IMPORTANT INFORMATION FOR FILING APPLICATIONS

In order to provide for a smooth processing of your insurance application, we kindly ask you to observe and check the following points:

Completion of Application Documents

- ☐ You have filled in **all the information in the application completely** and in **block letters**, and you have the **signatures of the applicant** and of **all persons of legal age to be insured**.
- ☐ You - and, if applicable, all persons of full age to be insured - have signed the **application** and thereby acknowledged and accepted the **Terms and conditions of insurance** as well as the **Explanations on the legal particularities of a group insurance policy**.
- ☐ You - and, if applicable, all persons 16 years of age or older who are to be insured - have signed the **Statement of consent in accordance with the GDPR** and the **Release from secrecy** obligations.
- ☐ You - and, if applicable, all persons of full age to be insured - have conscientiously completed and signed the **Information on the state of health**. You have also read and accepted the information on the consequences of incorrect statements.
- ☐ You have chosen a **payment method** and provided **all necessary information**. All required signatures are present, especially if the account holder is different.

With respect to the insurance products EXPAT GERMANY, EXPAT PRIVATE Premium and EXPAT INFINITY, please note as follows:

- ✔ EXPAT GERMANY: In the event that the person to be insured has, upon commencement of insurance coverage, already stayed **in Germany for a period of more than 31 days**, a **health certificate** or evidence supporting a German **prior insurance** must be submitted. At the time of application, the health certificate must not be older than 14 days.
- ✔ EXPAT FLEXIBLE: For ages 50 and older, **Information on the state of health** must be submitted with the application.
- ✔ EXPAT PRIVATE Premium: **Information on the state of health** must be submitted together with the application. As from an age of **50 years**, a health certificate that must not be older than three months at the time of application is to be filed.
- ✔ EXPAT INFINITY: **Information on the state of health** must be submitted together with the application. From the age of **60 years**, a health certificate not older than three months at the time of application is also required.

Completion of the Health Certificate

- ☐ The health certificate has been drawn up in a clearly legible manner in the German or English language and all necessary signatures of the examining physicians have been made.
- ☐ Each individual question has been answered.
- ☐ Questions answered with “yes” or questions indicating a diagnostic finding have been explained in more detail.
- ☐ For the supplementary modules EXPAT GERMANY PLUS as well as for the product variants EXPAT INFINITY CLASSIC and EXPAT INFINITY PREMIUM a dental status has been prepared.
- ☐ The name and the complete address of the treating primary physician have been indicated.
- ☐ For the case that inpatient treatments (hospital stays) have taken place, the findings report and the discharge report have been attached to the application.

One more recommendation: If we have any further questions with respect to the information to be rendered by you we kindly ask you to answer them within the terms set forth by us so that your insurance coverage can commence on the desired date.

Thank you very much for your cooperation!

State: 01.12.2021

APPLICATION FOR HEALTH INSURANCE

for stays abroad of up to 60 months

Affiliate ID	

leave blank if not available

Applicant/Person to be Insured

Surname		Sex	☐ m ☐ f
First name(s)			
Date of birth (dd.mm.yyy)		Nationality	
Complete address		Phone	
		Fax	
		E-mail	
Current profession			

Insured Person

If you as Applicant are also the Insured Person please render the following additional information:

Product selected: EXPAT FLEXIBLE	☐ BASIS ☐ PLUS		
Planned country of stay			
Scope of Application	☐ Zone 1		☐ Zone 2
Monthly premium in Euros		Desired commencement date for the insurance (dd/mm/yyyy)	

Is there another current health insurance?	☐ yes ☐ no	If so, please indicate as follows:	Name of insurance	
			Insurance number	
			Insured period (dd/mm/yyyy to dd/mm/yyyy)	

Details of the insured persons:

Please ensure that the personal details such as surname, first name and date of birth match the details from the identity card or passport.

Place, date

Signatures
(Applicant, if appropriate as legal representative of persons to be co-insured and all persons of full legal age to be insured)

State: 01.01.2023 • Insurer: Allianz Partners AWP Health & Life • Policyholder: BDAE Expat GmbH

Relatives to be Co-Insured

Relative 1

Surname		Sex	☐ m ☐ f
First name(s)			
Date of birth (dd.mm.yyy)		Nationality	

Product selected: EXPAT FLEXIBLE	☐ BASIS ☐ PLUS		
Planned country of stay			
Scope of Application	☐ Zone 1	☐ Zone 2	
Monthly premium in Euros		Desired commencement date for the insurance (dd/mm/yyyy)	

Is there another current health insurance?	☐ yes ☐ no	If so, please indicate as follows:	Name of insurance	
			Insurance number	
			Insured period (dd/mm/yyyy to dd/mm/yyyy)	

Relative 2

Surname		Sex	☐ m ☐ f
First name(s)			
Date of birth (dd.mm.yyy)		Nationality	

Product selected: EXPAT FLEXIBLE	☐ BASIS ☐ PLUS		
Planned country of stay			
Scope pf Application	☐ Zone 1	☐ Zone 2	
Monthly premium in Euros		Desired commencement date for the insurance (dd/mm/yyyy)	

Is there another current health insurance?	☐ yes ☐ no	If so, please indicate as follows:	Name of insurance	
			Insurance number	
			Insured period (dd/mm/yyyy to dd/mm/yyyy)	

Place, date

Signatures
(Applicant, if appropriate as legal representative of persons to be co-insured and all persons of full legal age to be insured)

State: 01.01.2023 • Insurer: Allianz Partners AWP Health & Life • Policyholder: BDAE Expat GmbH

Information on Payment Procedures

☐ Direct Debiting

Please fill in the attached SEPA direct debiting mandate and send it back to us together with the application.

☐ Remittance (in advance)

Payment method	☐ annually ☐ twice a year (+ 2 %)

☐ Credit Card (+ 6 %)

Surname, First name(s) of credit card holder			
Credit card	☐ Master-/Eurocard ☐ Visa ☐ Diners	valid	
Card number		Payment	☐ annually ☐ twice a year (+ 2 %)

For reasons of security, we furthermore need your credit card check digits. Please inform us about this number by phone under +49-40-30 68 74-0 or send us a separate e-mail to info@bdae.com (The credit card number should not be specified in this context!). According to data protection provisions, please be advised that a transmission by e-mail shall take place in an unencrypted form.

Place, date

Signature of Credit Card Holder

Host country at the time of conclusion of this insurance
(To be indicated in any case)

Place, date

Signatures
(Applicant, if appropriate as legal representative of persons to be co-insured and all persons of full legal age to be insured)

State: 01.01.2023 • Insurer: Allianz Partners AWP Health & Life • Policyholder: BDAE Expat GmbH

SEPA DIRECT DEBIT MANDATE

I hereby authorise BDAE Holding GmbH, in turn authorised by BDAE Expat GmbH for contract management and collection, to collect payments owed by me from my account by means of direct debiting.

At the same time, I instruct my financial institution to honour direct debits drawn by BDAE Holding GmbH for the insurer.

Collection shall be identifiable on the basis of the Creditor Identifier DE23ZZZ00000131378 and the personal mandate reference number shown in the confirmation of cover. Depending on the chosen payment method, collection shall take place on the 1st day of each month.

Please note: I shall be entitled to request the refund of the debited amount within a term of eight weeks commencing on the date of debiting. In this context, the terms and conditions agreed upon with my financial institution shall apply.

In the event that the funds on my account are insufficient, the financial institution in charge of my account shall not be obliged to honour the direct debit. Partial payments shall be excluded from direct debiting procedures.

In addition, the following regulations shall apply:

- Depending on the payment method elected below, the total amount shall be paid in advance in each case.

The person owing the premiums shall, towards the policyholder, be the person entitled to be insured and, towards the insurer, the policyholder.

- The premium shall be due for payment after receipt of the confirmation of cover, but in no case later than as to the inception date. I am aware that the policyholder will refrain from registering or will deregister the aforementioned persons as insured persons with the insurer if the amount to be paid, inclusive of ancillary costs, fails to be paid or to be paid completely for reasons the person entitled to be insured is to be made responsible for. I am aware that no insurance coverage shall exist in such case.
- In the event that the person paying the premium is not identical with the person entitled to be insured / the insured person, the person entitled to be insured / the insured person shall be obliged to give the premium-paying person notice of the rendered information.
- Advance information on the collection of the owed amounts shall be given in the confirmation of cover addressed to the person entitled to be insured. In this context, the premium amounts, the due dates, the Creditor Identifier and the mandate reference number shall be indicated.

Applicable to premiums as from (dd/mm/yyyy)				
Information on the person paying the premium	Surname		Sex	☐ m ☐ f
	First name(s)			
	Complete Address			
	Phone			
	IBAN			
	BIC/SWIFT		Bank	
	Payment method	☐ annually	☐ twice a year (+ 2 %)	☐ quarterly (+ 3 %) ☐ monthly (+ 5 %)

Information on the insured person	Surname (if different from the person paying the premium)		Sex	☐ m ☐ f
	First name(s) (if different from the person paying the premium)			
	Date of birth (dd/mm/yyyy)		Insurance number(s) (if available)	

Place, date

Signature of Account Holder

State: 30.09.2019

INFORMATION ON THE STATE OF HEALTH

Person to be Insured:

Surname		Date of birth (dd/mm/yyyy)	
First name(s)			

If you are 50 years of age or older, you must complete the health information and submit it with the application. They are used to determine whether it is possible to take out this insurance.

			Answer
1.a	Please indicate your height and weight	Body height	
		Body weight	
1.b	Are there any infirmities, organ defects, anomalies, prostheses (e.g. leg or knee prostheses, artificial joints), body implants (e.g. breast implants, pacemakers), disabilities, invalidity, occupational disease, occupational disability and/or military service injuries?		☐ yes ☐ no
1.c	Are **outpatient or inpatient treatments**, examinations (including check-ups and pregnancy examinations, with the exception of statutory preventive examinations for the early detection of illnesses) or **operations** planned or recommended? This also includes the regular intake of medication, so-called long-term medication		☐ yes ☐ no
1.d	Have you been diagnosed with an **immune defence, metabolic or respiratory disease** in the last 5 years and/or have you undergone appropriate treatment or follow-up examinations? Examples: Diabetes mellitus (diabetes), chronic lung diseases (e.g. asthma, COPD, pulmonary fibrosis, obstructive sleep apnoea syndrome), sarcoidosis, immunodeficiencies, HIV		☐ yes ☐ no
1.e	Have you been diagnosed with a **disease of the cardiovascular system, internal organs or blood vessels** in the last 5 years and/or have you undergone appropriate treatment or follow-up examinations? Examples: Coronary heart disease (CHD), heart failure, heart attack, arterial occlusive disease, arteriosclerosis (hardening of the arteries), aneurysm, liver disease, pancreatic disease, kidney dysfunction, organ or tissue transplantation, chronic inflammatory bowel disease (e.g. Crohn's disease, ulcerative colitis)		☐ yes ☐ no
1.f	Have you been diagnosed with a **disease of the nervous system, the psyche or the brain** in the last 5 years and/or have you undergone appropriate treatment or follow-up examinations? Examples: Alcohol, drug or medication addiction, chronic diseases of the nervous system or the psyche (e.g. Alzheimer's, neuropathy, polyneuropathy, dementia), spinal cord diseases, craniocerebral trauma, cerebral circulatory disorders, cerebrovascular diseases (e.g. stroke - also TIA, apoplexy cerebral haemorrhage), epilepsy, paralysis (also polio), brain power disorder		☐ yes ☐ no
1.g	Have you been diagnosed with **cancer or a disease of the bones, joints or musculoskeletal system** in the last 5 years and/or have you undergone appropriate treatment or follow-up examinations? Examples: Malignant tumours, leukaemia, arm and/or leg amputations, osteoporosis, arthritis, arthrosis, rheumatism, fibromyalgia, gout, chronic illnesses (lasting longer than 3 months/12 weeks or described as chronic or recurring, e.g. tension, back pain, slipped discs) of the spine.		☐ yes ☐ no

Important note regarding your health status information

Please note that it is very important that you provide information about your health status and the health status of the persons to be persons to be insured with you conscientiously and, above all, truthfully.

In the „Explanatory notes on the legal particularities of group insurance and on the obligations the German Insurance Contract Act (VVG)", we have described the main consequences of an incorrect answer. Please note that incorrect information will threaten the insurance coverage applied for.

If you have any questions, please contact our customer service or your insurance broker.

State: 01.05.2024

Place, Date

Signature (of the Insured Person or its legal representative)