

Application Form for Individuals

SI Insurance (Europe), SA is registered in Luxembourg with company registration number B221096 and registered address 40 Montereve, L2163, Luxembourg and represented by AKD Insurance.

Insurance Intermediary:

Tax Identification Code: **No. of Special Registry:**

SECTION 1 – Personal details

1.1 Applicant (the individual requesting that an insurance policy be issued in his/her own name).

Full Name:

Date of birth: **ID or Passport no:**
(DD/MM/YYYY)

Occupation: **Male:** **Female:**

T.I.C.: **Height (cm):** **Weight (kg):**

Nationality:

Is the Applicant requesting cover? Yes No

1.2 Family members of the Applicant requesting cover

Full Name:	<input type="text"/>
Date of birth: (DD/MM/YYYY)	<input type="text"/> ID or Passport no: <input type="text"/>
Occupation:	<input type="text"/> Male: <input type="checkbox"/> Female: <input type="checkbox"/>
T.I.C.:	<input type="text"/> Height (cm): <input type="text"/> Weight (kg): <input type="text"/>
Nationality:	<input type="text"/>

Full Name:	<input type="text"/>
Date of birth: (DD/MM/YYYY)	<input type="text"/> ID or Passport no: <input type="text"/>
Occupation:	<input type="text"/> Male: <input type="checkbox"/> Female: <input type="checkbox"/>
T.I.C.:	<input type="text"/> Height (cm): <input type="text"/> Weight (kg): <input type="text"/>
Nationality:	<input type="text"/>

Full Name: _____

Date of birth: _____ **ID or Passport no:** _____
(DD/MM/YYYY)

Occupation: _____ **Male:** **Female:**

T.I.C.: _____ **Height (cm):** _____ **Weight (kg):** _____

Nationality: _____

Full Name: _____

Date of birth: _____ **ID or Passport no:** _____
(DD/MM/YYYY)

Occupation: _____ **Male:** **Female:**

T.I.C.: _____ **Height (cm):** _____ **Weight (kg):** _____

Nationality: _____

Full Name: _____

Date of birth: _____ **ID or Passport no:** _____
(DD/MM/YYYY)

Occupation: _____ **Male:** **Female:**

T.I.C.: _____ **Height (cm):** _____ **Weight (kg):** _____

Nationality: _____

1.3 Address of permanent residence

Street name & no: _____

Town/village: _____

District: _____ **Postal code:** _____ **Country:** _____

1.4 Contact details

Mobile phone: _____ **Other phone:** _____

Fax: _____

Email: _____

SECTION 2 – Details of your cover

2.1 Plan selection

BASIC CORE CLASSIC CLASSIC PLUS PRIME PRIME PLUS

2.2 Area of Cover selection

Worldwide including USA Worldwide excluding USA

2.3 Deductible selection

Nil €150 €350 €650 €1.700 €3.500 €6.500

2.4 Frequency & method of payment

Premiums are paid in euro only.

Annually Semi-annually Quarterly Monthly*

*This option is only available via direct debit (SEPA)

Direct debit (SEPA) Bank transfer

2.5 Requested effective date of the Policy Period

Date the Application Form is approved Other: (DD/MM/YYYY)

In no case can the start date be before the date of submission of this Application Form or 30 days after it was signed.

2.6 Underwriting options

Option A: Coverage based on a fully completed Application Form

Option B: Coverage based on a moratorium Application Form

Option C: Coverage based on a Continued Personal Medical Exclusion (CPME) Application Form

Available only for Applicants not older than 65 years old
(a copy of your existing insurance certificate is required)

SECTION 3 – Questionnaire

All applicants (the main applicant and his/her family members requesting cover) must answer questions 3.1 to 3.6.

3.1	Have you ever been hospitalised in the last 5 years, or do you have a hospitalisation planned?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.2	Have you ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV), or any other immune system disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.3	Have you ever had, been advised to have, or are you currently on a waiting list for any organ transplant (other than corneal)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.4	Have you ever been diagnosed with or treated for any type of cancer or pre-cancerous condition?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.5	Are you currently pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.6	Do you participate in professional or high-risk sports, or in activities that are generally recognised as hazardous?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

All applicants (the main applicant and his/her family members requesting cover) must answer questions 3.7 to 3.27 unless **Underwriting Option B: Coverage based on a moratorium Application Form** (see question 2.6 above) has been selected.

Have you experienced symptoms of, suffered from, been advised to seek or have sought consultations, examinations, or testing for, been treated for (including medications), or been diagnosed with any of the conditions listed below?

3.7	Heart, cardiac, cardiovascular, or circulatory issues — including heart failure, heart attack, angina, chest pain, arteriosclerosis, atherosclerosis, high blood pressure, swelling of the feet or ankles, thrombosis, phlebitis, rheumatic fever, or a heart murmur?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.8	Blood or circulatory disorders involving the blood, blood vessels, spleen, arteries, or veins — including anaemia, haemophilia, leukemia, hepatitis, lymph gland disorders, or high cholesterol?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.9	Diabetes, hyperglycemia or hypoglycaemia?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.10	Asthma or allergies?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.11	Liver, pancreas, gallbladder, or endocrine disorders — including pituitary, thyroid, metabolic conditions, or obesity?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.12	Kidney or urinary tract issues, including kidney or bladder stones or infections?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

3.13	Respiratory conditions — including tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, asthma, pleurisy, or pneumonia?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.14	Mental or nervous system disorders — including psychosis, behavioural or mental disorders, substance or drug abuse or dependency, alcoholism, psychiatric counselling or support, depression, anxiety, chronic fatigue syndrome, or eating or sleeping disorders?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.15	Neurological disorders — including multiple sclerosis (MS), muscular dystrophy, ALS, Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient ischemic attacks?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.16	Muscular, skeletal, spine, bone, or joint disorders — including scoliosis, disc disease, vertebral degeneration, back or neck conditions, rheumatism, arthritis, gout, tendonitis, osteoporosis, or inflammation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.17	Miscarriage, complicated pregnancy or delivery, infertility consultation, advice, diagnosis or treatment, vaginal bleeding, fibroids, nodules, breast cysts, or conditions involving the fallopian tubes, ovaries, or uterus?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.18	Reproductive system disorders — including prostate conditions, elevated PSA, or infertility consultation, advice, diagnosis, or treatment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.19	Congenital, genetic, or hereditary conditions — including developmental disabilities, Down syndrome or other chromosomal disorders, physical disorders, deformities, or birth defects?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.20	Digestive system, stomach, or intestinal disorders — including esophageal regurgitation, gastritis, ulcers, or conditions of the colon or rectum?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.21	Eyes, ears, nose, mouth, throat, or jaw disorders — including cataracts, glaucoma, nasal septum deviation, chronic sinusitis, or temporomandibular joint conditions?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.22	Any other disease, condition, illness, injury, medical problem, disorder, or health issue not listed above?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.23	Have you ever used anabolics, narcotics or other hallucinogenic substances?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.24	Do you use any nicotine products (such as cigarettes, e-cigarettes, vaping devices, cigars or nicotine substitutes? If yes, how much and how often?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.25	Do you drink alcohol often (more than: 2 glasses of wine or 2 beers or 30ml of other alcoholic beverages per day)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.26	Has any insurer ever cancelled, declined to renew, renewed on special terms, or otherwise rejected your application for life, personal accident, or health insurance?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3.27	Do you currently hold any other health insurance policy in force?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If you have answered "Yes" to any of the above questions 3.1 to 3.27, please identify each claimant to whom the answer applies and provide information such as: details of the accident/illness and current medical condition, details of treating doctor, hospital and healthcare providers involved, diagnosis, dates and type of treatment etc. You can attach additional pages if necessary.

SECTION 4 – Transfer from another insurance policy

This Section is completed ONLY if **Underwriting Option C: Coverage based on a Continued Personal Medical Exclusion (CPME) Application Form** (see question 2.6 above) has been selected. A copy of your existing insurance certificate is required.

Statement

I, _____, confirm that the health / hospitalization / medical expenses insurance policy number: _____, is currently in force with insurer _____. I acknowledge that the terms of "Dcare" differ from those of my existing insurance policy. It is further understood that any waiting period stipulated under the terms of "Dcare" shall not apply, and that, in the event of an insurable claim, I will submit a claim simultaneously under any other insurance policy I maintain in force.

The Applicant: _____

Date: (DD/MM/YYYY) _____

SECTION 5 – Declaration

I declare that all statements made in this Application Form are true and complete to the best of my knowledge, and that I have neither concealed nor falsified any fact or information, nor knowingly made any misleading statement. I agree that this Application Form, together with this Declaration, shall be binding upon me and shall form the basis of the Policy between the Insurer and myself. I further acknowledge that, upon issuance of the Policy, this Application Form shall be deemed incorporated therein.

I also declare that I understand and accept that the Insurer's liability shall commence only upon the Insurer's written acceptance of this Application Form.

Furthermore, I declare that I have received all the relevant pre-contractual information and disclosures in accordance with the applicable provisions of the Law.

The Applicant: _____

Date: (DD/MM/YYYY) _____

SECTION 6 – Consent for personal data processing

Privacy Statement

This privacy notice provides an overview of the personal data that we (SI Insurance (Europe), SA, part of the Sompo group) process as a controller for the provision of our services. It also provides information on how we protect personal data and third-party rights. It applies to **Insureds**, claimants and any third parties who interact with us about our products and services. Our long form privacy notice is available at www.sompo-intl.com/privacy-policies/.

Categories of personal data we process include standard personal data, e.g. contact information; where necessary, special categories of personal data, e.g. health information; and criminal offence data, obtained from anti-fraud checks. Our reasons for processing commonly include policy administration, claims and complaints handling and to carry out identity and credit checks. The legal reason we process personal data depends on the circumstances, but usually it is for performance of a contract or to ensure legal compliance. For special category personal data, this is either because processing is necessary for an insurance purpose, to protect a vital interest, or we rely on consent. We may process information on criminal convictions (if any) to prevent a crime.

Where we have consent or a legitimate interest, we occasionally use personal data to send targeted marketing emails about related products and services. Such emails always contain an opt-out process. Occasionally we use automated decision-making, for example, to assess the likelihood of a claim being made. More information about this and related rights is available in our long form privacy notice.

Personal data is shared with us both directly, and indirectly through authorised individuals or organisations, such as insurance brokers or claims handlers. Anyone providing information about another person must first ensure that person has seen a copy of this privacy notice and consents to their information being shared with us.

We share personal data within the Sompo group and with relevant third parties including service providers, insurance intermediaries and reinsurers. The Sompo group and many of the companies we work with are international organisations. As such, we transfer personal data outside of the UK and EEA. We ensure that any international transfers are subject to appropriate safeguards and technical and organisational measures, in accordance with data protection law.

We retain personal data only for as long as necessary to fulfil the processing purpose to which it relates and having regard to our business needs and legal requirements.

Data protection law affords access, rectification, erasure, restriction, and objection rights to any individual whose personal data we process. Any request to exercise these rights, or any complaints about how we handle personal data should be directed to privacy@sompo-intl.com. Our data protection officer may be contacted at mhinze@sompo-intl.com. Complaints may also be lodged with the relevant data protection supervisory authority. This is the Information Commissioner's Office for our UK business and the National Commission for Data Protection for our EEA business.

Declaration of consent for personal data processing

I hereby give my express consent to the processing of my personal data to **SI Insurance (Europe), SA** for the purposes mentioned above.

1. Applicant's full name: _____

ID No.: _____

Signature _____

2. Applicant's full name: _____

ID No.: _____

Signature _____

3. Applicant's full name: _____

ID No.: _____

Signature _____

4. Applicant's full name: _____

ID No.: _____

Signature _____

5. Applicant's full name: _____

ID No.: _____

Signature _____

6. Applicant's full name: _____

ID No.: _____

Signature _____

SECTION 7 – Professional Secrecy Waiver

By signing this proposal form the **Applicant** (i) acknowledges having been informed about the Luxembourg professional secrecy obligations and having read the secrecy waiver document accessible here [www.sompo-intl.com/locations/luxembourg-luxembourg/] and (ii) explicitly accepts to waive SI Insurance (Europe), SA's professional secrecy obligations to the extent and under the conditions set forth in this secrecy waiver.