



Avenue Louise 166 Box 1
1050 Brussels
Belgium
+ 32 (0)2 550 04 00

2006/AFI

Masterkey²Health

- Request for proposal Individuals** (fill in the red and blue fields)
- Application Form Individuals** (fill in all the fields)
- Modification Form Individuals** (fill in red and other necessary the fields)

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 and premiums can be found on the separate leaflet or on the website www.expatinsurance.be.

1. Reference _____ Addition to Policy number _____

2. Policyholder

Name _____

First name _____ Mr. Mrs.

Date of birth (dd/mm/yyyy) _____ nationality _____

Profession
(please describe accurately) _____

Civil status married(*) living together(*) single widower/widow divorced
(*) Name of partner _____

Profession of co-insured partner
(please describe accurately) _____

Address in the country of residence

Street and house number _____

Postal code & city _____ Country _____

Telephone _____ fax _____ E-mail _____

Correspondence address

Kind of address own address family Company other, _____

Street and house number _____

Postal code & city _____ Country _____

Telephone _____ fax _____ E-mail _____

Communication

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

3. Insurance

Desired commencement date (dd-mm-yy) _____

Policy Language English Dutch French

4. Premium payment

Payment Annual (100%) Quarterly (4 x 26%) Due date: 01/ _____

5. Insured persons list (Families with more than 6 insured members should add a separate list)

Only the named people who are filled in here are included in the insurance.

Insured no.:

1. **Name and first name:** _____ **date of birth (dd-mm-yy):** _____ **gender** M F
If different address please mention: _____

Category of personnel: Employee Civil Servant Self-employed Dependant
Statute: Resident Immigrant Expatriate International Commuter International Student / Trainee / Au-pair
Job description _____ Physical labour/machines

CoR: _____ CoSS: _____ CoH: _____
Country of Residence (CoR) Country entitled for Social Security (CoSS) Home Country (CoH) = Nationality

2. **Name and first name:** _____ **date of birth (dd-mm-yy):** _____ **gender** M F
If different address please mention: _____

Category of personnel: Employee Civil Servant Self-employed Dependant
Statute: Resident Immigrant Expatriate International Commuter International Student / Trainee / Au-pair
Job description _____ Physical labour/machines

CoR: _____ CoSS: _____ CoH: _____
Country of Residence (CoR) Country entitled for Social Security (CoSS) Home Country (CoH) = Nationality

3. **Name and first name:** _____ **date of birth (dd-mm-yy):** _____ **gender** M F
If different address please mention: _____

Category of personnel: Employee Civil Servant Self-employed Dependant
Statute: Resident Immigrant Expatriate International Commuter International Student / Trainee / Au-pair
Job description _____ Physical labour/machines

CoR: _____ CoSS: _____ CoH: _____
Country of Residence (CoR) Country entitled for Social Security (CoSS) Home Country (CoH) = Nationality

4. **Name and first name:** _____ **date of birth (dd-mm-yy):** _____ **gender** M F
If different address please mention: _____

Category of personnel: Employee Civil Servant Self-employed Dependant
Statute: Resident Immigrant Expatriate International Commuter International Student / Trainee / Au-pair
Job description _____ Physical labour/machines

CoR: _____ CoSS: _____ CoH: _____
Country of Residence (CoR) Country entitled for Social Security (CoSS) Home Country (CoH) = Nationality

5. **Name and first name:** _____ **date of birth (dd-mm-yy):** _____ **gender** M F
If different address please mention: _____

Category of personnel: Employee Civil Servant Self-employed Dependant
Statute: Resident Immigrant Expatriate International Commuter International Student / Trainee / Au-pair
Job description _____ Physical labour/machines

CoR: _____ CoSS: _____ CoH: _____
Country of Residence (CoR) Country entitled for Social Security (CoSS) Home Country (CoH) = Nationality

IMPORTANT

Please enclose following certificates:

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

6. Coverage

Please tick which coverage is desired.

6.1. Choice of Version

Light Standard Gold

6.2. Choice of zone

10 - EEA & CH 20 - Worldw. (excl. N-Am) 30 - Worldwide

extended at 90 days/year in
(insured no: _____)

Not applicable zone 20 zone 30

6.3. Choice of Cover

6.3.1. 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

6.3.2. Assistance

1. Basic Assistance

Yes (compulsory)

2. Travel Assistance

Yes (compulsory)

3. Option 1: Baggage

Yes (insured no: _____) No

4. Option 2: Cancellation/Curtailment

Yes (insured no: _____) No

6.3.3. Personal Accident & Critical Illness

Coverage desired ?

Yes (insured no: _____) No

Beneficiary in case of death

Spouse, failing children by equal share, failing the legal inheritors by equal share.

6.3.4. Disability Pension

Yes (insured no: _____) No

• Chosen Rent

€ _____ (max. 80% of gross revenue,
eventual allowance from Soc. Sec. included)

• Qualifying period

30 days 90 days 180 days

7. 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?

IMPORTANT

Please enclose following certificates:

- If the insured person has Social Security in Europe, please enclose a copy of the **E-form**, stating the cover.
- If the insured person has been covered before, please enclose a **copy of his policy** (only if less then 20 insured members)

The policyholder and the insured person(s) declare that the above stated details are true and sincere in all details, even if they haven't written it personally. They declare to be aware of the fact that with holding information or reporting facts incorrectly, can lead tot annulment of the contract or non-payment of the insured benefits, within the limits given by the Belgian insurance act of 25 June 1992.

The signatory/signatories declare(s) to have knowledge of the provisions regarding the protection of privacy, which are written below. If the involved persons do not want to be informed concerning direct marketing actions of the Company, please tick this box .

Signed, at _____, on _____

The policyholder,

The insured person, if not, the policyholder 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.