Application for Participation in Group Medica Health Plan

Name of Policyholder

Group Policy Number

Registration Date to the Plan

(a1) Main Member Details

Title

Name

Surname

Date of Birth

Gender:

Male ☐ Female ☐ Other ☐

Family Status:

Unmarried ☐ Married ☐ Divorced / Other ☐

Identification Document Type:

Id. Card ☐

Passport ☐

Identification Document Number

Identification Document Country of Issue

Identification Document Expiration Date

Email

Smoker:

Yes ☐ No ☐

Home Address

No.

P.C.

City

Country

Personal Mobile Telephone Number

Country of Personal Mobile Telephone

Occupation

Employment Status:

☐ Self-employed ☐ Civil Servant ☐ Private Employee ☐ Retired ☐ Unemployed ☐ Student ☐ Rentier

(a2) Spouse Details

Title | Name | Surname

Date of Birth | Gender: Male Female Other

Identification Document Type: Id. Card Passport | Identification Document Number | Identification Document Country of Issue | Identification Document Expiration Date

Home Address | No. | P.C. | City | Country

Email | Personal Mobile Telephone Number | Country of Pers. Mob. Tel.

Occupation | Smoker: Yes No

Employment Status:

Self-employed Civil Servant Private Employee Retired Unemployed Student Rentier

(a3) Dependents' (children) Details

Title | Name | Surname

Date of Birth | Gender: Male Female Other

Identification Document Type: Id. Card Passport | Identification Document Number | Identification Document Country of Issue | Identification Document Expiration Date

Home Address | No. | P.C. | City | Country

Email | Personal Mobile Telephone Number | Country of Pers. Mob. Tel.

Occupation | Smoker: Yes No

Employment Status:

Self-employed Civil Servant Private Employee Retired Unemployed Student Rentier

(a4) Dependents' (children) Details

Title | Name | Surname

Date of Birth | Gender: Male Female Other

Identification Document Type: Id. Card Passport | Identification Document Number | Identification Document Country of Issue | Identification Document Expiration Date

Home Address | No. | P.C. | City | Country

Email | Personal Mobile Telephone Number | Country of Pers. Mob. Tel.

Occupation | Smoker: Yes No

Employment Status:

Self-employed Civil Servant Private Employee Retired Unemployed Student Rentier

(a5) Dependents' (children) Details

Title | Name | Surname

Date of Birth | Gender: Male Female Other

Identification Document Type: Id. Card Passport | Identification Document Number | Identification Document Country of Issue | Identification Document Expiration Date

Home Address | No. | P.C. | City | Country

Email | Personal Mobile Telephone Number | Country of Pers. Mob. Tel.

Occupation | Smoker: Yes No

Employment Status:

Self-employed Civil Servant Private Employee Retired Unemployed Student Rentier

(b) Medical History

The questions should be answered for each of the Proposed for Insurance Persons.

1. Daily cigarette consumption:	**2. Daily alcohol consumption:**	
3. Date of last visit to a Physician or receipt of medical advice:		
Cause/ Diagnosis:		
Therapy:		
Prescription:		
Diagnostic Exams:		
Name /Address of Physician:		
4. Have you been hospitalised? If yes, please provide:		NO ☐
Reason for hospitalisation:		
Period of hospitalisation:		
Name/ Address of Physician:		
5. Have you been advised to undergo medical diagnostic exams or to follow medical treatment which is still pending? If yes, please state:		NO ☐
For what reason?		
6. Have you been examined by a Physician or have you been treated or are you being treated for the ailments or illnessess mentioned below:		
Abnormal blood pressure (e.g. hypertension, hypotension)		YES ☐ NO ☐
Respiratory system conditions/diseases		YES ☐ NO ☐
Hyperlipidaemia (cholesterol, triglycerides)		YES ☐ NO ☐
Musculoskeletal system conditions (e.g. spine, disks, muscles)		YES ☐ NO ☐
Nervous system conditions, anxiety disorders, depression		YES ☐ NO ☐
Cardiovascular system conditions (e.g. heart disease, myocardial infarction, stroke, vascular disease)		YES ☐ NO ☐
Gastrointestinal system conditions (e.g. ulcer, Crohn's disease, ulcerative colitis)		YES ☐ NO ☐
Diabetes of any kind		YES ☐ NO ☐
Cancer, pre-cancerous condition		YES ☐ NO ☐
Urinary system conditions (e.g. kidney disease, kidney stones, abnormal urinalysis)		YES ☐ NO ☐
HIV, hepatitis, sexual transmitted diseases		YES ☐ NO ☐
Thyroid gland condition/ disease		YES ☐ NO ☐
Other condition/ disease/ accident		YES ☐ NO ☐
7. Have you experienced any symptom or indication that makes you suspect that you will require medical advice or even treatment in the near future?		YES ☐ NO ☐
8. Have you had or have any treatment using medication?		YES ☐ NO ☐
9. For women only:		
Breast disease or disease of genital organs?		YES ☐ NO ☐
Are you pregnant now?		YES ☐ NO ☐
If yes, in what month is the gestation period?		

Note: For each affirmative answer details should be given in paragraph "Additional Details" by indicating the relevant number of the question and the person concerned.

(c) Family History
Have any of your family members (parents, brothers or sisters) ever had or have (whether living or deceased) diabetes, heart disease/condition, tumor or cancer, Huntington's disease, polycystic kidney disease, stroke, multiple sclerosis, neuropathies or hypertension? If yes please give details under paragraph "Additional Information".

(d) Country of Residence
If any of the proposed for insurance persons, temporarily reside abroad, information such as Country, duration and purpose of stay is required to be given in the paragraph "Additional Information".

(e) Simultaneous Coverage
If there are any Insurance Policies in-force or pending Applications for In-Hospital Benefit or Personal Accident Insurance with our Company or with any other Insurance Company, details should be given in the paragraph "Additional Information".

(f) Hobbies
Should any of the proposed for insurance persons occupy themselves or intend to occupy themselves with any kind of dangerous hobbies, details should be given in the paragraph "Additional Information".

Additional information regarding the positive answers (b) 1-9 and (c) - (f)

Proposed Insureds' Full Name	Question	Details

All the information that is material for the evaluation of this Application should be disclosed to the Company. Any non-disclosure may give cause to the rejection of a Claim. Material fact is any fact that, in the insurer's opinion, may affect the evaluation of the risk and the acceptance of the Application. If you are in doubt about the materiality of a circumstance you should disclose it. You can keep a photocopy of this Application.

Important Information

1. Our intention is to best serve our customers. For this reason, in case you have any complaints in relation to our services in the process of completing your application or after, please contact our Customer Service Department, either in writing or by phone at **80008880**. More information about the Complaints Procedure can be found on our website at **www.eurolife.com.cy**. Regardless of the Complaint Review Procedure you have the right to appeal to a Court of Law.

2. Please ensure that:
   - The history that you have declared is complete and accurate
   - If you have answered YES to any question, you have provided us with all the details
   - You have included in the history you have declared, any medical history from claims or policy applications that you have previously submitted to us in relation to another insurance policy you may have/had with us.

All your details are important for the evaluation of your Application and should be stated in writing. Any omission on your behalf of any written information may lead to the non- payment of a claim and/or the cancellation of a policy or additional benefit or the imposition of special terms. For any information you are in doubt of as to its importance, you should declare such information in writing.

Personal Data Protection

We are committed to protecting your privacy and handling your data in an open and transparent manner. Details in relation to how we use your data can be found in the Privacy Statement available at: **www.eurolife.com.cy**. If you do not have access to the internet, we can provide you with a hard copy upon your request.

Member Declaration

I/We responsively declare the following:

- To the best of my knowledge and belief, all above statements and answers are true and complete
- I have read, understood and accept all the information in this Application
- I have read and understood the section Personal Data Protection above, and have been informed of my rights in relation to the processing of my personal data
- With my signature below I hereby provide my express consent for the processing of Sensitive Data, that is, data concerning my health, by Eurolife and by relevant recipients for the purposes of execution of the Insurance Policy for which I am an insured person and for compliance with the terms of such Policy. I acknowledge that I have the right to withdraw my consent or object to the processing of such data, however in such a case, Eurolife may have the right to not accept the Application for Insurance, terminate the Insurance Policy and/or reject any claim or request under this Policy.

I hereby expressly consent to the processing of my Personal Data by Eurolife for the purposes of direct marketing and receiving information for any Eurolife product, insurance plan and/or service through any medium including electronic communication.

YES* NO*

* *Please note that if you have given your consent to the processing of your personal data by Eurolife for direct marketing purposes, you have the right at any time to withdraw such consent or oppose the profiling that may take place for the purposes of direct marketing. For further information on your Personal Data rights please see the Personal Data Protection section above.*

Communication Language: Greek English

Full Name and Signature of Proposed Insured Member*

** To be signed by the Parent/Legal Guardian of any Proposed Insured under 18 years old.*

Date and Place

Signature of Policyowner

Date and Place

Documents to be attached with the original application

- **Certified copy of ID or Passport for all members**
- **IBAN Certificate (for the reimbursements of future claims)**

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