global health

Foyer Group

Application for health insurance

- [x] New client
- [ ] Existing client of Foyer S.A., if yes, please indicate the client reference
- [ ] Individual
- [ ] Group, group contract partner

Foyer Santé S.A.
12, rue Léon Laval - L-3372 Leudelange
Adresse postale: L-2986 Luxembourg - Tél.: +352 437 43 4245 - e-mail: sales@foyerglobalhealth.com - www.foyerglobalhealth.com
R.C.S. Luxembourg B 72153 - TVA LU 181 857 30

Application for health insurance

Please note: We will not be able to process your application if any columns are left incomplete.
Please refer to the terms and conditions before completing this form.

I hereby apply for a health insurance contract for the persons to be insured as listed below.

1. Policyholders personal details

◯ I act as the policyholder only
◯ I act as both policyholder and insured person

Desired start date of insurance coverage (dd/mm/yyyy)		
Title	First Name	Title First Name Surname
Gender ◯ M ◯ F	Date of Birth (dd/mm/yyyy)	Occupation
Correspondence Address	Address	
Contact details	Business Phone	Private phone
	Mobile number (+ country code / area code)	
	E-mail address	
Nationality		
Country of origin		Locality
Country of expatriation		Locality

Contractual language (all correspondence / documents will be provided in this language)

◯ German ◯ English ◯ French

2. Persons to be insured

Person 2

Start date of insurance coverage (dd/mm/yyyy)		
Title	First Name	Title First Name Surname
Gender ◯ M ◯ F	Date of Birth (dd/mm/yyyy)	Occupation
Correspondence Address ◯ same as person1	Town / city	Postal / zip / area code
	Country	additional address details
Données de contact ◯ same as person1	Business Phone	Private phone
	Mobile number (+ country code / area code)	
	E-mail address	
Nationality		
Country of origin		Locality
Country of expatriation		Locality

Person 3

Start date of insurance coverage (dd/mm/yyyy)		
Title	First Name	Title First Name Surname
Gender ◯ M ◯ F	Date of Birth (dd/mm/yyyy)	Occupation
Correspondence Address ◯ same as person1	Town / city	Postal / zip / area code
	Country	additional address details
Données de contact ◯ same as person1	Business Phone	Private phone
	Mobile number (+ country code / area code)	
	E-mail address	
Nationality		
Country of origin		Locality
Country of expatriation		Locality

Person 4

Start date of insurance coverage (dd/mm/yyyy)		
Title	First Name	Title First Name Surname
Gender ◯ M ◯ F	Date of Birth (dd/mm/yyyy)	Occupation
Correspondence Address ◯ same as person1	Town / city	Postal / zip / area code
	Country	additional address details
Données de contact ◯ same as person1	Business Phone	Private phone
	Mobile number (+ country code / area code)	
	E-mail address	
Nationality		
Country of origin		Locality
Country of expatriation		Locality

3. Plan level and geographical area

Person	Plan level			additional Assistance*	Region	Premium (monthly)
	Essentiel	Special	Exclusive			
1	**Deductible:** ◯ None ◯ 250 € ◯ 500 € ◯ 1 000 €	**Deductible:** ◯ None ◯ 250 € ◯ 500 € ◯ 1 000 €	**Deductible:** ◯ None ◯ 250 € ◯ 500 € ◯ 1 000 €	◯ no ◯ yes	◯ worldwide ◯ worldwide excl. USA	
2	**Deductible:** ◯ None ◯ 250 € ◯ 500 € ◯ 1 000 €	**Deductible:** ◯ None ◯ 250 € ◯ 500 € ◯ 1 000 €	**Deductible:** ◯ None ◯ 250 € ◯ 500 € ◯ 1 000 €	◯ no ◯ yes	◯ worldwide ◯ worldwide excl. USA	
3	**Deductible:** ◯ None ◯ 250 € ◯ 500 € ◯ 1 000 €	**Deductible:** ◯ None ◯ 250 € ◯ 500 € ◯ 1 000 €	**Deductible:** ◯ None ◯ 250 € ◯ 500 € ◯ 1 000 €	◯ no ◯ yes	◯ worldwide ◯ worldwide excl. USA	
4	**Deductible:** ◯ None ◯ 250 € ◯ 500 € ◯ 1 000 €	**Deductible:** ◯ None ◯ 250 € ◯ 500 € ◯ 1 000 €	**Deductible:** ◯ None ◯ 250 € ◯ 500 € ◯ 1 000 €	◯ no ◯ yes	◯ worldwide ◯ worldwide excl. USA	
					Total amount ** for all insured persons:	

*** the monthly premium for the additional assistance package amounts to 5 Euros. Please add to your monthly premium if applicable.**
**** I am informed that depending on the country of expatriation taxes and fees might be added to the premium.**

4. Data concerning the state of health

◯ Moratorium (coverage only available if you and all the persons to be insured are at the age of 55 or under at the date of application)
I am not required to fill in the health questions below and understand that pre-existing medical conditions and related conditions are not covered for a qualifying period of at least 24 months.

	Person 1	Person 2	Person 3	Person 4
4.1. Height in cm				
4.2. Weight in kg				
4.3. Do you currently have any afflictions, diseases or health troubles?	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
4.4. Do you regularly take any medication? If yes, which one(s)?	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
4.5. Do you have a disability, a total or temporary invalidity to work? If yes, at what degree?	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
4.6. Do you have any handicaps, any malformation or any prosthesis?	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
4.7. Have you stayed in a hospital, a sanatorium or another medical institution in the last 5 years?	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
4.8. Have you had any afflictions, diseases or troubles following an accident over the last 3 years? (Even if they haven't been treated).	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
4.9. Have you followed any treatments over the last 3 years? (Also psychotherapy) or exams of any kind? Have there been any consequences?	◯ no ◯ yes ◯ no ◯ yes	◯ no ◯ yes ◯ no ◯ yes	◯ no ◯ yes ◯ no ◯ yes	◯ no ◯ yes ◯ no ◯ yes
4.10. Are there any necessary, planned or advised treatments or operations? (including dental treatments, dental prosthesis or orthodontic treatments)	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
4.11. Are you currently pregnant? If yes, what is the estimated due date?	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
4.12. Have you been diagnosed with an HIV infection, for ex. following an AIDS test?	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
4.13. Are you using any vision aids? (Glasses or contact lenses)? • Dioptre on the right: • Dioptre on the left:	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
4.14 Are you missing any teeth, – with the exception of wisdom teeth - that have not been replaced? Number of missing teeth?	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes

Please give further details concerning the questions that you answered with "yes". In that case please answer the following questions: What was the diagnosis? What was the date of the treatment? Who is treating you/ treated you? (Information concerning the doctor / Heilpraktiker (healer) / name of the hospital etc. including the address). What medication is/ was necessary?
In case the space for the answers is not sufficient please use a separate sheet as an annex to the application for health insurance.
Annexed sheet?
◯ no ◯ yes

Person	Concerning question n°	Type of disease, troubles, afflictions (please indicate the exact diagnosis), possibly denomination of prescribed medication	Duration of the treatment From ... until ...	Treating doctor, hospital (name and address)	Are any other treatments planned?
					◯ no ◯ yes
					◯ no ◯ yes
					◯ no ◯ yes
					◯ no ◯ yes
					◯ no ◯ yes
					◯ no ◯ yes

5. Did or does a statutory or private health insurance exist with another insurer? Or have you applied for another one?

	Person 1	Person 2	Person 3	Person 4
If yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes	◯ no ◯ yes
Name and address of the company				
Duration from ... until ...				

6. Payment of premiums

a) Payment frequency

☑ monthly (only possible for direct debit and credit card) ◯ quarterly ◯ semi-annually ◯ annually

b) Payment method

◯ Bank Transfer (Only possible for quarterly, bi-annual (2% discount) or annual (3% discount) payments)

◯ **Credit Card**
Together with your welcome package you will receive a link to a secure webpage where you will be prompted to enter credit card details in order to activate insurance coverage. Please note that the following loadings are added to the premium when paid with credit card depending on the frequency of payment: 0% for yearly payment, 2% for half-yearly payment and 4% for quarterly and monthly payment.

◯ **Direct debit SEPA** (applies only for Euro premiums within the Eurozone*). Please complete the SEPA Direct Debit Mandate (page 7) and return with the application form. A 2% discount applies to bi-annual payments and a 3% discount applies to annual payments.
*Eurozone includes: Austria, Belguim, Cyprus, Estonia, Finland, France, Germany, Greece, Italy, Latvia, Luxembourg, Malta, Netherlands, Portugal, Republic of Ireland, Slovakia, Slovenia, Spain.

7. Bank account for reimbursements

One account must be specified for reimbursements by the policyholder if available.

Account holder	Name of bank
Account No.	Branch No. (BLZ)
Postal / zip / area code / Town / city	Country
Swift (BIC)	IBAN
Currency	

8. Special conventions: (subject to written approval of FOYER SANTE)

9. Broker

This contract has been concluded in cooperation with

Broker name ERICON broker GmbH (200164) via Finance Consult Maklerpool

Broker number 5769

10. Basis of the contract and declaration of the policyholder and the persons to be insured.

This application for insurance commits neither the policyholder nor Foyer Santé to conclude the contract. Within 30 days of reception of the application Foyer Santé is obliged under penalty of paying damages to notify the policyholder either an insurance offer, the subordination of the insurance on a medical control or the refusal to insure. The application for insurance including the health questionnary and other medical information provided top Foyer Santé serve as a basis of the insurance contract and will be part thereof.

The policyholder and the persons to be insured are held to reply in all sincerity, scrupulously and exhaustively to all questions in this application. All changes in the state of health that could occur between the signature of the present application and the conclusion of the insurance contract as well as any treatments, consultations and exams (including those that were intended or recommended) and any modification of the professional activity are immediately to be declared in writing to Foyer Santé.

The persons to be insured respectively the legal representatives of minors authorize Foyer Santé to obtain further information at any time regarding diseases, troubles following an accident, previous and existing afflictions that could occur until the expiration of the contract. With that objective Foyer Santé has the right to question doctors, dentists and the members of other health professions as well as all medical establishments. For this purpose the persons to be insured expressly release them of their professional secrecy – also beyond their death.

Concerning the insured persons, other than the policyholder, in case where the latter would ask to benefit from a household view for "Espace Client Foyer" they consent to the inclusion of the data concerning them and relative to the conclusion and execution of the aforementioned contract by signing the present application.

11. Signature(s)

Location and date

Signature of the policyholder (name and first name)

Signature of person 1 to be insured, if not the policyholder (name and first name), his legal representative (if applicable)

Signature of person 3 to be insured, if not the policyholder (name and first name), his legal representative (if applicable)

Signature of person 2 to be insured, if not the policyholder (name and first name), his legal representative (if applicable)

Signature of person 4 to be insured, if not the policyholder (name and first name), his legal representative (if applicable)

FS18DA-ANV1Eng

European Direct Debit / S€PA Direct Debit

MANDATE BUSINESS CORE

Please return to:

service@foyerglobalhealth.com
Or by post to:
Foyer SA
Comptabilité Clients
12, rue Léon Laval
L-3372 LEUDELANGE

Mandate Reference

L	F	S	-																												

Identification of the creditor party (A)

Creditor Identifier	L	U	7	3	Z	Z	Z	0	0	0	0	0	0	0	0	0	6	3	9	9	0	0	2	0	0	8

Name of the creditor	FOYER SANTE SA
Address	12, RUE LEON LAVAL L-3372 LEUDELANGE

Type of payment	◯ Recurrent payment

Identification of the policy holder (B)

Policyholder's name	
Address	

Account number - IBAN																								
Swift BIC																								

Account holder's details. Full address only if different from the policyholder.

Account holder's name	
Address	

By signing this mandate form, you authorise (A) FOYER SANTE SA to send instructions to your bank to debit your account (B) and your bank to debit your account in accordance with the instructions from FOYER SANTE SA.

As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited.

Date and location in

Signature(s)