Allianz

CARE
International Healthcare Plans
for you and your family

Switch Form for policies with Continued Personal Medical Exclusions / Continuous Transfer Terms

If you have a policy for a minimum of 12 consecutive months with another recognised global health insurer with full medical underwriting, you may be able to switch to an international healthcare solution with Allianz on the same underwriting terms.

You must submit this Application Form **within one month of leaving your current policy as there must be no break in cover**.

Who is eligible for this cover:

- To be eligible, your current policy must have been underwritten within the last 3 years.
- The cover we offer will be on a 'best match' basis only.
- Only those family members who were covered under your current policy can apply for these terms using this Application Form.
- If you have a policy with moratorium, Continuous Transfer Terms (CTT), Continued Personal Medical Exclusions (CPME) or medical history disregarded terms, you will not be eligible to switch on the same terms.
- We rreserve the right to decline cover. This may happen in instances such as additional disclosures on your CPME application or where Allianz rules or risk assessment differs to that of your existing insurer regarding your personal details or medical condition.

Guidelines on how to complete this form:

- If you choose to complete a printed version of this form, PLEASE COMPLETE IT IN BLOCK CAPITALS.
- You must complete this form in full and tell us all relevant information. Once you have sent us the form, 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.
- Please select a similar level of cover (or lesser cover) as the one provided by your current global health insurer. If you are unsure about which plan to select, please contact our Sales Team. If you choose a more comprehensive plan than your existing cover, you will be subject to medical underwriting and waiting periods will apply to certain benefits.
- Please ensure that you enclose the current Insurance Certificate, proof of premium payment and the Table of Benefits for the policy that you currently hold from the other health insurer.
- On page 9, 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 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.

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 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. **We will consider applicants for cover up to the day before their 65th birthday.**

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 this here)

Details of current 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 65th birthday. Applicants over 65 and up to the day before their 76th birthday, will be considered on full medical underwriting basis.**

Please note that all dependants you wish to include in your new policy with us must be insured under your current policy with the other health insurer. Please submit the relevant certificate from your current health insurer that shows them as dependants on your policy.

If there is insufficient space for all dependants, please use another copy of this 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 ☐
Occupation (mandatory, please state if student)			
Email address (mandatory for dependants over 18)			
Home country			
Principal country of residence			
Nationality			

3 Start date of your cover

From what date do you require cover: 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

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 ☐

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 Pro	Care Plus	Care
Policyholder	☐	☐	☐ If you select Care, this Core Plan and any optional plans you select will apply to all persons included on your policy.
	If you select Care Pro or Care Plus, you can either select the same Core Plan for all of your dependants (if any) or you can choose between Care Pro or Care Plus for each of your dependants:		
Dependant 1	☐	☐	
Dependant 2	☐	☐	
Dependant 3	☐	☐	

Select your optional plans

Out-patient Plans

Policyholder	Active Pro ☐ **OR** Active Plus ☐ **OR** Active ☐	Active ☐
Dependant 1	Active Pro ☐ **OR** Active Plus ☐ **OR** Active ☐	
Dependant 2	Active Pro ☐ **OR** Active Plus ☐ **OR** Active ☐	
Dependant 3	Active Pro ☐ **OR** Active Plus ☐ **OR** Active ☐	

Maternity Plans

Policyholder	Bloom Plus ☐ **OR** Bloom ☐	Our Maternity Plans are not available with the **Care** Core Plan.
Dependant 1	Bloom Plus ☐ **OR** Bloom ☐	
Dependant 2	Bloom Plus ☐ **OR** Bloom ☐	
Dependant 3	Bloom Plus ☐ **OR** Bloom ☐	

Dental Plans

If you select Smile Plus for anyone, all other applicants on your policy must select the Dental Plan available under their chosen Core Plan.

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

Repatriation Plan

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

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

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 co-payment 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 in your policy	Discount if a Maternity Plan is included in your policy
No deductible	☐	0% premium discount	0% premium discount
£ 374 / € 450/ US$ 610 / CHF 585 deductible	☐	5% premium discount	2.5% premium discount
£ 625 / € 750 / US$ 1,015 / CHF 975 deductible	☐	10% premium discount	5% premium discount
£ 1,245 / € 1,500 / US$ 2,025 / CHF 1,950 deductible	☐	20% premium discount	10% premium discount
£ 2,490 / € 3,000 / US$ 4,050 / CHF 3,900 deductible	☐	35% premium discount	17.5% premium discount
£ 4,980 / € 6,000 / US$ 8,100 / CHF 7,800 deductible	☐	50% premium discount	25% premium discount
£ 8,300 / € 10,000 / US$ 13,500 / CHF13,000 deductible	☐	60% premium discount	30% premium discount

Select your Out-patient Plan co-payment

Please note that either an Out-patient Plan co-payment OR a Core Plan deductible can be chosen. Where a co-payment 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 co-payments		Discount
No co-payment	☐	0% premium discount
10% co-payment, max. £ 1,255 / € 1,480 / US$ 2,000 / CHF 1,925	☐	12% premium discount
20% co-payment, max. £ 2,461 / € 2.962 / US$ 4,000 / CHF 3,861	☐	24% premium discount
30% co-payment, max. £ 3,076 / € 3,705 / US$ 5,000 / CHF 4,815	☐	35% premium discount

5 Pre-existing medical 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 issue 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.

As you are applying for a policy with Continuous Personal Medical Exclusions and Continuous Transfer Terms, please note that you will not be subject to any new personal underwriting terms than those already applied to your policy with your previous insurer. Your cover will still be governed by the benefits, terms and conditions of the plan with us.

6 Your Health

This health declaration is valid for two months from the date you complete and sign the form.

Please take reasonable care to provide accurate and complete answers to the following questions on the basis of your own and your dependants' 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.**

Please note the following definition:

Chronic condition is defined as a sickness, illness, disease or injury that lasts longer than six months or requires medical attention (such as check-up or treatment) at least once a year. It also has one or more of the following characteristics:

- Is recurrent in nature.
- Is without a known, generally recognised cure.
- Is not generally deemed to respond well to treatment.
- Requires palliative treatment.
- Leads to permanent disability.

Please indicate if any person(s) included in this application:

a) Has sought medical advice or been treated for a chronic, ongoing medical condition or received repeat medical treatment since your insurance policy was last medically underwritten. Yes ☐ No ☐

b) Experienced within the past 12 month period any signs, symptoms or medical complaints of a continuous or recurring nature, with incomplete recovery and for which medical advice has not yet been sought and/or fully investigated? Yes ☐ No ☐

c) Is awaiting results of tests/investigations or have any medical review, treatment planned or pending (including but not limited to hospital admission or surgery)? Yes ☐ No ☐

If you have answered "Yes" to any of the questions above, please provide full medical details of each condition in the table below, as this may be subject to further medical underwriting or additional exclusions.

Please tell us if a full recovery has been made and if you or your dependants have any condition or disease related to or arising from the original diagnosis.
If you are unsure about your own or your dependants' condition, please contact us.

Please tell us immediately if you or your dependants' experience any symptoms between the time you complete this form and the start date of the policy.

Question	Name of the person affected by the medical condition	Diagnosis – where applicable state the area of the body (e.g. left arm, right foot or tooth affected)	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

If there is insufficient space in the table above, please use another copy of this form.

Please provide the name, address and telephone number of the regular/family doctor (and dentist, where applicable) 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. 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 medical 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 this form and the earliest of the following:
  - The date we issue your Insurance Certificate
  - 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 relating to me, 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 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 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 policy terms and conditions that apply at the time of start or renewal date of the policy and are set out in the Benefit Guide.
  - The cover provided by Allianz is not suitable if my dependants and I are or become resident in countries where local compulsory health insurance requirements 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 insurance cover is legally appropriate.
- I hereby declare that my existing international health insurance policy, policy number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ is currently in-force with the following insurance company: _____
  and that the terms offered by Allianz are based on the premise that I have, at the point of application, an in-force health insurance policy with the above declared insurance company. I accept that I am required to provide a copy of my Insurance Certificate and a proof that my existing international health insurance policy is paid up to date. I understand that claims may be rejected if at the point of claim it is revealed that I did not have an in-force health insurance policy with the above declared insurer at the point of applying to switch my cover to Allianz, or where I failed to answer the questions on this declaration correctly. This declaration is deemed to be part of the contract with Allianz.
- I understand that I will be subject to full medical underwriting if I fail to fulfil any of the above terms or if the contract with my existing international healthcare provider is cancelled more than 30 days before my coverage with Allianz starts.

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, 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

1. **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.
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 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.
3. **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, Dependant 1, Dependant 2 and Dependant 3 agree that the insurer may collect, use and disclose my personal data to provide me with marketing information, and I understand that my personal data will only be processed for the following reasons and activities that I have expressly agreed to by ticking the boxes below.

	Name of applicant	Name of dependant 1	Name of dependant 2	Name of dependant 3
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 shall 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 shall 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)	☐
10. Your personal data**	☐
11. Data consent**	☐
12. Marketing preferences	☐

Broker name:

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

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	Quarterly	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/**.

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

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.

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

Please return this fully completed form with a copy of your current international healthcare Insurance Certificate, proof of premium payment and Table of Benefits by:

Email: individual.joining@e.allianz.com

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

If you have any questions regarding this 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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www.tiktok.com/@allianzcare

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