Core Plan

☐ Essential

☐ Bronze

Choose a deductible amount for outpatient treatment (deductible is per insured per insurance year):

- ☐ € 0 - $ 0
- ☐ € 100 - $ 125
- ☐ € 300 - $ 375
- ☐ € 1000 - $ 1250
- ☐ € 2500 - $ 2675

☐ Gold

Choose a deductible amount for outpatient treatment (deductible is per insured per insurance year):

- ☐ € 0 - $ 0
- ☐ € 300 - $ 375
- ☐ € 500 - $ 625
- ☐ € 1000 - $ 1250
- ☐ € 2500 - $ 2675

▶Choose your Additional Insurances

☐ Dental (select one of the below plans)

☐ Dental 1 ☐ Dental 2

☐ Life Cover

☐ Main insured member
Insured amount(1)

☐ Partner
Insured amount(1)

☐ Accidental death and invalidity

☐ Main insured member
Insured amount(1)

☐ Partner:
Insured amount(1)

☐ Temporary Incapacity

☐ Main insured member
Insured amount(2)

☐ Partner:
Insured amount(2)

☐ Permanent Disability (available only as an additional insurance to the Temporary Incapacity cover)

☐ Main insured member
Insured amount(3)

☐ Partner:
Insured amount(3)

(1) The minimum sum insured shall be 50,000 EUR/65,000 USD and can be increased up to a maximum sum insured of 500,000 EUR/625,000 USD. Premiums and benefits (insured amount) are calculated on the basis of the sum insured.
(2) The minimum amount to be insured is 1,000 EUR/1,250 USD (monthly allowance). The amount insured cannot exceed 80% of the gross (monthly) Salary of the Insured, nor can it exceed an amount of 10,000EUR/12,500USD per month. The Policyholder must submit a copy of the latest Salary statement of the Insured to HENNER.
(3) The amount of the monthly allowance can be determined freely, however the amount may not exceed a maximum of 80% of your gross monthly salary, with a minimum of 1,000 EUR/1,250 USD and a maximum of 10,000 EUR/12,500 USD. In no event should the monthly allowance amount be higher than the monthly allowance of the Temporary Incapacity cover.

Your declaration

I, the undersigned, certify that the information filled in the present Application Form, as well as in the Health Declaration Form, is correct and sincere, and certify not having declared or withheld any information which might falsify the risk assessment. I understand and have taken note that any false declaration or non-disclosure will void coverage under this policy and in this case the insurer would retain paid premiums as civil damages and I and my dependants will be obliged to reimburse perceived benefits.
I acknowledge that I have read and understood the guarantees described in the table of benefits and the General Conditions of the International Expat Insurance Package policy provided with this Application Form.
I have duly noted that my enrolment under the International Expat Insurance Package policy shall be effective subject to:

- Approval by the HENNER SAS Medical Advisory Board of the enclosed health declaration duly filled out by myself and all my dependants who have reached majority
- Payment of premium

In the event of my death, I appoint as beneficiary my surviving spouse unless legally separated; otherwise in equal shares my children born or to be born, the share of a deceased child going to his/her own children or to his/her brothers and sisters if he/she has no children; otherwise in equal shares my surviving parents; or in their absence, my heirs.
I further note that should I wish to change beneficiaries at any time, I shall write formally to HENNER SAS with details of the requested changes and clearly identify any new beneficiaries.

Signature: ..... Signed on date (dd/mm/yyyy).....

Signed in which city ..... Signed in which country .....

Write 'read and agreed' on the dotted lines .....

How to apply?

To apply for cover, please complete this Application Form as well as the Health Declaration Form. These forms should then be sent directly to your insurance broker (by email or by post) at the following address:

JOHO Insurances
Stationsweg 2 - D
2312 AV Leiden (Den Haag)
THE NETHERLANDS
Email: **contact@johoinsurances.org**

When submitting, remember also to include:

- A copy of your ID or passport
- A copy of the Insured's latest Salary statement (this applies only for Temporary Incapacity and Permanent Disability)

If your Application is accepted you will be sent a Premium Invoice and your Policy will not be in force until that premium is paid. Please make sure to answer all questions and to sign the forms.

We look forward to being of service.

INFO

For your future claims, you can either include your bank details here below, or alternatively update your account details yourself online once you have been registered:

Bank name:_____ **Currency:**_____

IBAN / account number:_____ **Swift/BIC:**_____

Insurance contract n°:
HEALTH - 080719/501(USD) 080719/502 (EUR)
LIFE & DISABILITY - 080719/001 (1st USD) 080719/002 (1st EURO)

SEPA Direct Debit Mandate

By signing this mandate, you authorize Henner to send instructions to your bank to debit your account in accordance with the instructions from Henner.
As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks, starting from the date on which your account was debited.

CREDITOR:

Henner GMC
14 boulevard du Général Leclerc,
CS 20058, 92527 Neuilly-sur-Seine Cedex
France

Creditor identifier
FR56ZZZ414162

DEBTOR: (Please complete the following fields in capital letters

Last & First Name:……..

Address:…..……..
……

ZIP Code: …… City: ……..…… Country: ……..…….....

Account number to debit (Please enclose bank details):

IBAN : |_|_|_|_| |_|_|_|_| |_|_|_|_| |_|_|_|_| |_|_|

THIRD PARTY- DEBTOR (If different from DEBTOR):

If you are paying someone else's bill, please indicate your first and last name.
If you are paying for yourself, do not complete.

Last & First Name: ……..……..

Type of payment: Recurrent

Place : ……...Date : …../…../…….

Payer's Signature:

To return to:

Henner
14 boulevard du Général Leclerc,
CS 20058, 92527 Neuilly-sur-Seine Cedex
France

H7854 – 03/2017

Your rights concerning the present debit mandate are explained in a document which you can obtain from your bank.

Tips on how to fill out the Health Declaration

The health declaration needs to be completely filled out for every family member who needs to be insured:

- Yourself
- Partner and/or children if you also want to insure them

The pink questions

The pink questions (nr. 14 to 22) only need to be answered if you have chosen additional insurances (Life, Accidental death and disability, Temporary Incapacity and Permanent Disability)

"Signing of the health declaration (last page of the document)"

1. Please elaborate on all questions you have answered 'yes' to.
2. Place the date of signing this declaration on the bottom of the page
3. Place your signature
4. Add the place you are when signing this declaration (city + country)
5. **ADD THE WORDS 'READ AND APPROVED' IN HANDWRITING.**

Important explanation from JoHo Insurances for the health declaration

Where do you send the health declaration?

There is specific legislation for processing medical information via health declarations. This legislation is also applicable to the health declaration in this document. We (JoHo Insurances) would like to point out some specific points relating to providing the health declaration to the insurance company.

OPTION 1 – Sending the health declaration directly to the insurance company.

Because of privacy legislation there is no need for us (JoHo Insurances) to have insight in the health declaration completed by you. You can send the health declaration directly to Henner (insurance company), via regular mail or email: (medical.questionaire@henner.com).

If you prefer to send the health declaration directly to the insurance company, you can also work with a 'separated' health declaration. You can request this version from us via email (contact@johoinsurances.org). You can also 'snip' this health declaration from this document. There are several programs online which allow you to split pdf documents. Could you please inform us by email of the date you have sent the health declaration to the health insurance company? This enables us to monitor the application process.

OPTION 2 – Sending the health declaration to JoHo Insurances

Because of speed, review and proper monitoring you can also send the entire application (application + health declaration + copy ID/passport) by email to us (contact@johoinsurances.org). We will review the documents for completeness and make sure that these documents will be provided to the correct department of the insurance company. This is the only action we perform with your health declaration. Of course we do not use the declaration for other purposes.

In order to review your health declaration for completeness and to send it to the insurance company, the privacy legislation requires us to ask for your approval for these actions. By signing this document you provide us with this approval.

Thank you in advance!

By signing this document, I authorize JoHo Insurances to receive, review and forward the health declaration completed by me, to the insurance company for the (medical) acceptance of my insurance application.

Date: _____

Place: _____

Signature: _____

INTERNATIONAL EXPAT INSURANCE PACKAGE
YOUR HEALTH DECLARATION FORM
SECTION 1

Kindly complete all of the following questions carefully for all persons that are to be covered under the policy. Henner will not be able to process your application until they have received this form. Should there be any changes in the health status of the persons to be covered between the date of submission and the date of acceptance into the insurance, please notify Henner and/or JoHo Insurances immediately. Please note that this health declaration form is part of your insurance contract and is valid for 90 days from the date of the submission. Thereafter, a new application and health declaration may be required.

If your answer is 'Yes' to any of the following questions, please provide further details in the document titled "Health Declaration Form Section 2" at the end of this document. We have included 3 of such pages. If you need more pages please copy the number of pages you need and add to your health declaration. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information which you may have given to JoHo Insurances but is not written in this document. Please check your answers to make sure you are fully satisfied with the information stated in this document before signing.

If you are applying with more than 3 children, please complete a second form for the additional children.

KINDLY COMPLETE YOUR HEALTH DECLARATION

		Main Insured	Spouse	Child 1	Child 2	Child 3
1	**Family name**					
2	**First name**					
3	**Date of birth** (DD/MMM/YYYY)					
4	**Height** ☐ Cm ☐ Inches					
5	**Weight** ☐ Kg ☐ lbs					
6	**Gender**	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F
7	Have you smoked over the past seven years? *If yes, kindly indicate the average number of cigarettes smoked per day and when you ceased smoking if relevant*	☐ Yes ☐ No	☐Yes ☐No	☐ Yes ☐ No	☐ Yes ☐ No	☐Yes ☐No
8	**Over the past 10 years, have you undergone:**					
a.	A surgery ?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b.	A laser treatment, chemotherapy, radiation therapy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9	**Over the past 5 years, have you been afflicted by an illness or been the victim of a self-motivated accident :**					
a.	Have taken sick leave for over 3 consecutive weeks?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b.	Undergone medical treatment for over a month	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10	**Have you suffered from or ever been diagnosed with?**					
a.	Nervous disorders (for example: chronic fatigue, anxiety, depression, migraine, epilepsy)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b.	Spinal cord disorders (for example: lower back pain,	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

	sciatica, herniated disc, stiff neck…)					
c.	Arthritis and / or rheumatism (for example: hip, knee, shoulder, hands…)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d.	Heart disease and / or vascular disorders (for example: hypertension, angina / chest pain, heart attack, heart rhythm abnormalities, aneurysm…)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e.	Diseases of the esophagus, stomach, intestines, liver, pancreas (for example: stomach ulcers, Crohn's disease, ulcerative colitis…)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f.	Urinary problems (for example: renal colic, testicular or prostate disorders, bladder or kidney problems, polyp...)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g.	A trauma, disease or illness requiring regular medical care and / or regular medical treatment in the future.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Any other trauma, accident, complaint, disease or illness (not mentioned in the above categories)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐No	☐ Yes ☐ No
11	**Have you ever performed a serological screening test as follows:** ***If yes, kindly specify the result in the table on page 3***					
a.	Hepatitis B virus (HBV) ?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b.	Hepatitis C (HCV) ?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c.	HIV (AIDS) ?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
12	**Have you ever had addiction problems related to alcohol and / or drugs?**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
13	**Within the next 12 months following the effective date of your contract, do you think you may:**					
a.	Go to see a doctor or require any medical test (for example. laboratory, imaging, endoscopy…) and / or see a specialist and / or seek medical or surgical treatment?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b.	Receive hospital treatment? (for example: removal of tonsils, removal of a cyst, removal of a mole…)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

INTERNATIONAL EXPAT INSURANCE PACKAGE

YOUR LIFE INSURANCE HEALTH DECLARATION FORM

The below section (questions 14-22) is only to be completed if you have chosen to take out one or more of the following additional insurances; Life Cover, Accidental Death and Invalidity, Temporary Incapacity, Permanent Disability.

		Main Insured	Spouse
14	Do you suffer from a handicap, disability or chronic illness?	☐ Yes ☐ No	☐ Yes ☐ No
15	In the 12 months preceding the effective date of your contract, have you taken more than 3 days sick leave?	☐ Yes ☐ No	☐ Yes ☐ No
16	Do you or anyone in your family have a history of the following diseases? Heart disease, vascular, neurological, psychiatric, cancer, diabetes?	☐ Yes ☐ No	☐ Yes ☐ No
17	Are you currently on sick leave?	☐ Yes ☐ No	☐ Yes ☐ No
18	Are you entitled to a disability pension?	☐ Yes ☐ No	☐ Yes ☐ No
	Are you going to be declared disabled?	☐ Yes ☐ No	☐ Yes ☐ No
19	Are you currently the beneficiary of anyone's insurance?	☐ Yes ☐ No	☐ Yes ☐ No
	Have you ever been refused, restricted or received a premium loading for a previous health insurance policy?	☐ Yes ☐ No	☐ Yes ☐ No
20	Do you pilot or fly as a passenger in a private or aviation club aircraft (excluding regular commercial aircrafts)?	☐ Yes ☐ No	☐ Yes ☐ No
21	Have you suffered any condition other than those mentioned above?	☐ Yes ☐ No	☐ Yes ☐ No
22	Please add any other information regarding your health status that we should know.		

INTERNATIONAL EXPAT INSURANCE PACKAGE
YOUR HEALTH DECLARATION FORM
SECTION 2

If you answered 'yes' to any of the questions In Section 1 of the health declaration form, please refer to the section below in order to provide more details to your answer. For more than one question, please attach another copy of Section 2

Question Number: _____

1	Name of Person Concerned:		
2	Relationship *(Main Insured, Spouse, Child 1, Child 2, Child 3)*		
3	State the precise diagnosis		
4	State the result of the type of tests/ explorations, dates and results that led to the diagnosis		
5	Please describe your symptoms		
6	When did the symptoms first occur?		
7	How frequently did the symptoms occur in the last 12 months?		
8	When was the last occurrence of the symptoms?		
9	Please provide date(s) and full details including type of treatment, names of hospital and consultant/ surgeon.		
10	Have you experiences any symptoms following treatment or surgery?	☐ Yes	☐ No
11	If Yes, please provide details		
12	Please provide details of your treatment, including names of medication, dosage and frequency of dosage.		
•	☐ Currently		
•	☐ In the past		
13	How often do you attend follow up?		
14	Please add in attachment to this 'health declaration form' all relevant medical info - in English - from your doctors, physicians, hospitals or treatment centers which provides a thorough explanation / insight on the diagnosis.		

INTERNATIONAL EXPAT INSURANCE PACKAGE
YOUR HEALTH DECLARATION FORM
SECTION 2

If you answered 'yes' to any of the questions In Section 1 of the health declaration form, please refer to the section below in order to provide more details to your answer. For more than one question, please attach another copy of Section 2

Question Number: _____

1	Name of Person Concerned:		
2	Relationship *(Main Insured, Spouse, Child 1, Child 2, Child 3)*		
3	State the precise diagnosis		
4	State the result of the type of tests/ explorations, dates and results that led to the diagnosis		
5	Please describe your symptoms		
6	When did the symptoms first occur?		
7	How frequently did the symptoms occur in the last 12 months?		
8	When was the last occurrence of the symptoms?		
9	Please provide date(s) and full details including type of treatment, names of hospital and consultant/ surgeon.		
10	Have you experiences any symptoms following treatment or surgery?	☐ Yes	☐ No
11	If Yes, please provide details		
12	Please provide details of your treatment, including names of medication, dosage and frequency of dosage.		
•	☐ Currently		
•	☐ In the past		
13	How often do you attend follow up?		
14	Please add in attachment to this 'health declaration form' all relevant medical info - in English - from your doctors, physicians, hospitals or treatment centers which provides a thorough explanation / insight on the diagnosis.		

INTERNATIONAL EXPAT INSURANCE PACKAGE
YOUR HEALTH DECLARATION FORM
SECTION 2

If you answered 'yes' to any of the questions In Section 1 of the health declaration form, please refer to the section below in order to provide more details to your answer. For more than one question, please attach another copy of Section 2

Question Number: _____

1	Name of Person Concerned:		
2	Relationship *(Main Insured, Spouse, Child 1, Child 2, Child 3)*		
3	State the precise diagnosis		
4	State the result of the type of tests/ explorations, dates and results that led to the diagnosis		
5	Please describe your symptoms		
6	When did the symptoms first occur?		
7	How frequently did the symptoms occur in the last 12 months?		
8	When was the last occurrence of the symptoms?		
9	Please provide date(s) and full details including type of treatment, names of hospital and consultant/ surgeon.		
10	Have you experiences any symptoms following treatment or surgery?	☐ Yes	☐ No
11	If Yes, please provide details		
12	Please provide details of your treatment, including names of medication, dosage and frequency of dosage.		
•	☐ Currently		
•	☐ In the past		
13	How often do you attend follow up?		
14	Please add in attachment to this 'health declaration form' all relevant medical info - in English - from your doctors, physicians, hospitals or treatment centers which provides a thorough explanation / insight on the diagnosis.		

INTERNATIONAL EXPAT INSURANCE PACKAGE
HEALTH DECLARATION

Please complete and sign this page.

I declare, represent and warrant that the information given in this form (which includes Sections 1 and 2) is true and complete with respect to all persons mentioned herein. Where I have provided information on the behalf of any other persons to be covered under this policy, I confirm that I have checked with them that the information is correct before completing this form and I have their express agreements to submit this form on their behalf, and/or I am acting as their legal representative in submitting the information.

I agree that this form and the information provided herein shall form a part of the insurance contract to be issued. I understand that coverage under the policy shall not become effective unless it has been accepted and confirmed by either Henner or JoHo Insurances.

I agree to provide the medical board of Henner all the medical information that they need. Any misrepresentation or omission shall render the policy null and void and the premiums paid will be retained by the insurer as damages. The insured and his/her dependents will have to refund the benefits they have received.

Henner collects and process your medical information in a confidential manner and in strict compliance with the rules and regulations regarding medical and professional secrecy.

To be completed by the main insured:

Main Insured's name: .....

Write 'read and approved' on the dotted lines .....

Signature: ..... Signed on date (dd/mm/yyyy).....

Emailaddress: .....
(this is necessary for our medical board to contact you in regards to this health declaration)

Signed in which city ..... Signed in which country .....

To be completed by the insured dependents who have reached majority:

Name: .....

Write 'read and approved' on the dotted lines .....

Signature: ..... Signed on date (dd/mm/yyyy).....

HOW TO APPLY?

1. Documents

1. Application form
2. Copy of your passport

2. Send to:

Send the documents per email to: contact@johoinsurances.org

3. Confirmation

Your will receive a confirmation of receipt within 48 hours (2 working days). If you do not receive this confirmation by email within 48 hours, please feel free to contact us.

Do you apply for Temporary Incapacity (and Permanent Disability) cover?
If you apply for Temporary Incapacity/Permanent Disability cover we need additional info:

- Proof of income
- Joho document.

In most cased we have provided you with a separate explanation including the document about these requested documents. If not, please ask us for it.

Do you apply for the Life Cover and/or Accidental Death and Disability (ADD) cover?
If you apply for Life and/or AD&D, this package reimburses a pre-chosen insured amount if an insured person dies because of an accident (AD&D) or an accident or illness (Life). The insurance taker can decide who receives the reimbursement.

- Option 1 - Standard Beneficiary Clause as mentioned on page 9 in the conditions.
- Option 2 - Choose your own beneficiaries.

If you choose option 2, please inform us so we can send you the 'beneficiary form'.