



**Application for Delta Lloyd
Privé Zorgverzekering (Abroad Policy)**

Please fill in this form with capital letters, using a blue or black ballpoint pen. You can only use this form to obtain insurance with Delta Lloyd if you do not qualify for compulsory cover under the Dutch Health Insurance Act, or if you are not eligible for health care provision in your country of residence. For this insurance policy, we require evidence of your current state of health. We will return these documents to you as soon as we have received your application.

Commencement date: (dd-mm-yyyy)

| | |
|---|------------------------------------|
| Intermediary details (to be filled in by the intermediary) | |
| Intermediary no. | <input type="text"/> |
| Intermediary's customer no. | <input type="text"/> |
| Collective details (to be filled in by the collective) | |
| Collective no. | <input type="text" value="15490"/> |
| Employee no. / membership no.* | <input type="text"/> |
| Declaration no. / company unit no.* | <input type="text"/> |
| (* if applicable) | |

Policyholder details

1 The policyholder is the person applying for the insurance

Initials Prefix Surname

Date of birth Sex M F Delta Lloyd Customer no. (if known)

Street House no. Apartment no.

Postcode Town/City Country

Daytime tel. no. Evening tel. no. SOFI no. / BSN

Email By filling in your email address you give Delta Lloyd permission to use your email address for correspondence

Name of employer/company/collective

Do you want to take out insurance cover for yourself? Yes No

Details of other persons to be insured

| Family member no. | Initials | Prefix | Surname | Date of birth | Sex | SOFI no. / BSN |
|-------------------|----------------------|----------------------|----------------------|----------------------|---|----------------------|
| 2 | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="text"/> |
| 3 | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="text"/> |
| 4 | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="text"/> |
| 5 | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="text"/> |

1 Insurance details

Please indicate below the excess and additional insurance you require

Excess € 100/200, € 200/400, € 300/600, € 400/800, € 500/1000

The excess is the amount you yourself pay per year if you incur healthcare costs. This policy has a minimum excess of € 100/200 per year per policy, with a maximum of € 500/1000. If you require a higher excess, please indicate the amount in the box. The higher the excess, the lower your premium. The excess does not apply to the additional insurance.

Excess

Additional insurance

Please indicate in the table on the right any additional insurance you require. If you select the additional insurance Delta Lloyd Top, Delta Lloyd will require a dental declaration form, filled in by your dentist, for the medical assessment. We will send you the declaration form. The declaration needs to be signed by you and your dentist. Any costs incurred will be reimbursed by Delta Lloyd.

| Family member no. | : | 1 | 2 | 3 | 4 | 5 |
|----------------------|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| No cover required | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cover required | | | | | | |
| Delta Lloyd Start | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Delta Lloyd Extra | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Delta Lloyd Compleet | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Delta Lloyd Comfort | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Delta Lloyd Top | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

TandenGaaf

If you select a TandenGaaf policy with a maximum amount of 1000 Euros, Delta Lloyd will require a dental declaration form, filled in by your dentist, for the medical assessment. We will send you the declaration form. The declaration needs to be signed by you and your dentist. Any costs incurred will be reimbursed by Delta Lloyd.

| Family member no. | : | 1 | 2 | 3 | 4 | 5 |
|----------------------------|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| No cover required | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cover required | | | | | | |
| TandenGaaf 75% tot € 150 | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| TandenGaaf 75% tot € 250 | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| TandenGaaf 75% tot € 500 | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| TandenGaaf 100% tot € 150 | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| TandenGaaf 100% tot € 250 | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| TandenGaaf 100% tot € 500 | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| TandenGaaf 100% tot € 1000 | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Semi Private

This module entitles you to care in a semi-private institution

Family member no.:

Cover not required

Cover required

1 2 3 4 5

Note for Question 2: If you opt for direct debit, Delta Lloyd can automatically debit the amount payable by you from your bank or giro account. The account number for which you authorise payment must be the policyholder's account. You can cancel your direct debit at any time. We also use your account number for payments we make to you.

2 How do you want to pay your premiums?

- a Monthly Quarterly Six-monthly Annually
- b To Delta Lloyd To intermediary Via employer
- c Acceptgiro Direct debit Invoice
- d Your bank or giro account number:

3 Current insurance

- a Who is your current health insurer? Registration no.
- b How are you currently insured? Individual Collective Overseas
- c Have you taken out your current health insurance yourself (in your own name) or through someone else (e.g. a parent, your spouse or partner)? Self Through someone else

Note for question 4: Income from the Netherlands is income paid employment or Dutch social insurance benefits.

4 Do one or more of the persons to be insured receive income from the Netherlands?

- No Yes, the following person(s)
- | | | | |
|---------------|----------------------|---------------|----------------------|
| Date of birth | <input type="text"/> | Date of birth | <input type="text"/> |
| Date of birth | <input type="text"/> | Date of birth | <input type="text"/> |

Note for question 5: Income from abroad means income from work or foreign social security benefits.

5 Do one or more of the persons to be insured receive income from abroad?

- No Yes, the following person(s)
- | | | | |
|---------------|----------------------|---------------|----------------------|
| Date of birth | <input type="text"/> | Date of birth | <input type="text"/> |
| Date of birth | <input type="text"/> | Date of birth | <input type="text"/> |

Note for Question 6: Do one or more of the persons to be insured not have Netherlands nationality? In this case, Delta Lloyd requires a copy of the ID card or passport of any person from an EU country or an EEC treaty country. In the case of another country, we require a copy of the residence permit. Please send all relevant documents together with this form.

6 Do all persons to be insured have Netherlands nationality?

- Yes No, namely:
- | | | | |
|---------------|----------------------|---------------|----------------------|
| Date of birth | <input type="text"/> | Date of birth | <input type="text"/> |
| Nationality | <input type="text"/> | Nationality | <input type="text"/> |
| Date of birth | <input type="text"/> | Date of birth | <input type="text"/> |
| Nationality | <input type="text"/> | Nationality | <input type="text"/> |

Signature

The undersigned declares that all the questions in this application form have been answered carefully, completely and truthfully. This application form provides the basis for the health insurance and for any additional insurance agreements taken out with Delta Lloyd Zorgverzekering NV in The Hague, KvK 27118912 (Delta Lloyd) under the applicable terms and conditions. This public limited liability company forms part of the CZ group in Tilburg. The undersigned hereby agrees to the said terms and conditions.

Place _____ Date _____ Signature _____

Please send this form to:

Delta Lloyd
Postbus 4016
5004 JA Tilburg

The information provided to Delta Lloyd by the policyholder and the insured person(s) will primarily be used by Delta Lloyd to assess the insurance risk. When the cover becomes effective the data may be used to execute the insurance and the associated service provision, the customer service administration and activities geared to responsible operational management, the continuity of the insurance institution, fraud prevention and control, and to meet legal obligations. This health insurance agreement is offered by Delta Lloyd and subject to Netherlands law. Complaints should be directed to the Management Board. If you do not agree with the Board's decision, you can submit your complaint to a court or the Health Insurance Ombudsman (see Article 11 of the General Terms and Conditions).



To determine the state of health of the insurees we require medical information. Please complete all questions below in block letters. If you require more space please add a separate attachment. Thank you for your co-operation.

client number: []

Insurant: (this questionnaire is kept separately from your application due to privacy. Therefore some details need to be filled in again).

Surname: [] ZIP code: [] House number []

1. Length and weight:

Table with 6 columns: (date of birth), weight (kg), length (cm), (date of birth), weight (kg), length (cm). Rows 1-6 for individuals.

2. Are there any insurees with long term (longer than 3 months) physical or mental disorders, diseases or disabilities (also tick if this occurred longer than five years ago)?

For example: diabetes, neurological disorders, affection of the lungs, epilepsy, blood-disease, kidney failure, psychic or psychiatric disorders, incontinence, cardiovascular and/or heart diseases, chronic skin-affection, neck/back and/or limb conditions, oesophagic- abdominal and/or intestal disorders, dental problems after an accident, congenital disorders, hearing difficulties, malignant conditions, high cholesterol, hepatitis, AIDS or HIV antibodies in the blood (seropositivity).

Form for question 2: [] no [] yes, who? []-[]-[] (date of birth) []-[]-[] (date of birth) which condition? [] which diagnosis is reached? []

3. Are there any insurees who require an aid (like hearing aids, protheses, wheel chair, hypodermic needles or incontinence aids)?

Form for question 3: [] no [] yes, who? []-[]-[] (date of birth) []-[]-[] (date of birth) which aid? []

4. Are there any insurees who are currently receiving treatment by, or are under the supervision of a GP, specialist, dental surgeon or midwife?

Form for question 4: [] no [] yes, who? []-[]-[] (date of birth) []-[]-[] (date of birth) since when? [] what type of specialist care? [] what for? [] which diagnosis is reached? [] is/was the person concerned admitted? [] no [] yes [] no [] yes

| | | |
|---|--|--|
| when? | <input type="text"/> | <input type="text"/> |
| what for? | <input type="text"/> | <input type="text"/> |
| for how long (no. of days)? | <input type="text"/> | <input type="text"/> |
| has an operation taken place or is this to be expected? | <input type="checkbox"/> no <input type="checkbox"/> yes | <input type="checkbox"/> no <input type="checkbox"/> yes |
| when? | <input type="text"/> | <input type="text"/> |
| what kind of operation? | <input type="text"/> | <input type="text"/> |
| is further treatment or check-ups required? | <input type="checkbox"/> no <input type="checkbox"/> yes | <input type="checkbox"/> no <input type="checkbox"/> yes |
| how many a year? | <input type="text"/> | <input type="text"/> |

5. Are there any insurees who use drugs, special diets or diet preparations on a regular bases?

| | | |
|--|--|--|
| <input type="checkbox"/> no <input type="checkbox"/> yes, who? | <input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/> (date of birth) | <input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/> (date of birth) |
| what for? | <input type="text"/> | <input type="text"/> |
| which drugs? | <input type="text"/> | <input type="text"/> |
| which doses? | <input type="text"/> | <input type="text"/> |
| how many times? | <input type="text"/> | <input type="text"/> |
| which diet/preparations? | <input type="text"/> | <input type="text"/> |

6. Are there any insurees (besides question 4) who received treatment by, or have been under the supervision of a specialist in the past 5 years?

| | | |
|--|--|--|
| <input type="checkbox"/> no <input type="checkbox"/> yes, who? | <input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/> (date of birth) | <input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/> (date of birth) |
| since when? | <input type="text"/> | <input type="text"/> |
| what type of specialist care? | <input type="text"/> | <input type="text"/> |
| what for? | <input type="text"/> | <input type="text"/> |
| which diagnosis was reached? | <input type="text"/> | <input type="text"/> |
| was the person concerned admitted ? | <input type="checkbox"/> no <input type="checkbox"/> yes | <input type="checkbox"/> no <input type="checkbox"/> yes |
| when? | <input type="text"/> | <input type="text"/> |
| what for? | <input type="text"/> | <input type="text"/> |
| for how long (no. of days)? | <input type="text"/> | <input type="text"/> |
| has an operation taken place? | <input type="checkbox"/> no <input type="checkbox"/> yes | <input type="checkbox"/> no <input type="checkbox"/> yes |
| when? | <input type="text"/> | <input type="text"/> |
| what kind of operation? | <input type="text"/> | <input type="text"/> |

Please continue on the next page

client number:

Surname:

ZIP code:

House number

7. Has treatment or an examination with regards to alleviation of childlessness taken place?

no yes

examination, treatment completed

examination, treatment to be expected

8. Are there any insurees who are currently undergoing treatment by a speech therapist, physiotherapist or any other therapist or have been for a period of 6 weeks or longer in the past 5 years?

no yes, who?

---- (date of birth)

---- (date of birth)

what kind of therapy?

what for?

which period?

from

till

number of treatments?

9. Are there any insurees who are receiving alternative treatment or have received it in the past 5 years?

no yes, who?

---- (date of birth)

---- (date of birth)

which period?

from

till

which type of treatment?

10. Is the state of health of one or more of the persons who wish to be insured such that considerable medical expenses will be incurred or can be anticipated in the near future?

no yes, who?

---- (date of birth)

---- (date of birth)

11. Is the state of health of any of the insurees as such that substantial medical costs are being made or are to be expected in the near future?

no yes, who?

---- (date of birth)

---- (date of birth)

Comments:

If your current insurer has issued an approval certificate for one of the sections listed above, please enclose a copy.

This health questionnaire and the application form serve as the basis for the insurance contract, which will be concluded in accordance with the conditions that apply. The undersigned declares that he or she has answered all of the questions in this health questionnaire correctly, completely and truthfully. Owm Centrale Zorgverzekeraars groep aanvullende verzekering Zorgverzekeraar u.a. cannot be held liable for claims relating to conditions or handicaps that are not noted (in full) on this form. The undersigned declares that he or she agrees to these conditions.

City

Date

Signature

Please now complete the application form

Delta Lloyd uses the information provided by a person who applies for insurance primarily for the purpose of assessing the risk that needs to be insured. If the medical advisor advises Delta Lloyd to reject the application for insurance, we will notify you to this effect. You can then withdraw the application if you wish, by notifying us in writing to this effect. Once the insurance policy has been approved and issued, Delta Lloyd uses the information provided by the insured to implement the insurance and to provide the corresponding services, to carry out the activities required for sound operational management, to assure the continuity of the insurance company, to prevent and detect fraud and to meet statutory obligations.