

Please fill in all details to ensure that your application is processed as swiftly as possible and to avoid delaying your acceptance into the insurance. We kindly request that you complete this form in capital letters, sign it, attach all supporting documentation (as listed under paragraph 6 of this application form) and to return it either by electronic mail, fax or post to:

expatplus® | P.O. Box 69 | 2140 Antwerpen | Belgium | info@expatplus.com | F + 32 3 663 73 14

Approved intermediary expatplus®:

1. Policyholder details

Last name		First name	
Title	Date of birth (d - m - y)		/ /
Marital status	Gender	<input type="checkbox"/> M	<input type="checkbox"/> F
Occupation			
Nationality			
Telephone / Mobile number			
Primary e-mail address (obligatory)			

Home country

Address		
Postal code	Town / City	Country / State

Host country

Address		
Postal code	Town / City	Country / State

2. Company details (to be provided only if your employer is responsible for the premium payment of your individual policy)

Company name		
Address		
Postal code	Town / City	Country / State
E-mail address (obligatory)		



3. Dependants to be included in the plan

Please enter the details of all dependants to be covered under this policy. This can include your spouse/partner and any children financially dependent on the policyholder and not more than 28 years old.

Last name	First name	Relation	Sex	Date of birth (d - m - y)
			<input type="checkbox"/> M <input type="checkbox"/> F	/ /
			<input type="checkbox"/> M <input type="checkbox"/> F	/ /
			<input type="checkbox"/> M <input type="checkbox"/> F	/ /
			<input type="checkbox"/> M <input type="checkbox"/> F	/ /
			<input type="checkbox"/> M <input type="checkbox"/> F	/ /

4. Your expatplus® insurance

Core Plan

Start date - the acceptance date of the medical file at the earliest (d - m - y)

Area of cover Worldwide Worldwide excluding USA & Canada

Core Plan Globe Orbit Universe

Deductible € 0 / £ 0 / \$ 0 / CHF 0

€ 100 / £ 65 / \$ 125 / CHF 150 (only applicable within Globe and Orbit)

€ 300 / £ 200 / \$ 375 / CHF 450

€ 500 / £ 325 / \$ 625 / CHF 750 (only applicable within Universe)

€ 1,000 / £ 650 / \$ 1,250 / CHF 1,500

Additional Insurances

Dental Insurance	<input type="checkbox"/> Basic <input type="checkbox"/> Comprehensive					
	Policyholder	Spouse/Partner	Child 1	Child 2	Child 3	Child 4
Life Cover ³ With insured capital of (€ / £ / \$ / CHF)	<input type="checkbox"/>	<input type="checkbox"/>				
Accidental Death and Invalidity ³ With insured capital of (€ / £ / \$ / CHF)	<input type="checkbox"/>	<input type="checkbox"/>				
Temporary Incapacity ⁴ With monthly allowance of (€ / £ / \$ / CHF)	<input type="checkbox"/>	<input type="checkbox"/>				
Permanent Disability ⁵ With monthly allowance of (€ / £ / \$ / CHF)	<input type="checkbox"/>	<input type="checkbox"/>				
Travel Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Settlement Notes

Settlement notes online in following language EN FR DE NL ES IT

1 Additional Insurances can only be purchased in addition to the Core Plan, they cannot be purchased separately.
 2 The Additional Insurance Dental Care can only be taken out on family level and the minimum contract duration is one year (unless the contract is terminated).
 3 The minimum sum insured shall be € 50,000 / £ 32,500 / \$ 62,500 / CHF 75,000 up to a maximum sum insured of € 500,000 / £ 325,000 / \$ 625,000 / CHF 750,000.
 4 The minimum monthly allowance shall be € 1,000 / £ 650 / \$ 1,250 / CHF 1,500 up to a maximum of € 10,000 / £ 6,500 / \$ 12,500 / CHF 15,000. The monthly allowance cannot exceed 80% of the gross (monthly) salary of the insured.
 5 Permanent Disability can only be taken out as complementary to Temporary Incapacity and for a monthly allowance of maximum the monthly allowance for the Temporary Incapacity in the same contract.

5. Payment details

Mode of payment	<input type="checkbox"/> Bank Transfer	<input type="checkbox"/> Credit card		
Frequency	<input type="checkbox"/> Annual	<input type="checkbox"/> Half yearly	<input type="checkbox"/> Quarterly	
Currency	<input type="checkbox"/> EUR	<input type="checkbox"/> GBP	<input type="checkbox"/> USD	<input type="checkbox"/> CHF

6. Please enclose:



1. a **copy of the passport of the policyholder** and, if applicable, that of the **spouse/partner**;
2. a duly **completed expatplus® medical questionnaire**, signed by the policyholder and, if applicable, the spouse/partner;
3. a **copy of any relevant medical information** (medical report(s), doctor's statement(s), lab test result(s), etc.) in your possession, to document the assessment of medical acceptance of each person to be insured, by our medical consultant;
4. if the policyholder (and, if applicable, the working spouse/partner) subscribes to the **Temporary Incapacity** cover, a **proof of current income** is required;
5. if the policyholder (and, if applicable, the spouse/partner) subscribes to the **Accidental Death and Invalidity** cover and/or the **Life cover**, a **Nomination of beneficiaries form** needs to be completed for each person to be insured. (<https://www.expatplus.com/English/Info/Downloads/Downloads.htm>).

7. Declaration

1. I hereby apply for cover on behalf of all the persons named in this application form.
2. I declare that the answers given are to the best of my knowledge full, true and complete and that I have checked and agree with answers and statements in this application that are not in my own handwriting.
3. I accept that this policy will be subject to the policy terms and conditions as mentioned on the **expatplus®** website (<https://www.expatplus.com/English/Info/Downloads/Downloads.htm>). I confirm that I have read and understand the full definitions, benefits, exclusions and conditions of this policy.
4. I confirm and agree that the personal information collected or held by Vanbreda International, whether contained in this application form or otherwise obtained may be used by Vanbreda International, or disclosed to or transferred to any organisation for the purpose of 1) assessing this application and providing on-going insurance and customer service, 2) providing marketing material in respect of insurance related services of Vanbreda International or its associated companies and 3) processing claims or analysing the insurance.
5. I further accept that where funds have been outstanding to Vanbreda International for a period in excess of 15 days from notification my policy will be suspended automatically, without refund of premium.

Date (d - m - y)	Signature policyholder	Signature spouse/partner
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Please answer each of these questions fully and accurately, for each person included on your application. In case you have ticked 'Yes', please provide details in the additional information box on the last page.

	Policyholder		Partner		Child 1		Child 2	
Name								
Date of birth (d - m - y)								
1. Height / weight								
	cm		cm		cm		cm	
	kg		kg		kg		kg	
2. a. Do you currently have any health problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Is your capacity to work reduced?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Have you ever been unable to work for more than four consecutive weeks during the last five years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Do you suffer from or have you suffered from any illnesses, disturbances or problems connected with:								
a. the respiratory organs , such as asthma, recurrent or chronic bronchitis, pneumonia, pulmonary tuberculosis or other disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. the heart or vascular system , such as high blood pressure, circulatory problems, heart attack, heart defect, heart failure, palpitations, apoplexy, phlebitis, varicose veins or other disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. the nervous system or a mental disorder , such as epilepsy, dizziness, paralysis, neuritis, depression or other disorders? Have you ever attempted to commit suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. the digestive system , such as hiatus hernia, gastric or duodenal ulcers, or other disorders of the stomach or intestines, such as inflammations, haemorrhages, haemorrhoids, jaundice, diseases of the liver, gall bladder, pancreas?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. the urinary tract of sexual organs , such as kidneys, ureters, bladder or prostate, urinary tract, blood or albumin in the urine or other disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f. the metabolism or blood , such as diabetes mellitus, elevated cholesterol, gout, thyroid gland or hormonal disturbances, anemia, coagulation disturbances or other disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g. the immune system or infectious diseases , such as AIDS, HIV, sexually transmitted diseases, hepatitis, tropical diseases or other disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
h. the skin , such as eczema, allergies, psoriasis, fungal diseases, skin cancer or other disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
i. the musculoskeletal system , (bones, joints, spine, intervertebral discs, muscles, ligaments, tendons), such as disorders of the back, neck and shoulders, arthritis, rheumatism or other disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
j. the eyes , such as decreased visual acuity or refraction power, retinal disease or other disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

	Policyholder		Partner		Child 1		Child 2	
Name	<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
Date of birth (d - m - y)	<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
k. the ears , hearing difficulties, inflammation or other disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
l. other illnesses , disturbances or problems not listed above, such as congenital defects, deformities, tumours, cancers, etc?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you had any accidents , injuries or poisonings which necessitated a hospital stay or operation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. a. Have you been examined, received treatment or been operated on in hospital or similar institution?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Have you been advised to take a rest, diet, withdrawal or other cure, or is such a cure planned?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Is a hospital stay or operation planned?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Have you been treated by or consulted any of the following in the last 5 years:								
• psychotherapist? (e.g. psychiatrist, psychologist)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• chiropractors, physiotherapists?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Have you ever been given or prescribed a drug for a period in excess of 4 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f. Have you ever had radiation treatment (x-ray or radioactive substances)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you undergone any special examinations /tests during the last 5 years, such as x-rays, computed tomography, MRI (magnetic resonance imaging), ultrasound, echo, electrocardiogram, electroencephalogram, endoscopy or other tests?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you had an AIDS test that showed an HIV-positive or possibly positive result?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. a. Do you practise sports?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Do you take painkillers, sleeping tablets, tranquillisers or other medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Do you take or have you taken any narcotics (drugs)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. a. Which physician did you last consult?	<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
b. Have you consulted any physicians in the last 5 years not already mentioned?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Which physician is most familiar with your medical history?	<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
10. For female persons only:								
a. are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
if yes, has the pregnancy been normal to date?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. have you ever had a gynaecological disorder or a disease of the breast?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. have you undergone or do you plan to undergo (any) infertility treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

