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Ref \_\_\_\_\_

2006/AFC

# Masterkey<sup>2</sup>Health

- Project for proposal Companies** (fill in the red and blue fields)
- Application Form Companies** (fill in all the fields)
- Modification Form Companies** (fill in red and other necessary the fields)  
(Red fields are compulsory fields)

**Effective date of the modification :** \_\_\_\_\_

*Please complete this application form in block capitals and by ticking the relevant boxes . It is important that you answer all the questions so that we can properly assess your application. An explanation of the coverage can be found on the separate leaflet or on the website [www.expatinsurance.be](http://www.expatinsurance.be).*

**1. Employer N° or Reference** \_\_\_\_\_ Addition to Policy number \_\_\_\_\_  
(Please mention this reference on every page)

## 2. Policyholder / Business particulars

### Contact person Name

First name \_\_\_\_\_  Mr.  Mrs.

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ e-mail \_\_\_\_\_

E-mail is our standard communication form , if you prefer another way of communication please specify \_\_\_\_\_

Language  English  Dutch  French

### Company name

Address \_\_\_\_\_

Postal code, city, country \_\_\_\_\_

Sector / Activity \_\_\_\_\_

## 3. Insurance

Commencement date (dd-mm-yy) \_\_\_\_\_

Policy Language  English  Dutch  French

## 4. Premium payment

Payment  Annual  Monthly Due date: 01/ \_\_\_\_\_

**5. Coverage per category of employee** (to fill in by the employer, 1 page per category)**5.1. Category description:** \_\_\_\_\_

Manual work/ working with machines?  No  Yes, \_\_\_\_\_  
 Statute:  Civil Servant  Employee  Self-Employed

**5.2. Choice of Version**

Light  Standard  Gold

**5.3. Choice of zone**

extended (+ 90 days/year in)

10 - EEA & CH  20 - Worldw. (excl. N-Am)  30 - Worldwide  
 Not applicable  zone 20  zone 30

**5.4. Choice of Cover:****5.4.1. Medical Care**

1. Hospital Plan  **Yes** (compulsory)
- Type of Plan  Full Cover  Top-Up  Sleeper
  - Deductible:  € 0  € 250  € 500
2. Option 1: elective home country treatment  Yes  No
3. Option 2: outpatient treatment  Yes  No
4. Option 3: dental cover, vision & hearing aids  Yes  No

**5.4.2. Assistance**

1. Basic Assistance  **Yes** (compulsory)
2. Option 1: Travel  Yes  No
3. Option 2: Baggage  Yes  No
4. Option 3: Cancellation/Curtailment  Yes  No

**5.4.3. Personal Accident & Critical Illness**

Coverage desired ?  Yes  No  
 Multiplier \_\_\_\_\_ times the proposed lump sums

Beneficiary in case of death  Spouse, failing children in equal parts, failing the legal inheritors (excl. states)  
 \_\_\_\_\_

**5.4.4. Disability Pension**

- Yes  No
- Chosen Rent € \_\_\_\_\_ ( max. 80% of gross revenue, eventual allowance from Soc. Sec. included )
  - Type of rent Light = constant rent Standard = increasing rent Gold = indexed rent (2%)
  - Qualifying period  30 days  90 days  180 days

**IMPORTANT**

Please enclose following certificate for each policyholder :

- If the insured persons has Social Security in Europe, please enclose a copy of the **E-form**, stating the cover.

**6. List members of the personnel to be ensured**

(page \_\_\_\_\_ / \_\_\_\_\_ pages)

Insured no.:	Name and first name:	Date of birth (dd-mm-yy)	Gender	Category (see description point 5)	Country entitled for Social Security	Home country	Language
1.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
2.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
3.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
4.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
5.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
6.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
7.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
8.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
9.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
10.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
11.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
12.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
13.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
14.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
15.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
16.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
17.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
18.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
19.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
20.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
21.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
22.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
23.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
24.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL
25.	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	<input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> NL

**7. Addresses in the country of residence** (page \_\_\_\_ / \_\_\_\_ pages)

***It is necessary to supplement a page for each assured family (a page by member of the personnel quoted at the point 6)***

Insured no. (see point 6) \_\_\_\_\_ Name \_\_\_\_\_

Street and house number \_\_\_\_\_

Postal code, city \_\_\_\_\_ Country \_\_\_\_\_

Telephone \_\_\_\_\_ fax \_\_\_\_\_ E-mail \_\_\_\_\_

Statute  Resident  International Commuter  International Trainee  Expatriate

Country for Social Security \_\_\_\_\_ Home Country \_\_\_\_\_

Insured no. (see point 6) \_\_\_\_\_ Name \_\_\_\_\_

Street and house number \_\_\_\_\_

Postal code, city \_\_\_\_\_ Country \_\_\_\_\_

Telephone \_\_\_\_\_ fax \_\_\_\_\_ E-mail \_\_\_\_\_

Statute  Resident  International Commuter  International Trainee  Expatriate

Country for Social Security \_\_\_\_\_ Home Country \_\_\_\_\_

Insured no. (see point 6) \_\_\_\_\_ Name \_\_\_\_\_

Street and house number \_\_\_\_\_

Postal code, city \_\_\_\_\_ Country \_\_\_\_\_

Telephone \_\_\_\_\_ fax \_\_\_\_\_ E-mail \_\_\_\_\_

Statute  Resident  International Commuter  International Trainee  Expatriate

Country for Social Security \_\_\_\_\_ Home Country \_\_\_\_\_

Insured no. (see point 6) \_\_\_\_\_ Name \_\_\_\_\_

Street and house number \_\_\_\_\_

Postal code, city \_\_\_\_\_ Country \_\_\_\_\_

Telephone \_\_\_\_\_ fax \_\_\_\_\_ E-mail \_\_\_\_\_

Statute  Resident  International Commuter  International Trainee  Expatriate

Country for Social Security \_\_\_\_\_ Home Country \_\_\_\_\_

**Please enclose following certificates:** If the insured person has Social Security in Europe, please enclose a copy of the **E-form**, stating the cover.

**It is necessary to supplement a page for each assured family (a page by insured quoted at the point 6)**

**8. Other questions non-medical**

Do you practise sports ? If yes, which one ? (can you give more precise details)

No  Yes, explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is a similar insurance running with another company at present?

No  Yes, company \_\_\_\_\_  
 Per (dd-mm-yy) \_\_\_\_\_

Has a company ever refused to give you insurance, terminated it or imposed special conditions on it?

No  Yes, company \_\_\_\_\_  
 at (dd-mm-yy) \_\_\_\_\_  
 Policy number \_\_\_\_\_

What was the reason for the refusal or termination?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

1. I declare that I have answered all the questions truthfully and tot the best of my knowledge. If this form has been completed on my behalf, I agree that I have satisfied myself as tot the truthfulness of the responses given. I understand that any incorrect or incomplete answer or the concealment of any facts relevant to this insurance may invalidate this policy. I also understand that the insurer shall be entitled to retain all premiums paid prior to the insurance year by virtue of a breach of this declaration.
2. I am also aware that I have a legal obligation to notify the insurer of any fact material to this insurance, which appears between the date of this declaration and the beginning of the policy.
3. As of now, I authorize my general practitioner to transmit at the doctor of the company the certificate mentioned the cause of my death.

Signed, at \_\_\_\_\_, on \_\_\_\_\_

The insured person, with signature preceded by "read and approved"

**Protection of privacy**

The communicated facts can be processed by the insurance company with a view to customer service, the acceptance of risks, the administration of contracts and claims, as well as the payment of insurance sums.

To render an optimal service, these facts can be communicated to the companies of our group or to related companies and service providers.

The involved persons give their explicit permission for the processing of the health related facts when it is necessary for acceptance, administration and execution of the contract by the administrators acting in the scope of this contract. This processing has been determined by the Belgian Privacy code of 8 December 1992.

All information will be handled with the greatest discretion.

The involved persons have the right to peruse these facts, and to have them corrected. They also can resist, free of charge, against the processing of these facts for direct marketing.

For this purpose a dated and signed request accompagnied with a recto/verso copy of the identity card shall be sent to the customer service department of the Company.

Further information can be obtained at the customer service department of the Company.