

Insurance Intermediary	Code
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EuroLife

EuroLife Ltd
 4 Evrou Str.,
 2003 Strovolos,
 P.O. Box 21655,
 1511 Nicosia

Application for “medica / medica blue” health program

1. Policyholder’s Details

(a) Full Name: (Surname/Name/Initial):

(b) Sex: M F (c) I.D. Number:

(d) Date of Birth: / /

(e) Place of Birth: (f) Marital Status:

(g) (i) Home Address:
 Town/VillageP.C. Telephone:

(ii) Business Address:
 Town/VillageP.C. Telephone:

(h) Occupation (and duties):

2. Premium

(i) Annual Premium € (ii) Payable: Yearly
 Half-yearly
 (iii) Payable Premium € Quarterly
 (iv) Amount paid with the application € Monthly
 (v) Modal Premium Direct Debit

3. Annual Claims Excess Amount

Zero € 2.000* € 5.000*
 € 8.000* € 10.000* € 20.000*
 *not applicable for “medica blue” health program

4. Details of the Proposed for Insurance Persons

(a) Proposed for insurance persons:				
Full Name	Occupation	Date of Birth	Height / Weight	Identity Card Number
(i) / / /
(ii) / / /
(iii) / / /
(iv) / / /
(v) / / /
(vi) / / /
(vii) / / /
(viii) / / /

(b) Country of Residence

If any of the proposed for insurance persons temporarily resides abroad, information such as Country, duration and purpose of stay is required to be given in the paragraph "Additional Details".

(c) 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 Details".

(d) Hobbies

Should any of the proposed for insurance persons occupies himself or intends to occupy himself with any kind of dangerous hobbies, details should be given in the paragraph "Additional Details".

(e) Medical History

The questions should be answered in relation to each of the proposed for Insurance persons.

Has any of the Proposed for Insurance Persons ever had or has :

	YES	NO		YES	NO
1. Heart problems or abnormal cardiogram, blood or circulatory problems, anemia or high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	12. Been discharged or exempted from military or other service for medical reasons?	<input type="checkbox"/>	<input type="checkbox"/>
2. Lung, bronchial or other chest problem?	<input type="checkbox"/>	<input type="checkbox"/>	13. Any ailment, injury, fracture, disability, abnormality or contagious disease?	<input type="checkbox"/>	<input type="checkbox"/>
3. Stomach (ulcer e.t.c.) intestinal or liver problems?	<input type="checkbox"/>	<input type="checkbox"/>	14. Undergone surgical operation or been hospitalised?	<input type="checkbox"/>	<input type="checkbox"/>
4. Renal colic or any urinary track problem such as renal stones, haematuria, albuminuria or glycosuria?	<input type="checkbox"/>	<input type="checkbox"/>	15. Postponed any surgical operation?	<input type="checkbox"/>	<input type="checkbox"/>
5. Diabetes, thyroid or other lymph-node problems tumor or cancer?	<input type="checkbox"/>	<input type="checkbox"/>	16. Consulted in the past or at present any physician in relation to AIDS, or received medication or therapy for such a disease?	<input type="checkbox"/>	<input type="checkbox"/>
6. Arthritis, lumbago or other skeletal, joint or lumbar problems?	<input type="checkbox"/>	<input type="checkbox"/>	17. Had blood examination or been advised to have a blood examination for AIDS or any other related disease?	<input type="checkbox"/>	<input type="checkbox"/>
7. X-rays, electrocardiograms, blood or urine analysis, or medical check-ups the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	18. Received any blood transfusion or elements of blood during the last year?	<input type="checkbox"/>	<input type="checkbox"/>
8. Suffered from vertigo, loss of consciousness or any related mental problems such as epilepsy, spasms, paralysis, brain or other central nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	19. Been rejected as a blood donor?	<input type="checkbox"/>	<input type="checkbox"/>
9. Eye, ear, throat or sinuses problem?	<input type="checkbox"/>	<input type="checkbox"/>	20. Taken medicine or any other intravenous drugs without medical prescription?	<input type="checkbox"/>	<input type="checkbox"/>
10. Coccyx cyst, haemorrhoids, perianal fistula, varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>	21. For women only:		
11. Been indemnified for disability due to accident or illness?	<input type="checkbox"/>	<input type="checkbox"/>	Breast disease or disease of genital organs?	<input type="checkbox"/>	<input type="checkbox"/>
			Are you or is she pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
			If yes in what month is the gestation period?		

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

(f) Family History

Should any of your parents or brothers / sisters (alive or deceased) ever suffered from diabetes, neurological muscular or mental abnormalities, asthma, cerebral stroke, high blood pressure, any type of heart disease, cancer, epilepsy, renal deficiency, high cholesterol or other lipids in the blood, details should be given in the paragraph "Additional Details".

Personal Data Protection Law (138(I)/2001)

In accordance with the provisions of the above Law, the **Bank of Cyprus Ltd**, being the “Controller”, informs the Data Subject that in order to conclude and execute the Insurance Contract it is necessary to process Personal Data, some of which are considered Sensitive Data.

The Data will be entered, either in a manual or electronic form, into one or more interconnected archives, which will be kept by EuroLife or other company of the Bank of Cyprus Group or other affiliated / co-operating company.

In addition to the basic purpose of the processing of the Data, which is the execution of the Insurance Contract, the Data will also be subject to processing with the purpose of Promoting Products and Services and / or Research and Statistical Analysis.

Recipients of the Data will be the pertinent personnel of EuroLife or the Bank of Cyprus Group or the affiliated / co-operating company or person, who / which are under the control of the Processor and comply with the principles of secrecy. Any Medical Doctors who have examined or will be examining the Data Subject may also become Recipients of the Data.

The Data Subject has the rights for Information, Access, Rectification and Objection to the processing of his personal data. Specifically for the processing of Sensitive Data, explicit Consent of the Data Subject is required.

In case the Data Subject refuses to give his Consent or objects to the processing of his Personal Data, EuroLife is entitled to discontinue the Insurance Mediation process or to terminate the Insurance Policies or to reject any submitted Claims.

Data Subject's Declaration

I hereby declare that I have been informed of the provisions of the Law and that by signing this Application I give my explicit Consent for the collection and the processing of my Personal Data, whether being sensitive or not.

I also give my Consent for the processing of my Personal Data by the Companies of the Bank of Cyprus Group, for the purpose of Distance-Marketing of Products or Distance-Provision of Services.

YES NO

Data Subject's Signature :

Data Subject's Name :

Data Subject's Identity Card Number : Place and Date :

Important Note

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. Every material circumstance should be declared in this Application even if this has been disclosed previously in the past with either an Application or Claim or Letter or with any other way by the Owner or the Proposed for Insurance Person or by any other person. If you are in doubt about the materiality of a circumstance you should disclose it. You will receive a copy of this Application along with the Insurance

Declaration and Authorisation from the Proposed for Insurance Person

I hereby declare that to the best of my knowledge and belief, all statements and answers on the application are true and complete. I authorise EuroLife to request and obtain medical information about my physical and mental state of health from any doctor that has examined me or has medical records concerning my health and/or my minor dependants. I also authorise EuroLife to request and obtain information from other insurance companies to which I have applied for insurance cover. A photocopy of this Authorisation will be valid as the original.

Signature of each Proposed for Insurance Adult Person / Place and Date

- | | |
|-------------|--------------|
| (i) | (ii) |
| (iii) | (iv) |
| (v) | (vi) |
| (vii) | (viii) |

Signature of Policyholder / Place and Date

Signature of Insurance Intermediary / Place and Date

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