EuroLife Ltd
4 Evrou Str., 2003 Strovolos,
P.O.Box 21655, 1511 Nicosia
Tel: 22124000
Fax: 22341090

APPLICATION FOR ALTERATIONS / REINSTATEMENT OF INSURANCE POLICY

PART A: To be completed in every case

Insurance Policy Number	Name of Insurance Intermediary: ..... Code of Insurance Intermediary:. ..... B.O.C. Branch:. ..... Name & Code of Bank Clerk: .....
Policyholder's Identity Card No: Company Registration No.:	

Name of Policyholder	Telephone Numbers
Correspondence Address of Policyholder:	
E-mail Address of Policyholder:	

I hereby request the Alteration of the above-mentioned Insurance Policy as per my Application.

Requested Alteration:.....

.....

.....

..... Effective Date of the Alteration : .....

Note: A premium Alteration may cause a change in the Insured Amount.

PART B: INSURABILITY QUESTIONNAIRE To be completed in the event of policy reinstatement or where the Company assumes additional insurance risk.

The questions herebelow must be answered by the Insured.
The medical questions apply to all dependent persons of the Additional Benefit "In-Hospital Coverage", if there are any.

Name of Insured	Identity Card No.	Date of Birth
Address		Telephone Numbers

Marital Status Married ☐ Single ☐ Divorced ☐ Widower ☐	Occupation and specific duties
(a) Height : (b) Weight :	

	YES	NO
1.(a) Have you travelled by air in the last 3 years in any capacity other than as a fare paying passenger or are you engaged in any dangerous activity or do you intend to do so?	☐	☐
(b) Do you intend to travel or reside abroad (vacations excluded) or intend to change occupation?	☐	☐

2. Since the date you have submitted the application for insurance have you :

(a) Suffered from any physical or mental disease, ailment or disability, or taken drugs, medicine or injections, or have you been on a special diet?	☐	☐
(b) Consulted a doctor or suffered from any bodily injury or disease which lasted for more than a week?	☐	☐
(c) Been submitted to any medical examination, therapy or undergone an operation in a hospital or clinic, or you had a blood examination and what were the results? If yes, attach copy of the recent tests.	☐	☐
(d) Submitted application for a life insurance policy, health or disability to any other insurance company? If yes, specify the company, amounts and the type of insurance cover:.....	☐	☐
(e) Taken advice or do you believe that there is a reason to take advice, medical information, therapy or blood test which is related to a serious contagious disease, (such as fever, hepatitis, AIDS or other similar situation) or any sexually transmitted disease?.....	☐	☐

3.Family History

Has 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?	☐	☐

If you have answered "YES" to any of the above questions please give details :

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4. Are you a smoker? If yes, what is your daily consumption? ....

5. What is your daily consumption of alcohol? .....

6. Name & address of your Personal Physician or any other Physician whom you usually consult when needed.

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7. Current Life insurance cover with all insurance companies :

(a) With EuroLife : ..... (c) ..... : .....

(b) ..... : ..... (d) ..... : .....

To be completed in case of reinstatement of the Insurance Policy.

8.(a) This Application is submitted for reinstatement with : **Full Payment** ☐ **Partial Payment** ☐

(b) Amount which has been paid with this Application : €.....

PART C : To be completed in the event a dependent person is added or the Additional Benefit of "In-Hospital Coverage" / Health Plan "medica" is altered.

1. Proposed for Insurance Dependent Persons

Name	Occupation	Date of Birth	Height/Weight	Identity Card No.
(a)	.....	.....	..... /	.....
(b)	.....	.....	..... /	.....
(c)	.....	.....	..... /	.....
(d)	.....	.....	..... /	.....
(e)	.....	.....	..... /	.....

2. Medical History

The questions herebelow should be answered by all the proposed for insurance persons. For every affirmative answer, details should be given in the Section "Additional Information" specifying the relevant question and to whom it is related.

Has any of the proposed for insurance persons ever had or has :

	YES	NO
a. Heart problems or abnormal cardiogram, blood or circulatory problems, anemia or high blood pressure?	☐	☐
b. Lung, bronchial or other chest problem?	☐	☐
c. Stomach (ulcer e.t.c.) intestinal or liver problems?	☐	☐
d. Renal colic or any urinary track problem such as renal stones, haematuria, albuminuria or glycosuria?	☐	☐
e. Diabetes, thyroid or other lymph-node problems tumor or cancer?	☐	☐
f. Arthritis, lumbago or other skeletal, joint or lumbar problems?	☐	☐
g. X-rays, electrocardiograms, blood or urine analysis, or medical check-ups the last 5 years?	☐	☐
h. Suffered from vertigo, loss of consciousness or any related mental problems such as epilepsy, spasms, paralysis, brain or other central nervous system problem?	☐	☐
i. Eye, ear, throat or sinuses problem?	☐	☐
j. Coccyx cyst, haemorrhoids, perianal fistula, varicose veins?	☐	☐
k. Been indemnified for disability due to accident or sickness?	☐	☐

	YES	NO
l. Been discharged or exempted from military or other service for medical reasons?	☐	☐
m. Any ailment, injury, fracture, disability, abnormality or contagious disease?	☐	☐
n. Undergone surgical operation or been hospitalised?	☐	☐
o. Postponed any surgical operation?	☐	☐
p. Consulted in the past or at present any physician in relation to AIDS, or ever received medication or therapy for such a disease?	☐	☐
q. Had blood examination or been advised to have a blood examination for AIDS or any other related disease;	☐	☐
r. Received any blood transfusion or elements of blood during the last year?	☐	☐
s. Been rejected as a blood donor?	☐	☐
t. Taken medicine or intravenous drugs without medical prescription?	☐	☐
u. For women only:		
Breast disease or disease of genital organs?	☐	☐
Are you or is she pregnant?	☐	☐
If yes in what month is the gestation period?.....		

3. 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 Section "Additional Information".

4. Simultaneous Cover

If any of the Proposed for Insurance Persons has other Insurance Policies in force or any 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 Section "Additional Information".

5. Country of Residence

If any of the Proposed for Insurance Persons temporarily resides, or plans to reside abroad, additional information should be given in the Section "Additional Information". If the residence abroad commenced after the inception of this Benefit, this should also be declared to the Company.

6. Family History

If any of your parents or your brothers or sisters (whether living or deceased) has suffered or suffers from diabetes, heart problems, tumor or cancer, Huntington's disease, policystic kidneys, stroke, multiple sclerosis, neuropathy or high blood pressure, such information should be given in the Section "Additional Information".

Additional Information:

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PART D: To be completed in case the Additional Benefit "Income Replacement" is added/altered.
Note : To be submitted with a "Quotation".

(a) Proposed Plan

(i) Monthly Amount of Benefit € .....

(ii) Waiting Period..... Days

(iii) Period of Benefit Payment Two (2) years ☐ Until the age of 65 ☐

(b) Please give additional details of the duties of your main and secondary, if any, occupations as well as the weekly working hours of each one.

.....

.....

(c) What is your annual income from the above-mentioned occupations? (i) € ..... (ii) € .....

(d) Declare if you are right handed or left handed : .....

(e) Declare if the following are included in your duties :

(i) Driving a vehicle YES ☐ NO ☐

(ii) Use of heavy machinery YES ☐ NO ☐

(iii) Manual Work YES ☐ NO ☐

Where the answer is YES, give details such as distances, type of vehicle or machinery and how much time you utilise per week for each one.

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Additional Information or Requests:

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PART E: To be completed in case of alterations regarding the "Multiple Funds".
Note: You may complete either the part "Alteration of Apportionment of Premium" or the part "Transfer of Units/Value from one Fund to another Fund" or both parts.

PREMIUM REDIRECTION

Effective Date : .....

(This date should correspond to an unpaid installment. If the date which has been posted above corresponds to a paid installment the alteration will be effected on the next unpaid installment when this will be created).

New premium allocation (state the percentages you wish)

Guaranteed Fund : ..... Balanced Fund : .....

Income Fund : ..... Growth Fund : .....

Conservative Fund : …….

Attach copy of the payment of the Service Fee
(You are allowed to effect up to 4 alterations within one policy year, of which the first one is free of charge).

TRANSFER OF UNITS / EXCHANGE OF UNITS

Effective Date (Effective date will be considered as the date on which the Application is received by the Company. The exchange of units will be calculated by the Bid Price at the Valuation Date following the date of the Application).

FROM FUND	TO FUND	PERCENTAGE	OR VALUE	OR UNITS
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....

Attach copy of the payment of the Service Fee.
(You are allowed to effect up to 4 alterations within one policy year, of which the first one is free of charge).

TRANSFER OF OWNERSHIP

PART F : To be completed in the event of change of Ownership of the Insurance Policy.

Note 1. In the event that the new Policyholder is different from the Insured the Additional Benefit "Waiver of Premium" (if there is one) will be cancelled.

Note 2. To be accompanied with the respective amount of the fiscal stamp.

Note 3. The transfer / assignment of the rights and benefits of the Insurance Policy can be effected through a TRUST DEED or ASSIGNMENT.

THIS DOCUMENT FOR THE TRANSFER OF OWNERSHIP OF THE INSURANCE POLICY IS MADE BETWEEN

1. …….(The Transferor)

and

2. ……...(The Transferee)

and

The Transferor under no influence and for reasons of natural love and affection/against consideration (please strike through what is not applicable) to the Transferee assigns and transfers to the Transferee……... the Insurance Policy.

It is WITNESSED that:

The Transferor, being the beneficiary Owner of the Insurance Policy, assigns, transfers and delivers to the Transferee the Insurance Policy, and all the Benefits thereto, pecuniary or not, and the Rights which emanate from the Insurance Policy, will belong and be exercised by the Transferee in his capacity as the new and absolute Owner.

PERSONAL DATA OF NEW POLICYHOLDER

Identity Card or Company Registration No. : .....

Date of Birth/ Date of Registration : .....

Correspondence Address : .....

.....

Home telephone no. : ..... Business Telephone no. : .....

Signature of new Policyholder :.....

It is Agreed that:

1. In the event the Insured Amount is increased, the liability of the Company is limited to the insured amount which was in force prior to the alteration of the insured amount in case the insured commits suicide within one year from the date of this Application.
2. The alteration of the Insured Amount will be valid with effect from the date shown on the proposal form subject to the provisions 7(d) as shown on the back of the Premium Payment Receipt.

Information Subject to Rule 45

1. The Intermediary has a contractual obligation to act as Intermediary in the Life Insurance Business exclusively for EuroLife Ltd. YES / NO
2. The Intermediary is registered in the "Register of Insurance Advisors" of the Office of the Superintendent of Insurance of the Ministry of Finance.
3. The Policyholder has the right to file a complaint against the Intermediary to EuroLife as well as to the Intermediary.
4. The Premiums which the Intermediary collects are considered as being paid to EuroLife Ltd. on behalf of the Policyholder.

Important Note: All the information that is material for the assessment of this Application should be disclosed to the Company because any non-disclosure could give cause to a rejection of a claim and/or the cancellation of the amendment applied for and/or the imposition of special terms. Material fact is any fact that, in the insurer's opinion, can influence the assessment and the acceptance of the Application.

INFORMATION ON THE PROCESSING OF YOUR PERSONAL DATA

We would like to inform you that for the purposes of examining and executing the application for amendment of the insurance policy for which you are an insured person, and for the purposes of execution of this policy, we are required to process your personal data. Such data shall include (a) standard "Personal Data" that identifies or may identify you (e.g. contact and identification details, demographic data, financial information) and (b) if so necessary for the above purposes, special categories of data, mainly data concerning your health and to which we refer to as "Sensitive Data".

We share your information only for the purposes set out above, and only with third parties that are subject to an obligation for confidentiality and for processing your data in accordance with applicable data protection law.

We note that you have the right to access your information and to ask us to rectify, erase and restrict the use of your information. You also have the right to data portability, to not be subject to automated decision making processes or profiling, as well as to withdraw your consent for the use of your information by us at any time, provided that the legal basis on which we process is the provision of your consent. In the event that you wish to withdraw consent for the processing of Sensitive Data, it should be noted that this will likely impact our ability to execute the application for amendment and/or the insurance policy.

Further information with regard to how we use your data, the recipients of your data, as well as your rights with regard to your personal data, can be found in our full Privacy statement available on our website www.eurolife.com.cy. If you do not have access to the internet, we can provide you with a paper copy upon your request.

Declaration:

I hereby declare that I have been informed of the consequences of the above-mentioned Application and I am aware of the following :

1. The Company reserves the right to request evidence of insurability and/or decline to insure me in the event I submit a new Application for a Life Policy.
2. All the above statements and answers are complete and true to the best of my knowledge and belief.
3. In the event that I am the Transferee of the Policy I declare that I accept the processing of my Personal Data for the purposes of transferring the Policy to my name.
4. With my signature below, and in the event that the processing of my Sensitive Data is necessary for the purposes of examining and executing the application for amendment with regard to the insurance policy for which I am an insured person, I hereby give my express consent to such processing.

Name & Signature of Policyholder Date & Place

Name & Signature of Insured Date & Place

Signature of Proposed for Insurance Persons* / Date & Place
**To be signed by the Parent/Legal Guardian of any Proposed Insured under 18 years old*

(i) ..... (ii) .....

(iii) ..... (iv) .....

Name & Signature of Intermediary Date & Place
Identity Card Number / Registration Number

Address :

Name & Signature of Transferee/New Owner Date & Place

Name & Signature of Witness Date & Place

Name & Signature of Witness Date & Place