SWISS HEALTH INTERNATIONAL APPLICATION FORM

expatplus

Please make sure this form is signed and duly completed (in capitals) by the applicant. The applicant or intermediary should return this form, along with all the supporting documentation, to:

1. Policyholder details

Last name | First name
Title | Date of birth (d - m - y) / /
Marital status | Sex ☐ M ☐ F
Occupation | Host country
Does your occupation include aerial, underground, under or above water activities? ☐ Yes ☐ No
Nationality | Passport no.

Home country address
Postal code | Town / City | Country / State

Host country address
Postal code | Town / City | Country / State

Home telephone | Business telephone
Mobile number | Fax
Home e-mail | Business e-mail

2. Company details (if applicable)

Company name
Address
Postal code | Town / City | Country / State

3. Dependants to be included in the plan

Please enter the details of all dependants to be covered under this policy. This can include your spouse/partner and any children financially dependent on the policyholder and not more than 28 years old.

Last name	First name	Relation	Sex	Date of birth (d - m - y)
			☐ M ☐ F	/ /
			☐ M ☐ F	/ /
			☐ M ☐ F	/ /
			☐ M ☐ F	/ /
			☐ M ☐ F	/ /

5.90.105INVC (0110)

SWISS HEALTH INTERNATIONAL APPLICATION FORM

4. Policy start date

Start date (d - m - y)

5. Your ExpatPlus insurance

Core Plan			Essential (Globe) ☐	Essential (Globe) ☐	Classic (Obit) ☐	Platinum (Universe) ☐
Area of cover			Worldwide	Worldwide excl. USA & Canada	Worldwide excl. USA & Canada	Worldwide excl. USA & Canada
Deductible	Outpatient Care		$ 375	€ 300	€ 300	€ 300
Currency of payment			USD	EUR	EUR	EUR
Additional Insurances[1]	Dental Care[2]	Basic	☐	☐	☐	☐
	Accidental Death and Invalidity		☐	☐	☐	☐
	With insured capital of € / $		....	....	....	....
	Temporary Incapacity[4]		☐	☐	☐	☐
	With monthly allowance of € / $		....	....	....	....
	Permanent Disability[5]		☐	☐	☐	☐

Settlement notes online in following language ☐ EN ☐ FR ☐ DE ☐ NL ☐ ES ☐ IT

6. Nomination of beneficiaries (to be completed if you take the Additional Insurance Accident Death and Dimemberment)

I declare that in the event of death, any indemnities to which I am entitled by virtue of the ExpatPlus insurance to be paid to the listed persons below or, failing this, to my legal heirs. The nomination of the beneficiaries in the event of death can only be modified by the undersigned.

Last name	First name	Relation	Proportion of capital (%)

1 Additional Insurances can only be purchased in addition to the Core Plan, they cannot be purchased separately.
2 The Additional Insurance Dental Care can only be taken out on family level and the minimum contract duration is one year (unless the contract is terminated).
3 The minimum sum insured shall be € 50,000 / £ 32,500 / $ 62,500 / CHF 75,000 up to a maximum sum insured of € 500,000 / £ 325,000 / $ 625,000 / CHF 750,000.
4 The minimum monthly allowance shall be € 1,000 / £ 650 / $ 1,250 / CHF 1,500 up to a maximum of € 10,000 / £ 6,500 / $ 12,500 / CHF 15,000. The monthly allowance cannot exceed 80% of the gross (monthly) salary of the insured.
5 Permanent Disability can only be taken out as complementary to Temporary Incapacity.

5.90.105INVC (0110)

SWISS HEALTH INTERNATIONAL APPLICATION FORM

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7. Payment details

Bank Transfer	☐ Annual	☐ Half yearly	☐ Quarterly
Credit card	☐ Annual	☐ Half yearly	☐ Quarterly

8. Credit card authority

Credit card	☐ Mastercard	☐ VISA	☐ Eurocard	☐ AMEX
Credit card number		Expiry date		CVC code[6]
Cardholder's name[7]				
Address cardholder (if different from address on p. 1)				

I grant Vanbreda International, a power of attorney, as of today and until further notice, to collect all invoices in my name.
I will advise Vanbreda International immediately if the card becomes lost, stolen or if I wish to close my card account or cancel the authority.

Date	Cardholder's authorisation signature[7]

9. Bank account information (for the reimbursement of medical expenses)

Account holder name	
Account no. (IBAN no. for European countries)	
Full bank name and address	
BIC / SWIFT code	ID Bank (if applicable)

10. Declaration

1. I hereby apply for cover on behalf of all the persons named in this application form.
2. I declare that the answers given are to the best of my knowledge full, true and complete and have checked and found correct any answers and statements in this application that are not in my own handwriting.
3. I accept that this policy will be subject to the policy terms and conditions effective at the time of policy commencement. I confirm that I have read and understand the full definitions, benefits, exclusions and conditions of this policy.
4. I confirm and agree that the personal information collected or held by Vanbreda International, whether contained in this application form or otherwise obtained may be used by Vanbreda International, or disclosed to or transferred to any organisation for the purpose of 1) assessing this application and providing on-going insurance and customer service, 2) processing and giving effect to credit card payment, 3) providing marketing material in respect of insurance related services of Vanbreda International or it's associated companies and 4) processing claims or analysing the insurance.
5. I further accept that where funds have been outstanding to Vanbreda International for a period in excess of 15 days from notification my policy will be suspended automatically, without refund of premium.

Date	Signature of applicant

6 CVC Code (Card Verification Code): the 3 last numbers of the code on the back of your card.
7 To be completed only if the cardholder is not the addressee of the premium requests.

5.90.105INVC (0110)

MEDICAL QUESTIONNAIRE

Please answer each of these questions fully and accurately, for each person included on your application. In case you have ticked 'Yes', please provide details in the additional information box on the last page.

	Policyholder	Partner	Child 1	Child 2
Name				
Date of birth (d - m - y)				
1. Height / weight	cm kg	cm kg	cm kg	cm kg
2. a. Do you currently have any health problems?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
b. Is your capacity to work reduced?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
c. Have you ever been unable to work for more than four consecutive weeks during the last five years?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
3. Do you suffer from or have you suffered from any illnesses, disturbances or problems connected with:				
a. the **respiratory organs**, such as asthma, recurrent or chronic bronchitis, pneumonia, pulmonary tuberculosis or other disorders?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
b. the **heart or vascular system**, such as high blood pressure, circulatory problems, heart attack, heart defect, heart failure, palpitations, apoplexy, phlebitis, varicose veins or other disorders?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
c. the **nervous system or a mental disorder**, such as epilepsy, dizziness, paralysis, neuritis, depression or other disorders?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Have you ever attempted to commit suicide?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
d. the **digestive system**, such as hiatus hernia, gastric or duodenal ulcers, or other disorders of the stomach or intestines, such as inflammations, haemorrhages, haemorrhoids, jaundice, diseases of the liver, gall bladder, pancreas?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
e. the **urinary tract of sexual organs**, such as kidneys, ureters, bladder or prostate, urinary tract, blood or albium in the urine or other disorders?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
f. the **metabolism or blood**, such as diabetes mellitus, elevated cholesterol, gout, thyroid gland or hormonal disturbances, anemia, coagulation disturbances or other disorders?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
g. the **immune system or infectious diseases**, such as AIDS, HIV, sexually transmitted diseases, hepatitis, tropical diseases or other disorders?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
h. the **skin**, such as eczema, allergies, psoriasis, fungal diseases, skin cancer or other disorders?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
i. the **musculoskeletal system**, (bones, joints, spine, intervertebral discs, muscles, ligaments, tendons), such as disorders of the back, neck and shoulders, arthritis, rheumatism or other disorders?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
j. the **eyes**, such as decreased visual acuity or refraction power, retinal disease or other disorders?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

5.00.068NVC (0110)

MEDICAL QUESTIONNAIRE

	Policyholder		Partner		Child 1		Child 2	
Name								
Date of birth (d - m - y)								
k. the **ears**, hearing difficulties, inflammation or other disorders?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
l. **other illnesses**, disturbances or problems not listed above, such as congenital defects, deformities, tumours, cancers, etc?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
4. Have you had any **accidents**, injuries or poisonings which necessitated a hospital stay or operation?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
5. a. Have you been examined, received treatment or been operated on in hospital or similar institution?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
b. Have you been advised to take a rest, diet, withdrawal or other cure, or is such a cure planned?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
c. Is a hospital stay or operation planned?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
d. Have you been treated by or consulted any of the following in the last 5 years:								
• psychotherapist? (e.g. psychiatrist, psychologist)	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
• chiropractors, physiotherapists?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
e. Have you ever been given or prescribed a drug for a period in excess of 4 weeks?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
f. Have you ever had radiation treatment (x-ray or radioactive substances)?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
6. Have you undergone any **special examinations**/tests during the last 5 years, such as x-rays, computed tomography, MRI (magnetic resonance imaging), ultrasound, echo, electrocardiogram, electroencephalogram, endoscopy or other tests?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
7. Have you had an **AIDS** test that showed an HIV-positive or possibly positive result?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
8. a. Do you practise sports?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
b. Do you smoke?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
c. Do you drink alcohol?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
d. Do you take painkillers, sleeping tablets, tranquillisers or other medications?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
e. Do you take or have you taken any narcotics (drugs)?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
9. a. Which **physician** did you last consult?								
b. Have you consulted any physicians in the last 5 years not already mentioned?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
c. Which physician is most familiar with your medical history?								
10. For **female** persons only:								
a. are you pregnant?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
if yes, has the pregnancy been normal to date?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
b. have you ever had a gynaecological disorder or a disease of the breast?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
c. have you undergone or do you plan to undergo (any) infertility treatment?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

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MEDICAL QUESTIONNAIRE

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Additional information

If you answered 'Yes' to any of the questions above, please provide details here. Please provide the precise question number(s), name of the person, diagnosis, dates and duration of illness/injury/treatment and the names and addresses of attending physicians and medical facilities.

I certify that the statements made by me in answer to the above questions are true, complete and correct to the best of my knowledge and belief.
I understand that nullity of the insurance or reduction of the insured capital sum might be applied in the event of claim if it were proved that the person to be insured had established a false declaration.

In view of a smooth administration of the contract and/or settlement of the insurance claim, and only for that purpose, the signatory hereby gives his/her specific and informed consent regarding the processing of the medical data concerning him/herself and/or the members of his/her family (article 7 of the Belgian law of December 8, 1992 concerning the private life).

Date	Place
Signature policyholder	Signature partner

(Signature must be preceded by the handwritten words: 'Read and approved'.)

5.00.068INVC (0110)