

Please make sure this form is signed and duly completed (in capitals) by the applicant. The applicant or intermediary should return this form, along with all the supporting documentation, to:

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

Approved intermediary ExpatPlus:

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1. Policyholder details

Last name		First name	
Title		Date of birth (d - m - y) / /	
Marital status		Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Occupation		Host country	
Does your occupation include aerial, underground, under or above water activities? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Nationality		Passport no.	
Home country address			
Postal code	Town / City	Country / State	
Host country address			
Postal code	Town / City	Country / State	
Home telephone		Business telephone	
Mobile number		Fax	
Home e-mail		Business e-mail	

2. Company details (if applicable)

Company name		
Address		
Postal code	Town / City	Country / State

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. Policy start date

Start date (d - m - y)

5. Your ExpatPlus insurance

Area of cover	<input type="checkbox"/> Worldwide	<input type="checkbox"/> Worldwide excl. USA & Canada					
Core Plan		Globe <input type="checkbox"/>	Orbit <input type="checkbox"/>	Universe <input type="checkbox"/>			
Deductible	€ 0 / £ 0 / \$ 0 / CHF 0	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Outpatient care	€ 100 / £ 65 / \$ 125 / CHF 150	<input type="checkbox"/>	<input type="checkbox"/>	NA			
	€ 300 / £ 200 / \$ 375 / CHF 450	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	€ 500 / £ 325 / \$ 625 / CHF 750	NA	NA	<input type="checkbox"/>			
	€ 1,000 / £ 650 / \$ 1,250 / CHF 1,500	NA	NA	<input type="checkbox"/>			
Additional Insurances ¹	Dental Care ²	Basic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		Comprehensive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Accidental Death and Dismemberment		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	With insured capital of € / £ / \$ / CHF			
	Temporary Incapacity ⁴		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
With monthly allowance of € / £ / \$ / CHF				
Permanent Disability ⁵		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Currency of payment		<input type="checkbox"/> EUR	<input type="checkbox"/> GBP	<input type="checkbox"/> USD	<input type="checkbox"/> CHF		
Settlement notes online in following language		<input type="checkbox"/> EN	<input type="checkbox"/> FR	<input type="checkbox"/> DE	<input type="checkbox"/> NL	<input type="checkbox"/> ES	<input type="checkbox"/> IT

6. Nomination of beneficiaries (to be completed if you take the Additional Insurance Accident Death and Dimemberment)

I declare that in the event of death, any indemnities to which I am entitled by virtue of the ExpatPlus insurance to be paid to the listed persons below or, failing this, to my legal heirs. The nomination of the beneficiaries in the event of death can only be modified by the undersigned.

Last name	First name	Relation	Proportion of capital (%)

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.

7. Payment details

Bank Transfer	<input type="checkbox"/> Annual	<input type="checkbox"/> Half yearly	<input type="checkbox"/> Quarterly
Credit card	<input type="checkbox"/> Annual	<input type="checkbox"/> Half yearly	<input type="checkbox"/> Quarterly

8. Credit card authority

Credit card	<input type="checkbox"/> Mastercard	<input type="checkbox"/> VISA	<input type="checkbox"/> Eurocard	<input type="checkbox"/> AMEX
Credit card number	Expiry date		CVC code ⁶	
Cardholder's name ⁷				
Address cardholder (if different from address on p. 1)				

I grant Vanbreda International, a power of attorney, as of today and until further notice, to collect all invoices in my name.
I will advise Vanbreda International immediately if the card becomes lost, stolen or if I wish to close my card account or cancel the authority.

Date	Cardholder's authorisation signature ⁷
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9. Bank account information (for the reimbursement of medical expenses)

Account holder name	
Account no. (IBAN no. for European countries)	
Full bank name and address	
BIC / SWIFT code	ID Bank (if applicable)

10. Declaration

- I hereby apply for cover on behalf of all the persons named in this application form.
- I declare that the answers given are to the best of my knowledge full, true and complete and have checked and found correct any answers and statements in this application that are not in my own handwriting.
- I accept that this policy will be subject to the policy terms and conditions effective at the time of policy commencement. I confirm that I have read and understand the full definitions, benefits, exclusions and conditions of this policy.
- 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) processing and giving effect to credit card payment, 3) providing marketing material in respect of insurance related services of Vanbreda International or it's associated companies and 4) processing claims or analysing the insurance.
- 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	Signature of applicant
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⁶ CVC Code (Card Verification Code): the 3 last numbers of the code on the back of your card.

⁷ To be completed only if the cardholder is not the addressee of the premium requests.

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

