



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 make a request for a Delta Lloyd Health Insurance if you do not qualify for compulsory coverage by law 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" value="88788"/>
Intermediary's customer no.	<input type="text"/>
Collective details (to be filled in by the collective)	
Collective no.	<input type="text" value="22210"/>
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 name House no. Floor no.

Postcode Place of residence Country

Tel. no. Daytime Tel. no. evening Soc. sec. number

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

Name of employer/business unit/office

Does the policyholder also need to be insured? Yes No

People to be covered by the insurance (do not include the policyholder here)

Family member no.	Initials	Prefix	Surname	Date of birth	Gender	Social security number
<input type="text" value="2"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>
<input type="text" value="3"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>
<input type="text" value="4"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>
<input type="text" value="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.

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"/>

Family member no:	1	2	3	4	5
Delta Lloyd Brons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delta Lloyd Zilver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delta Lloyd Goud	<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 100% up to € 150,-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TandenGaaf 100% up to € 250,-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TandenGaaf 100% up to € 500,-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TandenGaaf 100% up to € 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 this account number for payments we make to you.

2 How do you want to pay your premiums?

- a Monthly Quarterly Six-monthly Annually
- b Direct debit Acceptgiro
- c What is your 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 Date of birth
- Date of birth Date of birth

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 Date of birth
- Date of birth Date of birth

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 Nationality
- Date of birth Nationality
- Date of birth Nationality
- Date of birth Nationality

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~~

Sporenburg Advies Groep
Ertskade 121
1019 ED AMSTERDAM

E info@sagbv.nl
T 020 419 80 09
Please attach your ID!

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).