

## International Healthcare Plans

# Application Form

Please read the following carefully, completing all relevant information in **BLOCK CAPITALS** and ticking  the relevant boxes



### 1 Applicant Details.

Please enter the details of all persons to be covered under this contract, including the principal member and any dependants.

Dependants can include your spouse/partner and any children financially dependant on the principal member up to the day before their 18th birthday, or up to the day before their 24th birthday if in full-time education. Where the child is 18 or older, please attach a letter from college/university confirming student status or a copy of the student's ID. Please note that we will only consider applicants for cover up to the day before their 65th birthday.

#### Principal Member

It is important that you notify us of any change of contact details so we can ensure that correspondence reaches you.

Mr.  Mrs.  Ms.  Miss  Other  First Name

Other Initials  Surname

Date of Birth       Gender: Male  Female

Correspondence Address

Home Telephone

Office Telephone

Mobile Telephone

Fax

Email Address (mandatory)

Please use my email address for Claims/Treatment Guarantee related correspondence

Occupation

Home Country   
*(The country from which you are expatriated and to which you would want to be repatriated)*

Country of Residence   
*(The country in which you occupy the majority of your time for the period of your insurance cover)*

Nationality

Please indicate the language in which you wish to receive your policy documentation: English  German  French  Spanish  Italian

**Details of any current domestic or international health insurance:**

Name of Insurer

Policy Number  Start Date

*The following details are only to be completed if you are applying to join an existing Group Scheme:*

Group Name

Group Number

**Dependant 1**

Mr.  Mrs.  Ms.  Miss  Other  First Name

Surname

Date of Birth     Gender: Male  Female  Relationship to Principal Member: Spouse  Child

Occupation

Home Country   
*(The country from which you are expatriated and to which you would want to be repatriated)*

Country of Residence   
*(The country in which you occupy the majority of your time for the period of your insurance cover)*

Nationality

**Details of any current domestic or international health insurance:**

Name of Insurer

Policy Number  Start Date

**Dependant 2**

Mr.  Mrs.  Ms.  Miss  Other  First Name

Surname

Date of Birth     Gender: Male  Female  Relationship to Principal Member: Spouse  Child

Occupation

Home Country   
*(The country from which you are expatriated and to which you would want to be repatriated)*

Country of Residence   
*(The country in which you occupy the majority of your time for the period of your insurance cover)*

Nationality

**Details of any current domestic or international health insurance:**

Name of Insurer

Policy Number  Start Date

**Dependant 3**

Mr.  Mrs.  Ms.  Miss  Other  First Name

Surname

Date of Birth     Gender: Male  Female  Relationship to Principal Member: Spouse  Child

Occupation

Home Country   
*(The country from which you are expatriated and to which you would want to be repatriated)*

Country of Residence   
*(The country in which you occupy the majority of your time for the period of your insurance cover)*

Nationality

**Details of any current domestic or international health insurance:**

Name of Insurer

Policy Number  Start Date

**Dependant 4**

Mr.  Mrs.  Ms.  Miss  Other  First Name

Surname

Date of Birth     Gender: Male  Female  Relationship to Principal Member: Spouse  Child

Occupation

Home Country   
*(The country from which you are expatriated and to which you would want to be repatriated)*

Country of Residence   
*(The country in which you occupy the majority of your time for the period of your insurance cover)*

Nationality

**Details of any current domestic or international health insurance:**

Name of Insurer

Policy Number  Start Date

*If there is not sufficient space for all Dependants, please use another Application Form.*

**2 Policy Commencement Date.**

Please indicate the month and year on which you wish your cover to commence

(individual policies must commence on the first day of the month):

However, if you are applying to join a Group Scheme, you can specify the date you require cover from:

Cover is conditional upon acceptance of your Application, which is only confirmed when an Insurance Certificate is issued to you.

### 3 Plan Details.

**(This section does not need to be completed if you are applying as part of a Group Scheme).**

#### International Healthcare Plans

Please tick  to indicate the type of plan(s) and deductible you require:

Core Plan	Out-patient	Out-patient Deductible	Maternity	Dental	Repatriation
Premier Individual <input type="checkbox"/>	Gold <input type="checkbox"/>	0 <input type="checkbox"/>	Premier Maternity <input type="checkbox"/>	Dental 2 <input type="checkbox"/>	Repatriation Plan <input type="checkbox"/>
Club Individual <input type="checkbox"/>	Silver <input type="checkbox"/>	£70/€100/\$125 <input type="checkbox"/>	Club Maternity <input type="checkbox"/>		
Classic Individual <input type="checkbox"/>	Bronze <input type="checkbox"/>	£130/€200/\$250 <input type="checkbox"/>			

*The Out-patient, Dental and Repatriation Plans can be bought with any of the Core Plans. They cannot be bought separately. Premier Maternity can only be purchased with the Premier Individual Core Plan. Club Maternity can only be purchased with the Club Individual Core Plan. Please note that an Out-patient Plan must be selected in conjunction with a Maternity Plan. Maternity Plans are available to couples and families i.e. a spouse/partner must also be insured on the policy. Your plan selection can only be amended at policy renewal.*

#### International Healthcare Plans for Asia

Please tick  to indicate the type of plan(s) and deductible you require:

Core Plan	Out-patient	Out-patient Deductible	Maternity	Repatriation
Elite Individual <input type="checkbox"/>	OP1 <input type="checkbox"/>	0 <input type="checkbox"/>	Elite Maternity <input type="checkbox"/>	Repatriation Plan <input type="checkbox"/>
Select Individual <input type="checkbox"/>	OP2 <input type="checkbox"/>	\$125 <input type="checkbox"/>	Select Maternity <input type="checkbox"/>	
Essential Individual <input type="checkbox"/>	OP3 <input type="checkbox"/>	\$250 <input type="checkbox"/>		
Vital Individual <input type="checkbox"/>				

*Please note that the Out-patient and Repatriation Plans can be bought with any of the Core Plans. They cannot be bought separately. Elite Maternity can only be purchased with the Elite Individual Core Plan. Select Maternity can only be purchased with the Select Individual Core Plan. Please note that an Out-patient Plan must be selected in conjunction with a Maternity Plan. Maternity Plans are available to couples and families i.e. a spouse/partner must also be insured on the policy. Your plan selection can only be amended at policy renewal.*

**If your plan is not listed in the sections above, please state your chosen Core Plan and any supplementary plans:**

\_\_\_\_\_

Please tick  to indicate the area of cover you require: Worldwide  Worldwide excl. USA & Canada  Africa   
*(Not applicable to International Healthcare Plans for Asia)*

### 4 Payment Details.

**(This section does not need to be completed if you are applying as part of a Group Scheme)**

No payment should be made until you have been notified of your Policy Number.

#### 4.1 Payment Currency

Please tick  to indicate your preferred payment currency:

Euro  UK Sterling  US Dollars

*(For International Healthcare Plans for Asia only US Dollars can be selected)*

#### 4.2 Payment Frequency and Method

Please tick  to indicate your preferred payment frequency and method:

	Annual	Half yearly	Quarterly	Monthly
Credit Card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cheque	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Not Available
Bank Transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Not Available

#### 4.3 Credit Card Payment Details

If you choose to pay by credit card please provide the following information:

Type of credit card MasterCard  VISA

Card Number \_\_\_\_\_

CVC Code\* \_\_\_\_\_ Expiry date [m | m] [y | y]

#### Credit Card Authorisation

I authorise Allianz Worldwide Care to charge my credit card account unspecified amounts in respect of premiums for my healthcare cover as and when these become due, until the instruction is cancelled by my giving written notice to Allianz Worldwide Care. I understand I will be given one month's notice of any premium increase.

Cardholder's Name \_\_\_\_\_

Cardholder's Signature \_\_\_\_\_ Date [d | d] [m | m] [y | y]

\*CVC Code: *The last three digits after the card number on the back of the card or the last 3 digits in the signature field.*

#### Payment Charges and Details

Payments are subject to the following administration surcharges:  
**2% for half yearly payments,**  
**3% for quarterly payments and**  
**4% for monthly payments.**  
 There are **no administration charges for annual payments.**

- Cheques must be made payable to Allianz Worldwide Care, with Policyholder's name and Policy number marked clearly on the back of the cheque
- Bank transfers must be clearly marked with the Policyholder's name and Policy number
- We will only accept payment by credit card via MasterCard or VISA
- Allianz Worldwide Care does not accept liability for any payment which does not clearly identify the Policyholder
- If Insurance Premium Tax and other Government Levies apply, these will be stated on your Invoice/Payment Details

## 5 Pre-existing Conditions.

Pre-existing conditions are covered under the policy, unless otherwise advised by us in writing. Conditions arising between signing the Application Form and confirmation of acceptance by the Underwriting Department of Allianz Worldwide Care will equally be deemed to be pre-existing. Therefore, it is necessary that you advise us of any material changes to the information provided, between submission of this application and acceptance by us.

Pre-existing conditions are medical conditions or any related conditions, for which symptom(s) have been shown at some point during the five years prior to commencement of cover, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition about which you or your dependants know, knew or could reasonably have been assumed to have known, will be deemed to be pre-existing.

You are hereby obliged on request to provide any further information that we might require.

## 6 Health Declaration.

All information supplied will be treated in strict confidence. All material facts including those relating to these questions must be disclosed. Failure to do so may invalidate the Policy. A material fact is any information that would be likely to influence the insurer's assessment and acceptance of this Application Form. If you are in any doubt whether a fact is material then it should be disclosed.

	Principal Member	Dependant 1	Dependant 2	Dependant 3	Dependant 4
1. Height/Weight	cm <input type="text"/> kg <input type="text"/>	cm <input type="text"/> kg <input type="text"/>	cm <input type="text"/> kg <input type="text"/>	cm <input type="text"/> kg <input type="text"/>	cm <input type="text"/> kg <input type="text"/>
2. Have you consumed any form of tobacco in the past year? Type: Daily consumption/amount:	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/>
3. How many units of alcohol do you drink per week? (1 short = 1 unit, 250ml beer = 1 unit, 1 glass wine = 1 unit)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4. Are you currently suffering from any complaints, illnesses, after-effects of an accident, mental or physical disabilities, psychiatric disorders or chronic/long term medical or dental conditions?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Have you ever suffered from, been in hospital with, or received treatment, tests or investigations for:					
a) Rheumatism, gout, arthritis or disease of the muscles or joints including the back?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Epilepsy or other neurological disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c) Any digestive disorder including stomach and/ or bowel problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
d) Anxiety, depression or psychiatric or mental illness?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
e) Gynaecological disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
f) Any disorder of the kidneys, bladder or liver/ pancreas including diabetes?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
g) Any lump, cyst, mole or cancer?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
h) Any eye, ear, nose or skin disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
i) Any heart condition, stroke or raised blood pressure/cholesterol?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
j) Asthma, chronic bronchitis or any other respiratory condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
k) Any other illness or injury requiring medical attention (excluding colds and influenza)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Have you ever been advised to consult a doctor for a recurrent complaint, or been advised to have any diagnostic test or treatment which has not been completed or that you still await the results of?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Have you ever tested positive for HIV, Hepatitis B or C? Are you awaiting the results of such a test? <i>If the result is negative, having an HIV test will not, in itself, have any effect on your acceptance terms for insurance.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Have you ever suffered from or been in hospital for any other disorder or as a result of an accident which required that you:					
a) Received more than 14 days treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Were off work for more than one week?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c) Had specialised treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

9. Are you pregnant? Yes  No  If yes, please state expected date of childbirth: dd/mm/yy dd/mm/yy dd/mm/yy dd/mm/yy dd/mm/yy
10. Have either of your parents or any of your brothers or sisters, living or deceased, suffered (before the age of 65) from diabetes, heart disease, high blood pressure, cancer, kidney disease, raised cholesterol, nervous or brain disorders such as Alzheimer's, Parkinson's, or M.S., eye, hearing or speech disorders or any family disorder? Yes  No  Yes  No  Yes  No  Yes  No  Yes  No
11. Have you had cancer screenings or general check-ups within the last 5 years? Yes  No  Yes  No  Yes  No  Yes  No  Yes  No

## Additional Information.

**If you answered "YES" to any of the questions from 4 to 11, please provide details in the box below (in BLOCK CAPITALS).** Failure to provide complete information may delay the processing of your application. **If in doubt whether a fact or information is material then it must be disclosed.**

Name	Question Number	Where applicable, please provide date of 1st diagnosis/consultation, name and address of treating physician, frequency and severity of symptoms, date of last episode as well as details of any past, current or known future treatment.

*If there is not sufficient space for your additional information, please use another Application Form.*

**Please state the name, address and telephone number of your family doctor:**

Mr.  Mrs.  Ms.  Miss  Other  First Name

Surname

Address

Telephone Number  COUNTRY CODE  -  AREA CODE  -

Date of Last Visit  dd  mm  yy

## 7 Dental Declaration.

(Should only be completed if you are purchasing Dental cover).

	Principal Member	Dependant 1	Dependant 2	Dependant 3	Dependant 4
a) Are you currently undergoing, or have you been advised to undergo any treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Do you have missing teeth which have not been replaced (excluding wisdom teeth)? If 'Yes', how many:	Yes <input type="checkbox"/> No <input type="checkbox"/> _____	Yes <input type="checkbox"/> No <input type="checkbox"/> _____	Yes <input type="checkbox"/> No <input type="checkbox"/> _____	Yes <input type="checkbox"/> No <input type="checkbox"/> _____	Yes <input type="checkbox"/> No <input type="checkbox"/> _____
c) Have you denture sets (crowns, inlays, implants, bridges, fillings etc.)? If 'Yes', how many:	Yes <input type="checkbox"/> No <input type="checkbox"/> _____	Yes <input type="checkbox"/> No <input type="checkbox"/> _____	Yes <input type="checkbox"/> No <input type="checkbox"/> _____	Yes <input type="checkbox"/> No <input type="checkbox"/> _____	Yes <input type="checkbox"/> No <input type="checkbox"/> _____
d) Do you suffer from parodontosis?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
e) Have you had a dental check up within the last 5 years? If 'Yes', please state the: Date: Outcome:	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____ _____	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____ _____	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____ _____	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____ _____	Yes <input type="checkbox"/> No <input type="checkbox"/> _____ _____ _____

Please state the name, address and telephone number of your family dentist:

Mr.  Mrs.  Ms.  Miss  Other \_\_\_\_\_ First Name \_\_\_\_\_  
Surname \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone \_\_\_\_\_ COUNTRY CODE \_\_\_\_\_ AREA CODE \_\_\_\_\_

## 8 Data Protection Legislation.

All personal information and medical data provided will be dealt with in strict confidence and in accordance with European Union data protection legislation. Personal data may be given to hospitals and/or medical providers in relation to medical insurance claim services provided by us to you. You have a right to access the personal data that is held about you. You also have the right to amend or delete any information we hold about you if you believe that it is inaccurate or out of date. Allianz Worldwide Care, any of the Allianz Group companies or an organisation appointed by us, might contact you in the future in relation to other products/services that you might be interested in.

If you do not wish to receive information on other products or services from us, please tick  this box.

## 9 Declaration.

- 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 shall be the basis of the contract between Allianz Worldwide Care and I, and that any false, incorrect or misleading statement may render this insurance null and void.
- I undertake to inform Allianz Worldwide Care immediately in writing of any changes in my or my dependants' state of health occurring after the Application Form has been signed and before the Commencement Date.
- I understand that I can withdraw my application in writing by letter, email or fax, within 14 days from the policy commencement date, and provided that I have not submitted a claim I am 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, the situation will be considered accepted if I enter no protest within 14 days following the issue date of the Insurance Certificate.
- I consent to the fact that Allianz Worldwide Care, 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 release my medical records to Allianz Worldwide Care. I also make this statement for my co-insured dependants, including those who cannot assess the meaning of this statement.
- I accept that this policy will be subject to the standard Policy Terms and Conditions effective at the time of policy commencement contained within the Benefit Guide. I confirm that I have read and understand the full Definitions, Benefits, Exclusions and Conditions of this policy including the exclusion relating to Pre-existing Conditions.

As the Principal Member, I sign this Declaration on behalf of all persons included in this Application Form.

Principal Member's Signature

\_\_\_\_\_

Date \_\_\_\_\_

Please return this form fully completed to the address below:

Allianz Worldwide Care, 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

Helpline: + 353 1 630 1301

Fax: + 353 1 629 7117

Email: [underwriting@allianzworldwidecare.com](mailto:underwriting@allianzworldwidecare.com)  
[www.allianzworldwidecare.com](http://www.allianzworldwidecare.com)

For office use only - Agent details and stamp

**One Care International**  
**24 rue de la Tour d'auvergne**  
**75009 PARIS**

Thank you for completing this Application Form. Prior to submission, please ensure that:

- Your contact details are correct, as we will use these to communicate with you in the future
- The information provided in section 6 (Health Declaration) is complete and correct
- Payment method and details have been completed in full
- You have signed and dated the Declaration in section 9