Allianz Care

Preliminary Underwriting
Medical Enquiry Form

If you choose to complete a paper version of this form, **PLEASE COMPLETE IT IN BLOCK CAPITALS**.

This form is a preliminary enquiry only and does not form a binding agreement nor constitute an offer of terms from us. Terms and conditions can only be offered upon receipt and assessment of a fully completed Application Form and any necessary medical evidence/reports requested by the Underwriting Team of Allianz Care.

Mr.☐ Mrs.☐ Ms.☐ Miss☐ Other

First name

Surname

Date of birth D D / M M / Y Y Y Y

Gender: Male☐ Female☐

Height and weight cm kg

Do you smoke? Yes☐ No☐

If Yes, how many units do you smoke per day

(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)

Do you consume alcohol? Yes☐ No☐

If Yes, how many units per week

(1 short = 1 unit, 250ml beer = 1 unit, 1 glass wine = 1 unit)

Nationality

Principal country of residence

(The country where you live for more than six months of the year).

Occupation

Type of cover required In-patient☐ Out-patient☐ Repatriation☐ Dental☐ Maternity☐

Details of medical condition(s)

Diagnosis or symptoms

Date of first symptoms D D / M M / Y Y Y Y

Date of last symptoms D D / M M / Y Y Y Y

Results of investigations, blood tests or readings

Current medical treatment, including surgery *(if applicable)*

Complications *(if applicable)*

Details of any follow-ups

Has a full recovery been made? **Please attach any supporting medical documentation (e.g. letters or reports), where available**

If there is insufficient space for additional conditions, please use another Preliminary Underwriting Medical Enquiry Form

We care about your personal data protection

Our Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process your personal data. You should read it before submitting any personal data to us. 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, you can always contact us by e-mail at: **AP.EU1DataPrivacyOfficer@allianz.com**

Declaration

Please read the following declarations carefully and only sign below if you understand and accept them.

(a) 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 any false, incorrect or misleading statement or non disclosure of material medical information may render the insurance null and void.

(b) I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information and I consent to the fact that Allianz Care, if it considers it appropriate, will check statements concerning my health condition and will check with other healthcare insurers all statements concerning previous, or existing contracts applied for. I authorise all such practitioners, physicians, dentists, members of medical professions, employees of hospitals and health authorities as well as 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.

This declaration and form must be signed and dated by the proposed member. Where this enquiry relates to a minor, a parent or guardian should sign this section.

Signature of proposed member _____ Date D D / M M / Y Y Y Y

Printed name of proposed member

Data consent

We need your consent to collect and process your health and other data for the insurance policy that you would like to subscribe to. **If you do not provide your explicit consent for the processing of your personal data as outlined below, we will not be able to provide you with the policy that you would like to purchase or process any claims that may be owed to you.** If you agree, your data will be processed for the following reasons and activities.

A parent or guardian should complete the consent for any dependant that is under the age of 18.

I INSERT NAME OF APPLICANT **agree with the following:**

1. **Permission to collect, store and use my health data:** The insurer may collect, store and use my health data in order 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. The insurer may store my health data in accordance with the Consumer Code of the law applying to my insurance policy with the insurer or any other applicable law requiring its retention.
2. **Permission to obtain my data from third parties.** The insurer 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 to provide me with insurance cover, underwrite the risks to be insured or process any claims. I agree to release all individuals at these institutions and the insurer from their respective confidentiality obligations relating to my health data or other data that they are required to share and use for these aforementioned stated purposes.
3. **Sharing my data outside of the insurer.** The insurer may share my health and other data with the institutions set out below for them to use to the same extent, and for the same purposes as the insurer. I understand that the insurer has put in place contractual arrangements with these institutions to protect my data. I agree to release all individuals at these institutions and the insurer from their respective confidentiality obligations relating to my health data or other data that they are required to share and use for the purposes set out below:
    - With independent medical experts if this is necessary 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 the insurer, such as risk assessments and claims handling that involve the collection and use of my health and other data, without which the insurer would not be able to administer my policy or pay any claims due to me.
    - With coinsurers to distribute the coverage of the insurance risk jointly with other companies to which the insurer issue 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 to 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 the insurer know by emailing AP.EU1DataPrivacyOfficer@allianz.com

Applicant's signature _____

Date D D / M M / Y Y Y Y

Intermediary appointment

I hereby authorize INSERT NAME OF BROKER

to act for and on my behalf in relation to the administration of this application which may include the disclosure of sensitive medical information. This authorisation will remain in place until I provide a written request to Allianz Care to revoke it.

Email address of the Broker

Applicant's signature

Date D D / M M / Y Y Y Y

Once completed, please email this form and any supporting documentation to:
underwriting@allianzworldwidecare.com

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