

HEALTH INSURANCE APPLICATION FORM

ESPACIO RESERVADO
PARA LA ETIQUETA



DKV Integral • DKV Modular • DKV Mundisalud
DKV Residentes • DKV Top Health®

(Only complete white boxes, shaded boxes will be completed by the appropriate department of DKV Seguros.)

Branch	Office	Line	Number	Order	Client N°	Effective date	Expiry date	1st receipt.
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
						Day Month Year	Day Month Year	

Name of work centre Work centre code

(only complete for supplement application)

Branch	Office	Product	Policy N°	Order	Effective date of supplement	<input type="checkbox"/> Inclusion
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Exclusion
					Day Month Year	<input type="checkbox"/> Modificacion

Policy Holder (capitals)

Surname or company name Name

ID n° Address Post Code

City/Town Province/County Tel Mobile Tel.

Fax Fecha nacimiento Means of contact: Tel mobile Fax E-mail E-mail-work

E-mail-work @ E-mail personal @

Male Female Nationality Code Employed Self Salaried Castilian Catalan Galician Basque German English

Profession

Substitutes the policy: Branch Office Line Number Order

Do you wish to receive detailed information of medical visits (only for DKV Integral and DKV Modular) Yes No E.C. Yes No

Company codes

Period Charge Admin. Agency Charge Agency Policy/Receipt No Yes

Payment account IBAN

Refund account IBAN

Health insurance modality you wish to take out

DKV Integral Complet Plus Classic Élite

Optional module. Refund for gynaecology, obstetrics and paediatrics

DKV Modular (Mark the selected coverage with an "X" Please select at least one health and one accident coverage)

Health Coverage:

Primary Care Specialists and other means of diagnosis Hospital Care Health care in the event of an accident

Accident coverage: Basic: 1 2 3 4 5

DKV Mundisalud

Complet Plus Classic: A) total refund of medical expenses B) refund of hospital medical expenses

Elite Combinado Elección

DKV Residentes Basic coverage Basic coverage + Repatriation Basic coverage + Repatriation + Best care

DKV Top Health® Without excess 600 EUR Excess 1.200 EUR Excess

For all the modalities (Modular and Mundisalud with complete health coverage):

Do you wish to select coverage in the DKV Health Care Network, paying an extra premium and the corresponding risk selection, alterations to health (illnesses or injuries) and /or medical conditions (pregnancy) prior to contracting the health insurance?

Yes No

Total Premium

Take good care of yourself

a member of **MUNICH HEALTH**

2DNP1.FM/01_V111
DKV Seguros y Reaseguros, S.A.E. Torre DKV, Avda. María Zambrano, 31. 50018 Zaragoza, inscrita en el Registro Mercantil de la Provincia de Zaragoza, tomo 1.711, folio 214, hoja n.º Z-15.152. CIF: A-50004209
Mod. RE SOL-00001/January 2016

Insured persons (Indicate code for each person for their sex and relationship)

Relationship

[0] Holder [1] Spouse [2] Son [3] Daughter [4] Father [5] Mother [7] Other Sex [H] Male [M] Female

1) Surname

Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Sex	Relationship	DOB	ID N°	Nationality	Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Day Month Year

Profession

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

2) Surname

Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Sex	Relationship	DOB	ID N°	Nationality	Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Day Month Year

Profession

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

3) Surname

Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Sex	Relationship	DOB	ID N°	Nationality	Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Day Month Year

Profession

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

4) Surname

Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Sex	Relationship	DOB	ID N°	Nationality	Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Day Month Year

Profession

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

5) Surname

Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Sex	Relationship	DOB	ID N°	Nationality	Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Day Month Year

Profession

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

6) Surname

Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Sex	Relationship	DOB	ID N°	Nationality	Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Day Month Year

Profession

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

7) Surname

Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Sex	Relationship	DOB	ID N°	Nationality	Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Day Month Year

Profession

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

8) Surname

Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Sex	Relationship	DOB	ID N°	Nationality	Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Day Month Year

Profession

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

PRELIMINARY INFORMATION FOR THE POLICY HOLDER

Preliminary clause

This contract is subject to Insurance Contract Law 50/1980 dated October 8. The control of the activities of the insurance company DKV Seguros y Reaseguros S.A.E. (henceforth DKV Seguros) situated at Torre DKV, Avda. María Zambrano 31, 50018 Zaragoza corresponds to the Kingdom of Spain, and in particular to the Ministry of Economy via the General Directorate of Insurance and Pension Funds.

The Application, Health Declaration, the separate General, Particular and Special Conditions and the related Supplements or Appendices are integral parts of the contract. The transcriptions or references to legal precepts require no acceptance.

For the resolution of any conflicts that may arise with DKV Seguros, the policy holders of the insurance policy, beneficiaries, affected third parties or representatives of any of these, can make their complaint in the following ways:

- > Visiting any of DKV Seguros' offices or sending the complaint by mail or fax to the Clients' Attention Service at the address: Torre DKV, Avda. María Zambrano, 31, (50018 Zaragoza), telephone 902 499 499 - 913 438 596 - 934 797 539, fax 976 28 91 35, or via e-mail by sending it to: defensacliente@dkvseguros.es. The client can select the way and address to which he would like the reply to be sent. The complaint will be answered in writing within two months. The Regulations of DKV Seguros Clients' Attention Service are available from DKV Seguros' offices.
- > Once this term has lapsed and if the client is not fully satisfied with the proposed solution, he may visit the Commissioner for the Defence of Clients of Financial Services, situated at Pº. de la Castellana 44, (28046 Madrid), where on showing the previous procedure made to DKV Seguros, he will be able to make an official appeal.
- > In addition to the described complaints procedures, the client may also bring a legal claim before the corresponding Courts.

Protection of personal data

The policy holder declares that he is aware, in an expressed and precise way, of the existence of a file belonging to DKV Seguros. This file comprises personal data for processing (including health data) provided in the health application and, where applicable, that of reports or medical examinations, besides that obtained during the validity of the contract in order to fulfil its objectives.

The personal data will be processed for the following purposes:

- a) For administrative purposes of the activities of the insurance company. This administration represents, among other functions, those of the evaluation and limitation of the risk, the claims procedure, the payment of the premium, the payment of benefits, the administration of preventive plans and health promotion and additional services to the policy. To do so, personal data may be given to those providing insurance services, to the co-insurer and/or re-insurer of the risk, to the mediator that intermediates in the negotiation of the insurance contract and to the financial entities through which payments for the premiums and the compensation must be made. Similarly, for statistical purposes or for fighting against fraud, personal data may be made available to insurance companies that form part of the DKV Seguros and also to files linked to the insurance sector.
- b) To inform clients about products, preventive plans and promotion of health and services. To do so, personal data may be made available to other companies that form part of the DKV Seguros and /or to other companies linked to DKV Seguros, or which collaborate with them in the promotion and marketing of products and services that may be of the client's interest.

The policy holder is obliged to inform the other insured persons and beneficiaries that their personal data has been collected for processing by DKV Seguros.

To exercise your rights to access, modify, cancel or oppose your personal data, you should contact DKV Seguros (Departamento Legal), Apartado de Correos 8021 (50018 Zaragoza) or via e-mail on arco@dkvseguros.es.

Authorisation of access to health information

Henceforth and during the validity of the contract, the insured persons authorise DKV Seguros, with the aim of evaluating, defining, updating and administering the risk, anticipate the illness and promote health, to check the data necessary regarding their state of health, from present or past insurance contracts, and medical reports provided by professionals and health care centres that they have attended.

Similarly, according to Articles 16.3 and 18 of the Law of Insurance Contracts during the validity of the contract, the insured persons authorise the medical services of DKV Seguros to collect, directly from professionals, data or medical information, with the sole purpose of negotiating, settling and auditing the insurance contract. Health care professionals that have examined, advised and treated the insured persons are specifically released from their professional code of secrecy and are authorised to provide DKV Seguros with precise information, even when the insured persons have died.

Ratification and closing of the insurance contract

By means of his signature, the policy holder ratifies and expresses his conformity with all the statements given in the insurance application whose content he is aware of, understands and accepts. He also recognises having received the relative preliminary information for the particular nature of the insurance policy. The policy holder ratifies, particularly, the clauses relating to the treatment and protection of personal data and authorisation of access to health information, confirms the state of health of the insured persons -stated although not having been supplied personally by himself- and declares that neither concealment nor circumstances exist that can influence the evaluation of the risk covered by DKV Seguros or the rejection of the coverage requested.

In addition, he declares that he is aware that DKV will not cover any service derived from or related to health states prior to the contracting of the policy that are not reflected in the health declaration.

_____, _____ of _____ 201_____ Policy holder's signature

Dental health questionnaire (only for Top Health and Residentes).

If you answer yes to any of the following questions, please complete the table below.

**SPACE RESERVED
FOR LABEL**

1. When did the patient receive his last dental treatment? What was it for?

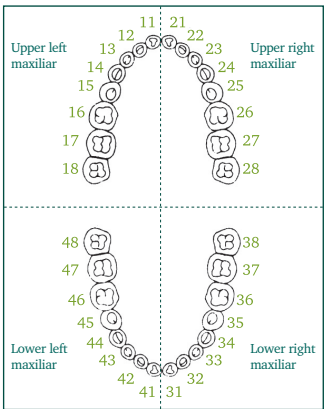
	Date	Motive
Insured person nº 1	_____	_____
Insured person nº 2	_____	_____
Insured person nº 3	_____	_____
Insured person nº 4	_____	_____
Insured person nº 5	_____	_____
Insured person nº 6	_____	_____
Insured person nº 7	_____	_____
Insured person nº 8	_____	_____

2. Has the patient received, in the last 3 years, regular preventative check-ups? Please indicate treatment.

	Yes	No	
Insured person nº 1	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insured person nº 1	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insured person nº 1	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insured person nº 1	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insured person nº 1	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insured person nº 1	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insured person nº 1	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insured person nº 1	<input type="checkbox"/>	<input type="checkbox"/>	_____

3. Are you waiting to receive, or have planned to receive any dental treatment. What kind of treatment?

	Yes	No	
Insured person nº 1	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insured person nº 2	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insured person nº 3	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insured person nº 4	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insured person nº 5	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insured person nº 6	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insured person nº 7	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insured person nº 8	<input type="checkbox"/>	<input type="checkbox"/>	_____



Present dental state (table of numbered teeth and references to damage)

- A = missing
- B = damaged or imperfect
- C = replaced or repaired

Nº insured person	1	2	3	4	5	6	7	8
Tooth/damage	/	/	/	/	/	/	/	/
	/	/	/	/	/	/	/	/
	/	/	/	/	/	/	/	/
	/	/	/	/	/	/	/	/
	/	/	/	/	/	/	/	/
	/	/	/	/	/	/	/	/

The policy holder/insured person declares that the data supplied regarding the insured persons' state of health is truthful and that no concealment or circumstances exists that may affect the calculation of the risk covered by the company or the rejection of the coverage requested.

Signed in _____ on _____ 20

Policy holder's signature