PassportCard

PASSPORTCARD INTERNATIONAL HEALTH INSURANCE PLAN INDIVIDUAL APPLICATION FORM

The PassportCard International Health Insurance Plan ("PassportCard Plan") is underwritten by AWP Health & Life SA ("AWP" or the "Insurer"), a member of the Allianz group. The PassportCard Plan is both distributed and administered by PassportCard Deutschland GmbH ("PassportCard" or the "Administrator").

Please note that by signing this form you will allow your spouse / partner full access to your health information. If you don't agree to share your health information, a separate application should be completed.

Insurance cover under the PassportCard Plan is conditional upon acceptance of this application and will be confirmed upon issuance of a Membership Certificate.

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

After completing this form and signing the declarations by all persons over the age of 18 to be included in the insurance cover, please return to your Insurance Intermediary or via email to vertrieb@passportcard.de

Insurance Intermediary Name:

If you are adding an additional person to an existing PassportCard Plan, please provide us with your existing policy no. as stated on your Membership Certificate.

Country of Destination: Requested start date of insurance cover:

1. Member Details (Please note that the applicant will be the Primary Member)

Applicant Details:

Surname: First Name: Gender: F M

Date of Birth: Nationality:

Passport Number: Email Address:

Phone Number: Mobile Number:

Spouse/Partner Details:

Surname: First Name: Gender: F M

Date of Birth: Nationality:

Passport Number: Email Address:

Phone Number: Mobile Number:

Dependent 1 Details:

Surname: First Name: Gender: F M

Date of Birth: Nationality:

Passport Number:

Dependent 2 Details:

Surname: First Name: Gender: F M

Date of Birth: Nationality:

Passport Number:

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Dependent 3 Details:

Surname: First Name: Gender: F M

Date of Birth: Nationality:

Passport Number:

2. Mailing Address

We may send written correspondence and details regarding your insurance cover to this address:

Address: Building Number: Floor Number: Apt. Number:

Entrance: City: Zip Code: Country:

3. Plan Details

Zone of Cover:

Your default zone of cover is determined by your Country of Destination. If you are not travelling to the USA and would like to extend the cover to worldwide excluding USA, please indicate:

☐ Worldwide excluding USA

Select your Plan: ☐ Compact ☐ Comfort ☐ Premium

Optional Rider:

☐ Extended Medical Evacuation

Inpatient deductible:

☐ None ☐ 1,000 EUR

☐ 2,500 EUR ☐ 5,000 EUR

4. Medical Questionnaire

Please answer the following questions on the basis of your own and your Dependent's (under the age of 18, if applicable) complete medical history. All material facts must be disclosed. Failure to do so may invalidate or severely limit your entitlement to cover or benefits under the PassportCard Plan. If you are in any doubt as to whether a fact is material, then such fact should be disclosed. Your Spouse/Partner (if applicable) must also answer the following questions on the basis of their medical past.

A. Please note that your answers to the following medical questionnaire will enable PassportCard to perform a risk evaluation concerning your medical insurance cover. Incomplete or incorrect answers may affect your entitlement for cover.
B. The questionnaire must be filled-in separately for each person seeking cover under this insurance plan.
C. Any positive answer to the questions in the questionnaire will require an additional description to be given in section 5.

If a certain question is not clear, or if you wish to receive additional information concerning the disclosure obligation or pre-existing conditions, do not hesitate to contact your broker or PassportCard: +49 40 4600 20 222.

	Applicant	Spouse/Partner	1st Dependent	2nd Dependent	3rd Dependent
Height (cm)					
Weight (kg)					

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QUESTIONS	Applicant		Spouse/ Partner		1st Dependent		2nd Dependent		3rd Dependent	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Do you currently smoke or did you smoke in the past 5 years?										
2. Did you gain or lose more than 10 kilograms in weight during the past 12 months?										
3. Have you been diagnosed with, or treated for, substance abuse or alcoholism in the past 5 years? Do you currently drink, take recreational drugs, or take any other dangerous substance?										
4. Do you drink more than one glass of alcoholic beverages (including beer) a day?										
5. Are you pregnant? If so, in which week of pregnancy?										
6. Have you had complications during pregnancy or birth including a caesarean section, abortions or miscarriages in the past 5 years?										
7. In the past 10 years, have you suffered from long-term exhaustion or chronic fatigue?										
8. Have you been found to be a carrier of HIV virus antibodies or hepatitis?										
9. Have you ever been involved in any accident or incident, including a road traffic accident that resulted in injury or loss of function?										
Do you or did you suffer, are you being treated or were you treated for or diagnosed:										
10. With disorders of the respiratory system, including lung diseases and/or diseases of the respiratory airways (anomaly of nasal septum, sinusitis, and asthma) in the past 10 years?										
11. With disorders of the digestive system (esophagus, stomach, intestines, anus), anorexia or bulimia in the past 5 years?										
12. With disorders or diseases of the urinary tract or the kidneys in the past 5 years?										
13. With disorders and diseases of the eyes, ears, nose, sinuses, jaws, pharynx, throat or teeth in the past 5 years? Are you under dental treatment or is any treatment planned or do you have any problems or symptoms relating to teeth, dentures or gums? Any missing teeth?										
14. With recurring ear infections or a ruptured eardrum (permanent perforation of the tympanic membrane) in the past 5 years?										
15. With disorders and diseases of the skeleton, joints, muscle system, or joint tissue in the past 5 years?										
16. With disorders and diseases of the back, spinal column, or limbs in the past 5 years?										
17. With skin diseases or disorders related to the skin (i.e. psoriasis, warts, multiple skin marks or acne) in the past 5 years?										
18. With disorders related to the functioning of the liver, gallbladder, appendix, spleen, or pancreas in the past 5 years?										
19. With disorders or diseases of the heart in the past 5 years, or have you ever had a heart attack?										
20. With diseases of the blood vessels, abnormal blood tests, high/low blood pressure, excess lipids in the blood, abnormal blood count, or clotting problems in the past 5 years?										
21. With brain or nerve disorders, epilepsy, or sleep disorders in the past 5 years?										
22. With long-term headaches, dizziness, migraines, head contusions, or loss of consciousness in the past 5 years?										
23. With any type of allergies in the past 5 years?										

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QUESTIONS	Applicant		Spouse/ Partner		1st Dependent		2nd Dependent		3rd Dependent	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Do you or did you suffer, are you being treated or were you treated for or diagnosed:										
24. With hormonal or metabolic disorders, including disorders of the thyroid gland in the past 5 years?										
25. With diabetes, sugar in the blood, or sugar in the urine in the past 5 years?										
26. With cancer or pre-cancer in the past 10 years?										
27. With disorders of the immune system including infectious diseases in the past 5 years?										
28. With paralysis or any form of disability in the past 5 years?										
29. With disorders of the prostate, testicles, or venereal disease in the past 5 years?										
30. With diseases of the female reproductive system including venereal diseases, or abnormal conditions in the breasts in the past 5 years?										
31. With a hernia in the past 5 years?										
32. With a malignant tumor, cyst, polyp, lump, or any other type of tumor in the past 10 years?										
33. With a congenital disease?										
34. With mental illnesses, including attention and concentration deficit disorders, autism, or did you undergo psychological/psychiatric therapy in the past 5 years?										
Additional Questions:										
35. Do you currently, or have you in the past 5 years, taken medication on a regular basis for the treatment of any medical condition (for a period of more than 60 days)?										
36. Were you hospitalizedin the past 5 years, were you a candidate for surgery, have you undergone surgery or are you currently a candidate for surgery or hospitalization?										
37. Have you had signs, symptoms, diagnosis, treatment or positive/ abnormal results of medical tests that you have not specified in this questionnaire?										
38. Are you currently being monitored for or do you regularly undergo preventative care for certain illnesses (such as skin, heart and prostate examinations)?										
39. Do you have additional medical insurance?										
40. In the past, have you ever submitted a request for health or life insurance that was cancelled, rejected, changed, or accepted under special conditions (including medical addendums)?										
41. To the best of your knowledge, do you have relatives (parents, brothers/sisters or children) who suffer or suffered from heart or blood vessel diseases, cancer, lipids in the blood, chronic mental illnesses or any hereditary disease?										

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5. Detailed Medical History

Please describe in detail (according to the questions you answered positively in the questionnaire) the status of the condition, dates of medical treatment, diagnosis, prognosis, course of treatment and data of the primary care physician.

Question Number Name of person who answered the question positively

Question Number Name of person who answered the question positively

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* An additional page, for providing a more detailed description, may be attached to this application form, if necessary.

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6. Declarations

In order to complete the application form, you, and your Spouse/Partner, are requested to read the statements below and to make the following declaration confirming your acceptance and understanding of each declaration.

I hereby declare that:

1. I request coverage in the PassportCard Plan offered through the Association for European Expatriate Insurance under their insurance agreement underwritten by AWP Health & Life SA.

2. I have checked and confirm the completeness, accuracy and truthfulness of the statements and information provided in the application form.

3. I understand that providing answers to the questions contained in this application form including the medical questionnaire that are either incomplete, incorrect, untruthful or imprecise may affect my cover or entitlement to benefits under the PassportCard Plan.

4. If a medical condition develops after submitting a completed application form to PassportCard, but before the insurance cover comes into effect, I am required to notify PassportCard and update the answers that were provided in the medical questionnaire above. Failure to do so will infringe upon my rights as aforementioned in declaration number 3 above.

5. I understand that my insurance cover will only be effective subject to acceptance to the PassportCard Plan.

6. I understand that my entitlement to benefits under the PassportCard Plan is subject to the terms and conditions of the PassportCard Plan and the Table of Benefits in effect at the time my insurance cover under the PassportCard Plan comes into effect.

7. It is my responsibility to check the accuracy of the information contained within the Membership Certificate, once issued. If the content is not in accordance with the Application Form, and I do not notify PassportCard otherwise, the information on the Membership Certificate will be assumed to be correct.

8. I understand that the insurance cover provided under the PassportCard Plan may not be suitable if I, or any of my Dependent's become residents in countries where local compulsory health insurance restrictions are in place. It is my responsibility to check whether I or my Dependents, are subject to any local compulsory health insurance requirements and to ensure that my insurance cover under the PassportCard Plan is legally appropriate in my country of residence.

9. The mailing address provided above is the address that will be used by PassportCard and/or the Insurer to deliver registered letters and/or court documents to me, if relevant. Delivery to this address will be deemed lawful delivery. Information, documents, letters, announcements will be sent to my address in my Country of Destination (if this was provided to PassportCard) or, to the email address provided above.

10. I understand that it is my obligation to update PassportCard about any change to any details contained in this application form including general and personal details.

Intermediary Appointment

I hereby authorize (the insurance intermediary above) _____ to act for and on my behalf in relation to the administration of the PassportCard Plan and to receive on my behalf all relevant communication, to the extent applicable, which I understand may include the disclosure of sensitive health information. This authorization will remain in place until I provide a written request to PassportCard to revoke it.

Medical Confidentiality Waiver

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 PassportCard, 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 authorize 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 relating to me, if requested by PassportCard, its medical advisers, its appointed representatives, or to any third party expert(s) in case of disputes, subject to any legal restrictions which may apply. I also make this statement for my Dependents under the age of 18 and for Dependents who cannot assess the meaning of this statement.

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Applicants' Signatures

Full name of Applicant		Signature		Date	
Full name of Spouse/Partner		Signature		Date	

Marketing Preferences
We'd like to stay in touch so that we can provide you with marketing information about products and services that may be of interest to you, including updates on promotions and new products and services.
If you would like to receive such communications, please check the box below. If you do not wish to receive such communication from us, do not check any box.

Applicant	Spouse/Partner
☐ Yes, I would like to receive such communication	☐ Yes, I would like to receive such communication

If you do not provide your consent, this won't affect your application or your insurance cover. Even if you provide your consent, you can change your mind and let us know at any time. You can do so (a) by selecting the 'unsubscribe' option on any email we send, or (b) by marketing emailing us at kundenbetreuung@passportcard.de

Definitions

Country of Destination
The country, outside the Home Country and Country of Residence (if applicable), which was indicated on the Application Form, in which the Applicant Person intends to stay for a period of more than 60 consecutive days, or in which the Primary Applicant is already residing, and based on that information, the Insurer has agreed to accept him / her to the insurance Policy.

Spouse/ Partner
A spouse not legally separated from the Primary Member, or his/her registered civil union partner, or Cohabiting Partner, as registered with the appropriate regulatory authority; or

A person cohabiting with the Primary Member in a legally recognized marital/conjugal relationship and who together fulfil both of the following conditions:

- Both individuals are free from matrimonial ties; and
- Cohabitation has been declared by the Primary Member to PassportCard, who shall communicate such information to the Insurer at the time of enrolment.

Dependent
The unmarried child/children of the Primary Member and those of his/her spouse (or civil union partner or Cohabitating Partner) up to the age of 18, living in the household of Primary Member, whether legitimate, recognized, adopted or taken in, including minors who are under the protection of the Primary Member.
The age limit of 18 is waived for handicapped/disabled dependent children who are recognized by the relevant local governmental agency as legal dependents of the Primary Member.
All other Dependents over the age of 18 will need to complete their own Application Form.

Membership Certificate
Confirmation of the insurance cover for the eligible person is indicated in a Membership Certificate as detailed in the PassportCard Plan Terms and Conditions.

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Payment Details

This section does not need to be completed if you are applying as part of a group scheme and your employer is paying the premium.

Please check the appropriate boxes below to indicate your preferred payment frequency and method.

Payment Currency	
☐ USD	☐ Euro

A. Credit Card Payment

If you choose to pay by credit card, please provide the following details below.
The undersigned hereby issues an instruction for the benefit of PassportCard Deutschland GmbH to charge the credit card using the details of which are listed below for the insurance premiums payable for the insurance cover, according to the terms and conditions of the PassportCard Plan and the Membership Certificate.

B. SEPA

Account Holder Name

IBAN

BIC (for EU Accounts outside Germany)

BANK Name

Frequency of payment (please select): ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Please also sign the SEPA mandate attached hereto.

C. Bank Wire Transfer: ☐ Semi-Annually ☐ Annually

Type of Card: ☐ Mastercard ☐ Diners ☐ Visa ☐ American Express

Name of Card Owner Expiration Date

Card Number

Applicant Name CCV

Cardholder's Signature Passport Number

Mode of Payment: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

* American Express payments in USD only

The PassportCard Plan is offered through the Association for European Expatriate Insurance, an association governed by the French law of 1901 on associations, and underwritten by AWP Health & Life SA (Allianz Partners), part of the Allianz Group.
The plan is brokered and administered by PassportCard Deutschland GmbH ("PassportCard"). PassportCard is an insurance intermediary incorporated in Germany with registration number HRB 158858 as a private limited liability company. Its registered address is Caffamacherreihe 8-10, 20355 Hamburg, Germany.
PassportCard receives a sales commission from Allianz Partners in this respect.

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DECLARATION OF CONSENT

Declaration of consent for the processing of health data, transfer of personal data to outside EU and release from confidentiality of medical providers and professionals, insurance companies and brokers.

PassportCard Deutschland GmbH, Address: Caffamacherreihe 8-10, 20355 Hamburg, Germany, Phone number: +49 40 4600 20 333, Email: kundenbetreuung@passportcard.de, Contact Data Protection Officer of Controller: Datenschutz@passportcard.de (hereinafter: "PassportCard" or "We") expressly informs and points out that you are free to confirm this declaration of consent and to object it for the future. We have to point out, however, that it will generally not be possible to conclude or implement an insurance contract with PassportCard without your consent in the processing of your health data. General and further information on the processing of personal data by PassportCard you can find in the Privacy Notice at https://www.passportcard.de/privacy-policy.

The confirmation of this declaration of consent also includes the following statements with regard to the **processing of your health-related personal data, also in countries outside the EU and the release of the general obligation to confidentiality for insurance companies and medical professions:**

By confirming this Declaration of consent, I agree that PassportCard collects, stores and processes the information I provide to PassportCard when applying for an insurance offer and in the future (including health related data) to the extent necessary to review the application and to establish, to perform and to finish an insurance agreement. I also agree that PassportCard stores my health-related data – if a contract with PassportCard is not concluded – for a period of 3 years from the end of the calendar year of my request.

By confirming Declaration of consent, I agree that PassportCard transfers my personal data including health related data if necessary, for the purpose of my insurance agreement to

- service providers,
- (re-)insurance companies,
- if necessary, also to my employer if my employer has concluded the insurance contract with PassportCard, which also covers my person, and
- in particular medical providers and medical experts

I agree that this personal data including health related data is processed there for the same purposes as stated in this Privacy Notice and that personal data including health related data is returned to PassportCard.

Insofar as necessary I release PassportCard and its employees as well as medical providers by confirming this declaration from its obligation to confidentiality with regard to personal data including health related data protected by Section 203 of the German Penal Code.

By confirming this Privacy Notice, I agree that PassportCard collects my health data from doctors and other medical providers, nurses, hospital staff, personal insurers, statutory health insurance funds and authorities and uses them for these purposes, insofar as this is necessary for risk assessment or for the performance of contractual obligations of PassportCard.

This confirmation also expressly refers to service providers in countries outside the EU in particular especially if I use services in these countries. I confirm and agree to the statement above, in particular that I am entitled to withdraw my consent declaration

Applicant:		Date:		Signature:	
Spouse/Partner:		Date:		Signature:	

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SEPA DIRECT DEBIT MANDATE

for recurrent payments (only by SEPA)

Address of bank:

Name of Bank:

Street Name, Number:

Postal Code, City:

IBAN: BIC/SWIFT:

Name and address of debtor:

Name of Debtor:

Street Name, Number:

Postal Code, City:

Policy Number:

Mandate Reference: Will be communicated to you in a separate email.

SEPA Direct Debit Mandate for recurrent payments
PassportCard Deutschland GmbH, Caffamacherreihe 8-10, 20355 Hamburg
Creditor identifier: DE52ZZZ00002202388

By signing this mandate form, I authorize PassportCard Deutschland GmbH to send instructions to my bank to debit my account and my bank to debit my account in accordance with the instructions from PassportCard Deutschland GmbH for this and future payments.

Note:
As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited. Your rights are explained in a statement that you can obtain from your bank.

Location, Date	Signature of account holder	Name of signatory in printed characters

130921

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