EXECUTIVE HEALTHCARE SOLUTIONS
Powered by Allianz Care

Individual Application Form

Executive Healthcare Plan (EHP)

Explanatory Notes: Please read through the following before completing this application and complete in **BLOCK CAPITALS** or check boxes as appropriate.

Allianz Medical Expert (AME) - our automated underwriting tool:

We may use an automated medical underwriting tool to determine whether we can provide cover to you and if so, on what terms. This tool is used to process personal and medical information you provide us in order to calculate the cost of your International Healthcare cover. Without this information we are unable to calculate the premium for your insurance which is relevant to your needs.

We regularly assess the way our automated underwriting tool works to ensure we continue to offer a fair assessment. This assessment is based on the plans you select and on the personal and medical information you provide to us on this application.

Permission to automate the underwriting decision

☐ By ticking this box you accept and agree that Allianz Care may use an automated medical underwriting tool to evaluate your personal and health data in order to make the underwriting decision on the risks to be insured. This is performed in accordance with GDPR guidelines on the processing of data using an automated underwriting tool.

Once the automated underwriting decision has been made, you have the right to request that we reconsider our decision which will involve a review by our medical underwriting team. If you wish to invoke this right please contact us at underwriting@allianzworldwidecare.com

Guidelines on how to complete this Application Form

1. You must complete the Application Form in full and tell us all relevant information. Once you have sent us your application, 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.
2. Section 7 must be signed by the policyholder. Section 9 must be signed by all adult applicants. In line with the European General Data Protection Regulation (GDPR), 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 information supplied will be treated in strict confidence. All material facts (e.g., a pre-existing health condition or involvement in a hazardous activity), which may affect our assessment and consideration of this application, should be declared. Failure to do so may invalidate your cover under the plan. If you are in doubt as to whether a fact is material, then it should be disclosed.

As the applicant, you should answer all the questions and sign the declaration on behalf of all persons included in this application. A copy of this application can be supplied to you on request within three months of completion. You should keep a record of all information provided.

Please complete in **BLOCK LETTERS** where applicable.

Please select your policy terms by ticking the relevant box in the table below:

Moratorium Terms ☐
Full Medical Underwriting (FMU) ☐
Continuous Transfer Terms (CTT) ☐

Are you applying as an addition to an existing Individual Policy? Yes ☐ No ☐

Policy name
Policy number

If you are applying on Continuous Transfer Terms, please tick the relevant box below:

Are you transferring from another insurer to an Allianz Care EHP Policy? ☐
Are you transferring from an existing Allianz Care EHP group policy to an Allianz Care EHP Individual Policy? ☐
Are you transferring from an existing EHP policy to a new Allianz Care EHP Policy? ☐

Kindly provide the details requested below (mandatory):

Name of insurer
Policy number

Kindly include the insurance certificates for all the years covered under the aforementioned insurer and any other international insurance providers (provided there is no break in cover).

Wherever the following words and phrases appear in this form, they will have the meanings as defined below.
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 (please note that the applicant will be the policyholder)

You must tell us if your contact details change so we can ensure that correspondence reaches you. 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: Male☐ Female☐

Home country

Nationality

Principal country of residence

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 any current domestic or international health insurance:

Name of insurer

Policy number

Start date D D / M M / Y Y Y Y

2 Dependants to be covered under the contract

Dependants can include 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 26 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. If there is insufficient space for all dependants, please use another Application Form.

	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	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			

Details of any current domestic or international health insurance

Name of current insurer (if applicable)			
Current policy number (if applicable)			

3 Start date of your policy

Subject to Section 7 of this application form, the start date of this policy will be the date on which this application is accepted in writing by us. If you wish your cover to start later, please indicate below. Please note the start date can be no more than 30 days from the date of completion of this application by you. Under no circumstances will policies be backdated.

Start Date D D / M M / Y Y Y Y

4 Plan selection

The Executive Healthcare Plan enables you to choose various Standard Plan Designs and Optional Modules to suit your personal requirements. Please clearly check the Standard Plan Design you require; any Optional Modules you have selected and the deductible you require. Your Policy will be issued on this basis. If no boxes are checked in this section, it will be assumed that cover required is Area 1 (Foundation Plan with standard US$ Nil Policy Deductible).

Geographical Cover

Core Products:	Major Medical	Major Medical Plus	Foundation	Lifestyle
☐ Area 1 - Africa plus India, Pakistan, Bangladesh and Sri Lanka	☐	☐	☐	☐
☐ Area 2 - Worldwide excluding USA	☐	☐	☐	☐
☐ Area 3 - Worldwide*	Not Applicable	Not Applicable	☐	☐

*(Deductible options are limited to US$40, US$80, US$150)

Please note that cover in some countries is subject to local health insurance restrictions, particularly for residents of that country. It is your responsibility to ensure that your health cover is legally appropriate. If you are not sure, please get independent legal advice, as we may no longer be able to cover you. The cover we provide is not a substitute for local compulsory health insurance.

Product Options: Individual

	Major Medical	Major Medical Plus	Foundation	Lifestyle
Maternity Cover	Not Applicable	Not Applicable	☐	☐
Wellness	Not Applicable	Not Applicable	☐	☐
Routine Dental Treatment	Not Applicable	Not Applicable	☐	Covered as standard

Please select a deductible for your core plan:

Major Medical	☐ No deductible	☐ US$250	☐ US$750	☐ US$1,500	☐ US$4,000
Major Medical Plus	☐ No deductible	☐ US$250	☐ US$750	☐ US$1,500	☐ US$4,000
Foundation	☐ No deductible	☐ US$40	☐ US$80	☐ US$150	☐ US$250
Lifestyle	☐ No deductible	☐ US$40	☐ US$80	☐ US$150	☐ US$250

5 Pre-existing medical conditions

Pre-existing conditions are medical conditions for which one or more symptoms have appeared 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 would deem any such condition to be pre-existing if we could reasonably assume you or your dependants have known about it. Your policy will cover pre-existing conditions unless we tell you otherwise in writing.

We will also treat as pre-existing any medical conditions that arise between the date you complete the Application Form and the later of the following:

- The date we issue your Insurance Certificate or
- The start date of your policy

Pre-existing conditions will be subject to full medical underwriting and if they are not disclosed, they will not be covered. **Therefore, it is important that in the periods outlined above, you inform us if there is any change to your and your dependants' health status or to any material facts (facts likely to influence our assessment and acceptance of this application)**. In addition, you will need to provide further information, if requested.

If you already have one of our healthcare plans and are applying for a cover upgrade or for a new policy, please tell us about any medical conditions you have claimed for since joining us.

6 Health Declaration

Please answer the following questions based on your own and your dependants' full medical history. **All material facts (facts likely to influence our assessment and acceptance of this application) must be disclosed. 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. This health declaration is valid for two months from the date you complete and sign the form.**

	Policyholder	Dependant 1	Dependant 2	Dependant 3
Height	☐☐☐ cm	☐☐☐ cm	☐☐☐ cm	☐☐☐ cm
Weight	☐☐☐ kg	☐☐☐ kg	☐☐☐ kg	☐☐☐ kg
Have you used any form of tobacco in the past year? 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, if none state NO	Yes☐ No☐ ☐☐☐ /day	Yes☐ No☐ ☐☐☐ /day	Yes☐ No☐ ☐☐☐ /day	Yes☐ No☐ ☐☐☐ /day
Do you drink alcohol? If Yes, how many units of alcohol do you drink per week? (1 short = 1 unit, 250ml beer = 1 unit, 1 glass wine = 1 unit, if none state "zero")	Yes☐ No☐ ☐☐☐ /week	Yes☐ No☐ ☐☐☐ /week	Yes☐ No☐ ☐☐☐ /week	Yes☐ No☐ ☐☐☐ /week
Do you wear glasses or contact lenses? If yes, please state:	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐	Yes☐ No☐
• Condition				
• Number of dioptres for each eye (this appears on the prescription from the optician)	☐☐☐ Right eye ☐☐☐ Left eye	☐☐☐ Right eye ☐☐☐ Left eye	☐☐☐ Right eye ☐☐☐ Left eye	☐☐☐ Right eye ☐☐☐ Left eye

1. Has any person included in this application ever suffered from, been in hospital with, or had tests, investigations or treatment of any kind, for the following conditions?

(a) **Any heart or circulatory disease or disorder,** such as, but not limited to, heart attack, coronary artery disease, vascular disease, irregular heartbeat, murmur, chest pain, clots, blood disorder, abnormal blood pressure, high cholesterol, etc. Yes☐ No☐

(b) **Any dermatological disease or disorder,** such as, but not limited to, psoriasis, dermatitis, eczema, allergy, acne, etc. Yes☐ No☐

(c) **Any endocrine disease or disorder,** such as, but not limited to, diabetes, pancreatitis, weight problems, gout or thyroid problems or other hormonal imbalances, etc. Yes☐ No☐

(d) **Any eye, ear, nose and throat disease or disorder,** such as, but not limited to, cataract, glaucoma, detached retina, hearing loss, ear infections, sinus problems, tonsillitis, adenoiditis etc. Yes☐ No☐

(e) **Any gastrointestinal disease or disorder,** such as, but not limited to, stomach problems, hernia, haemorrhoids, gall stones, colon polyps, Crohn's disease, colitis, liver problems, etc. Yes☐ No☐

(f) **Any infectious or viral disease or disorder,** such as, but not limited to, hepatitis A/B/C, herpes, HIV, SARS-CoV-2 / COVID-19, malaria, meningitis, blood infection, sexually transmitted disease, etc. Yes☐ No☐

(g) **Any muscular or skeletal disease or disorder,** such as, but not limited to, back, neck or joint pain, arthritis, fibromyalgia, joint replacement, any cartilage and ligament problem, carpal tunnel syndrome, etc. Yes☐ No☐

(h) **Any neurological disease or disorder,** such as, but not limited to, stroke, multiple sclerosis, epilepsy, neurodegenerative disorder, paralysis, seizures, migraine, Alzheimer's or other form of dementia, etc. Yes☐ No☐

(i) **Any oncological disease or disorder,** such as, but not limited to, any cancer, leukaemia, lymphoma, tumour, skin lesion, growth, lump, cyst, mole, polyp, naevus, etc. Yes☐ No☐

(j) **Any psychiatric or psychological disorder,** such as, but not limited to, attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, depression, anxiety, chronic fatigue syndrome, eating disorder, obsessive-compulsive disorders, phobic disorders, alcohol/drug problem, etc. Yes☐ No☐

(k) **Any respiratory or lung disease or disorder,** such as, but not limited to, chronic obstructive pulmonary disorder, sarcoidosis, asthma, bronchitis, sinusitis, shortness of breath, allergy, etc. Yes☐ No☐

(l) **Any urological or reproductive organs disease or disorder,** such as, but not limited to, kidney or urinary tract problem, menstrual impairment, fertility problem, fibroids, endometriosis, testicular or prostate problem, etc. Yes☐ No☐

(m) **Any other accident, injury, disease or disorder** not already disclosed. Yes☐ No☐

2. Please tell us whether you or your dependants:

(a) Are currently taking any prescribed or over-the-counter drugs, medication, tablets or other treatment. Yes☐ No☐

(b) Are expecting to have a medical review, has been referred for further tests/investigations, or is awaiting results or any treatment due to accident, injury, disease or disorder. Yes☐ No☐

(c) Have undergone any tests or investigations within the last 10 years which resulted in referral for further medical advice or treatment, such as, but not limited to biopsy, colonoscopy, colposcopy, computed tomography (CT), mammogram, magnetic resonance imaging (MRI), Papanicolaou test (PAP) or prostate-specific antigen test (PSA), echocardiogram (Echo), ultrasound (US), etc. Yes☐ No☐

Please do NOT disclose results of any genetic (DNA or RNA) tests, as these are not required for medical underwriting.

(d) Within the past 2 years have you experienced any recurrent or ongoing symptoms or medical complaints NOT related to a condition already disclosed such as, but not limited to: Yes☐ No☐

- Fever (103°F/39.4°C or above) and/or continuous cough
- Shortness of breath
- Hoarseness
- Severe/ongoing headache
- Mole or skin marking that has bled, changed or become painful
- Tingling
- Blurred or double vision
- Unexpected weight loss
- Bleeding per rectum, change in bowel habit or urine frequency
- Loss of sensation, seizures, loss of consciousness
- Abnormal bleeding
- Joint pain/stiffness etc.

(e) Within the past 30 days, have you been recommended or decided to self-isolate? Yes☐ No☐

Please complete question 3 only if you are purchasing dental cover

3. Is any person included in this application currently undergoing or have they been advised to undergo any dental treatment, dental surgery, dental prosthesis, orthodontics or periodontics? Yes☐ No☐

If yes, please complete a Dental Questionnaire, which you can download from our website:
https://www.allianzcare.com/en/welcome/ehs.html

Additional information for "Yes" answers

If you answered **Yes** to any part of the questions 1, 2 or 3 within the previous Health Declaration section, please provide details in the table below.
Please tell us if a full recovery has been made or if you or your dependants have any medical condition or disease related to or arising from the original diagnosis.

Please enclose supporting up-to-date medical reports/test results if possible.

Question number	Name of the person affected by the medical condition	Diagnosis - where applicable state the area of the body affected (e.g. left arm, right foot)	Exact date of onset of the condition	Frequency and severity of symptoms and 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)

If there is insufficient space in the table above, please use another Application Form

Please provide the name, address and telephone number of the regular/family doctor 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 and only sign below if 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 Care and myself, and that any false, incorrect or misleading statement or non-disclosure of material medical information may make this insurance null and void.
- I undertake to inform Allianz Care immediately in writing of any changes in my or my dependants' state of health occurring between completing the Application Form and 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 Care, 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 Care (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 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.
  - 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 Application Form is valid for 30 days 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 then 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. If the content is not in accordance with the Application Form but I enter no protest within 30 days following the issue date of the Insurance Certificate, I will be considered to have accepted the offer of cover.
  - Cover will be subject to the standard terms and conditions that apply at the start or renewal date of the policy and are set out in the Benefit Guide.
  - The cover provided by Allianz Care may not be suitable if my dependants and I are or become resident in countries where local compulsory health insurance restrictions are in place (e.g. Switzerland).
  - 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 healthcare cover is legally appropriate.

As the applicant, I sign and date this form for and on behalf of everyone included in this application.

Applicant's signature

Applicant's printed name

Date D D / M M / Y Y Y Y

8 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 email at: **AP.EU1DataPrivacyOfficer@allianz.com**

9 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 Care 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 Care 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 Care 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 Care 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 Care.** Allianz Care may share my personal, health and other data collected or held by Allianz Care, whether contained in this Application form or otherwise obtained with the experts or institutions set out below including Executive Healthcare Solutions – Kenya, MIC Global Risks (Tanzania) Limited, MIC Global Risks Insurance Brokers (Uganda) Limited, EHS Limited, with appropriate jurisdiction and when necessary for care or treatment, payment of services, and activities related to the operation of my health plan. They will only use the data to the same extent and for the same purposes as Allianz Care. I understand that Allianz Care has put in place arrangements with these institutions to protect my data. I agree to release all individuals at these institutions and Allianz Care 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 Care, such as risk assessments and claims handling, where:
        - these services involve the collection and use of my health and other data, and
        - Allianz Care 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 Care 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 Care know by emailing AP.EU1DataPrivacyOfficer@allianz.com

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

10 Payment details

Please don't make any payments until you receive your policy number.

Payment frequency and method

Payments are subject to the following administration surcharges: 0% for annual payment, 5% for half-yearly payments and quarterly payments and 8% for monthly payments.

Please tick to indicate your preferred payment frequency and method:

	Annual	Half-yearly	Quarterly	Monthly
Credit card	☐	☐	☐	☐
Bank transfer	☐	☐	☐	Not available
Bank draft	☐	☐	☐	Not available

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 Care to charge my card account with my healthcare premium. I understand I will be notified of the premium when my cover/renewal is accepted or if I make a request that affects the premium, such as adding a dependant. This payment will continue until I cancel the instruction by giving written notice to Allianz Care. 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 completed form to one of the following offices:

Executive Healthcare Solutions Limited
6th Floor, 9 West,
Ring Road Parklands
PO Box 14680, 00800, Westlands
Nairobi, Kenya

T: (254 20) 291 0000
M: +254 709 337 000
E: info@executive-healthcare.com

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

T: +353 1 630 1301
F: +353 1 629 7117
E: underwriting@allianzworldwidecare.com