APPLICATION FORM FOR GROUP HEALTH INSURANCE



Employee	e: Group Hea	nber:		Tas	sk:			Firm Na		
	the form with cap ty card. If your fa									
	lidate's name	Nationality	R.T. Identity No.			1	Father's Name	Marital Status	Height/ Weight	For women: Are you pregnant?
Employee:				//		M \square F]	M□S□	cm/kg	
Spouse:	Spouse:			//		M \square F			cm/kg	
1st child:	· .			//		M 🗆 F]		cm/kg	
2nd child:				//		M 🗆 F]		cm/kg	
3rd child:				//		M \square F			cm/kg	
Contact In employee's the policy. number an	eign citizens, fore formation: For n family and if the In case it is forwa d e-mail address d e-mail address	notification ere are not arded colle and in c	is to the insur tifications to the ectively by the F	rees, the e e employee Policy Owne	employee's s, they are er, it expres	CONT consid	ACT INFO ered as m employed	RMATIO nade to c e's office	other family address, r	members i nobile phon
Province			District			Qı	ıarter			
Town			Street				Alley			
Site			Apt.				Block/Apt. No.			
Door No.			Flat No.				Postal Code			
Home Tel No.	(0)		Office Tel No.	(0).		M	obile Phone I	No. (0)	
Office e-mail			Other e-mails							
Insured em	ployee's bank ac	count info	rmation for the	indemnity	payments	:				
IBAN No.	TR									
If it is a joi	nt account, the a	ccount ho	olders' names:							
Are you insured in scope of SGK? Y N If yes, Social Security Number:						umber:				
If until now you have a private health and/or life insurance and/or a rejected application at our company or another insurance company, please write the company name and its period.										
	CLARATION (Ple									
Is there any operation, disease/disorder which were underwent previously or any disease/disorder which is continuing its follow-up and treatment or any health complaint which was not applied to a physician for the persons to be insured (employee and their dependants)?										
No, In case the	If yes, please health group is r	mark fron	n following hea list, please spe	ecify details	by using '	other"	box.Pleas	se enclos	se the repo	rts
	reports, patholog							e group	marked.	
 1. Lung / Respiratory Tract Diseases 3. Nose, Head, Sinus, Concha Diseases 5. Joint Diseases (Knee, Hip, Shoulder, etc.) 					 2. Intestinal diseases 4. Dermatologic and/or Lymphatic Gland Diseases 6. Eye Diseases 					
7. Benign cyst, bulk/tumor 9. Endocrine System Disease (such as Hormonal Diseases)					8. Blood Diseases10. Muscular, Bone Diseases (including Fractures and dislocations)					
11. Breast Diseases 12.					12. Prostate and Testis Disease					
13. Uterus and Ovary Diseases					14. Nervous System, Brain/Cerebrovascular Diseases					
☐ 15. High Blood Pressure☐ 17. Anorectal Disorders (such as Hemorrhoid, Fistula)					☐ 16. Varicose vein☐ 18. Kidney and Urinary Tract Disorders					
19. Growth and Developmental Delay					20. Congenital, Genetic Diseases					
21. Hernia (such as Inguinal, Umbilical Hernia)				2:	22. All kind of cancer, malignant characterized tumors					
23. Cardiovascular Diseases					24. Ear-Balance Disorders					
25. Liver, Gall, Pancreas, Spleen Diseases27. Spinal Diseases (Neck, Back, Waist)					26. Diabetes, Insulin Resistance, Glucose Metabolism Disorders28. Psychiatric Diseases					
29. Rheumatic Diseases					30. Oesophagus, Stomach, Duodenum Diseases					
31. Thy	roid and Parathyi	3:	32. Other,							

Please explain the details below by specifying the disease group number above-marked according to the insuree candidates.

Name-Surname	No:	Disease	Date of Diagnosis	Method of Treatment	Date of Treatment	Examination	Actual Situation

DECLARATION AND COMMITMENT

I hereby accept, declare and undertake in advance following articles for me and my family members who I want to be insured in accordance with this Application Form which consisting 2 pages which I have filled completely by accepting the insurance conditions.

Assessment of the Application:

I accept, declare and undertake that Allianz Sigorta A.Ş. (Allianz) did not make a commitment upon the Form was filled by me; the information and documents forwarded by the Form, the policy scope and content will be assessed and its validity will be determined in frame of the Policy Special Conditions and if any, the Protocol, the Health Insurance General Conditions, the risk assessment principles of Allianz; it may do any transaction without the information and documents from companies which I had made insurance policies previously; in this scope, Allianz reserves its rights for changing the policy premiums, applying exception and/or extra disease premium or not accepting the application;

Full, Correct and Complete Information:

All information above-mentioned is full, correct and complete; there is no any information which I hesitate to share by considering as unimportant; I do not hide any situation which it must be known by Allianz; I know any diseases/disorders which are current on the signature date of the Form and/or previous diseases/disorders will not be included in the coverage and I accept it; in case there are questions which not marked on the Form, answer of this question will be considered as "no"; I know that in case there is any deficient and fault data on the Form and/or in the process of assessment of the application or before it, because of the diseases/disorders determined from information and documents from previous insurance company, Allianz have rights to not issue a policy on behalf of me, if a policy is issued, to not pay any indemnify or to give up the insurance under the Turkish Commercial Code, Policy Special and General Conditions; in case there is any deficient data on the Form and/or additional examination is requested by Allianz, after the requested documents arrive to Allianz and are assessed by it, it will be determined whether I will include in the policy;

Sharing of Information:

I authorize Allianz to provide and share data and documents by examining at R.T Prime Ministry Treasury Undersecretariat, Health Insurance Information and Observation Center (SBGM), Insurance Union of Turkey (Insurance Reinsurance and Pension Companies Union of Turkey), all health corporations and institutions in frame of relevant legal regulations including insurance legislation, relevant regulations, health legislation; therefore I will not claim against the company and private and public health institutions, physicians and other relevant corporations which share my health information and I will not make any legal and penal attempt against such corporations;

Communication Permits:

I agree that my personal information forwarded in scope of the contract/policy to be issued by and provided by Allianz Sigorta A.Ş. from relevant persons and corporations may be used in order to give general information, benefit from suitable products, improvement, advantage or campaigns in accordance with my requirements and to provide all kind of information to me and my personal information may be shared by Allianz Sigorta A.Ş. with Allianz Hayat ve Emeklilik A.Ş., Allianz Yaşam ve Emeklilik A.Ş. and their agencies and agencies and contracted business partners of Allianz Sigorta A.Ş. in accordance with it; visual and voice messages, presentation and marketing posts can be forwarded to me by Allianz Sigorta A.Ş., Allianz Hayat ve Emeklilik A.Ş. and Allianz Yaşam ve Emeklilik A.Ş. and their agencies directly or through MMS, telephone, fax, automatic calling machines, electronic mail and similar communication channels containing SMS, photo, animation, short message, multimedia objects; I know I have right to object to all data, voice, visual, etc. messages completely or according to products or channel when I want. Right of Objection:

I accept, declare and undertake that I know that the policy with all Special and General Conditions will ensure about me if I do not object to Allianz within maximum 30 days as from the issued.

Declaration Holder's (*):		
Name-Surname:	Date of Form Declaration):	Signature (Declaration Holder)

(*) One of 18 age and above insuree candidates or under 18 age insuree candidate's parents)

Allianz Sigorta A.Ş.

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