


This application concerns the Healthcare Insurance

Please answer the questions in capital letters with a black or blue ballpoint pen. With this form, you can apply for a Healthcare Insurance if you comply with at least one of the following conditions:

- you live in the Netherlands
- you work in the Netherlands (with an employment contract)
- you pay income taxes in the Netherlands

The start date of your insurance policy is January 1st of the year in question. Exceptions are described in the general terms and conditions. You can change health insurer every year.

Start date: (dd-mm-jjjj)

Registration date: (dd-mm-jjjj)

Details of agent (to be filled in by agent)

Agent number:

Client number:

Details of collectivity

Collectivity number:

Staff number (if applicable):

Declaration number/business line no.
(if applicable)

Policyholder details
1 The policyholder is the person applying for the insurance

| | | |
|------------------------------------|--|--|
| Initials <input type="text"/> | Prefix <input type="text"/> | Surname <input type="text"/> |
| Date of birth <input type="text"/> | Gender <input type="radio"/> M <input type="radio"/> F | Customer no. (if known) <input type="text"/> |
| Street name <input type="text"/> | House no. <input type="text"/> | Floor no. <input type="text"/> |
| Postal code <input type="text"/> | City <input type="text"/> | Country <input type="text"/> |
| Telnr. 1 <input type="text"/> | Telnr. 2 <input type="text"/> | Soc. sec. number <input type="text"/> |
| Email address <input type="text"/> | | |

By filling in your email address you give Nationale-Nederlanden permission to use your email address for correspondence

Name of employer/business unit/office

Are you taking out insurance for yourself? ☐ Yes ☐ No

Details of the person to be insured

| Family member no. | Initials | Prefix | Surname | Date of birth | Gender | Social security number |
|-------------------|----------------------|----------------------|----------------------|----------------------|---|------------------------|
| 2 | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="radio"/> M <input type="radio"/> F | <input type="text"/> |
| 3 | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="radio"/> M <input type="radio"/> F | <input type="text"/> |
| 4 | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="radio"/> M <input type="radio"/> F | <input type="text"/> |
| 5 | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="radio"/> M <input type="radio"/> F | <input type="text"/> |

1 Insurance details

Indicate below which deductible and which additional insurance you wish to choose.

Deductible € 385 € 485 € 585 € 685 € 785 € 885

Excess

The deductible is the amount that you pay yourself on a yearly basis if you incur medical expenses. The higher the deductible, the lower the premium. For insured persons aged 18 and above there is a compulsory deductible of € 385 per year. If you want a higher deductible, please indicate your choice. The choice includes the € 385 compulsory deductible. The deductible is not applicable to the additional insurance.

| | |
|---------------------|----------------------|
| Family member no. 1 | <input type="text"/> |
| Family member no. 2 | <input type="text"/> |
| Family member no. 3 | <input type="text"/> |
| Family member no. 4 | <input type="text"/> |
| Family member no. 5 | <input type="text"/> |

Additional insurance

Please indicate in the opposite table which additional insurance you wish to purchase. The additional policie Combi cover you for dental charges. You cannot take out additional dental insurance with this policy.

| Family member no: | 1 | 2 | 3 | 4 | 5 |
|---------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| No coverage desired | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Desired coverage | | | | | |
| Start | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Extra | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Compleet | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Combi | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

TandenGaaf

If you opt for a TandenGaaf product with a maximum amount of € 1.000 or € 1.500 Nationale-Nederlanden will need a dentist's statement for the medical assessment. Your dentist will need to complete and sign this statement. We will send the statement to you.

| Family member no: | 1 | 2 | 3 | 4 | 5 |
|----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| No coverage desired | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Desired coverage | | | | | |
| TandenGaaf € 250,- | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| TandenGaaf € 500,- | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| TandenGaaf € 1.000,- | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| TandenGaaf € 1.500,- | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Luxury care
(for insured persons over the age of 18)

| Family member no.: | 1 | 2 | 3 | 4 | 5 |
|--------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| No cover desired | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Cover desired | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

2 How would you like to pay the premium?

Explanation of question 2: With automatic debit orders, Nationale-Nederlanden will be entitled to debit your bank account (IBAN) for all amounts that pertain to your health insurance premium. You will need to sign a separate authorisation form for this purpose. We will send this form to you. The account number for which the authorisation is given must be the policyholder's own account number. This authorisation can always be withdrawn at a later stage. We will also use your account number for payments owed to you.

- a ☐ Monthly ☐ Quarterly ☐ Every six months ☐ Annually
- b ☐ Direct debit ☐ Acceptgiro
- c What is your bank account number? (IBAN) _____
- d BIC? * _____

**This only needs to be filled in for non-Dutch bank accounts*

3 Current insurance

- a Who is your current Health insurer? _____ Registration no. _____
- b How are you currently insured? ☐ Individually ☐ Collectively ☐ Overseas ☐ Not insured
- c Have you acquired your current health insurance yourself (in your own name) or through someone else (e.g. a parent, or your spouse or partner)?
☐ Self ☐ Through someone else

4 Cancellation of current insurance

With this application, I give Nationale-Nederlanden permission to cancel the main Health Insurance policy and any additional Health Insurances at my current Health Insurer. I also give this permission on behalf of all other persons mentioned on this form. If you do not wish for Nationale-Nederlanden to cancel all insurances for all persons, please indicate below which insurance Nationale-Nederlanden should cancel and for whom.

| | Name | Date of birth | Main insurance | Additional insurance |
|---|-------|---------------|----------------|----------------------|
| 1 | _____ | _____ | _____ | _____ |
| 2 | _____ | _____ | _____ | _____ |
| 3 | _____ | _____ | _____ | _____ |
| 4 | _____ | _____ | _____ | _____ |
| 5 | _____ | _____ | _____ | _____ |

5 Do one or more of the persons to be insured obtain incomes from abroad?

Explanation for question 5: Income from abroad is income from work or social security benefits in another country.

- ☐ No ☐ Yes, the following:
- | | | | |
|---------------|-------|---------------|-------|
| Date of birth | _____ | Date of birth | _____ |
| Date of birth | _____ | Date of birth | _____ |

6 Are all the persons to be insured Dutch citizens?

Explanation of question 6: In a number of cases Nationale-Nederlanden requires additional documents for insured persons. If you are an EU or EEA national and have a BSN (citizen service number) you do not need to send any additional documents. If you are NOT an EU or EEA national, please send a copy of your passport, a copy of your residence permit for the country of residence and, if necessary, a valid work permit.

- ☐ Yes ☐ No, the following do not:
- | | | | |
|---------------|-------|-------------|-------|
| Date of birth | _____ | Nationality | _____ |
| Date of birth | _____ | Nationality | _____ |
| Date of birth | _____ | Nationality | _____ |
| Date of birth | _____ | Nationality | _____ |

External Reference Register

We will verify your details, upon registration, via External Reference Register (EVR - Extern Verwijzingsregister). Any registered frauds may have consequences for your supplemental Insurance.

Signature

The undersigned declares to have answered all questions on this application form accurately, fully and truthfully. This application form is the basis of the health insurance and any potential additional insurance agreements which are concluded with Centrale Zorgverzekeringen NZV NV, Chamber of Commerce number 27118912 under the applicable conditions. This public limited company (NV) is part of the CZ group in Tilburg. The undersigned hereby declares his/her agreement.

| | | |
|-------|-------|-----------|
| Place | Date | Signature |
| _____ | _____ | _____ |

Please sent this form to: Nationale-Nederlanden, Postbus 4016, 5004 JA Tilburg

The information provided by the policyholder and the insured person(s) to Nationale-Nederlanden is primarily intended to be used by Nationale-Nederlanden for the assessment of the risk which is to be insured. Following the establishment of the insurance policy, the information may be used for the execution of the insurance and the related service provision, the management of the resultant relations, as well as for activities aimed responsible operational management, the continuity of the insurance company, the prevention and combating of fraud and the fulfillment of legal obligations. Nationale-Nederlanden provides this health insurance agreement. Dutch law is applicable to this agreement. If you have any complaints, you should contact the Executive Board. If you are not in agreement with the decision of the Board of Management, you can submit your complaint to the mediation body 'Klachten en Geschillen Gezondheidszorg (SKGZ)' (see article A23 of the General Conditions).