Evolution Health Plan (EU) Germany

FMU

morganprice europe

Application form

Part A

Please complete all parts of this form and return it to your agent/ insurance broker. It is important that you complete this Application Form fully. Failure to do so may result in the form being returned to you for completion.

This Application Form asks questions that are material to both the risk underwritten and the calculation of the premium by SI Insurance (Europe), SA (the "Insurer"). You must take care when answering any questions the Insurer asks by ensuring that all the information provided is accurate and complete (the 'Duty'), and the Duty applies when the policy is varied or renewed.

If you answer the questions incorrectly or incompletely, the Insurer can withdraw from the contract and be exempt from benefits in the event of intentional or grossly negligent breach of the duty of disclosure. If the breach of the duty of disclosure is neither intentional nor grossly negligent, the Insurer can terminate the contract or continue it under changed conditions.

All Application Forms are reviewed prior to acceptance and therefore no cover shall be granted until confirmation is provided.

Please indicate that you agree to communicate with Insurers in respect of this Application Form and all subsequent communications in the English language: I consent ◯ I do not consent ◯

1 Your personal details

Title | Forename(s) | Surname/Family Name

Date of birth | Gender | Height | Weight

Overseas address | Post/Zip code

Phone | Mob | Email

Home address | Post/Zip code

Occupation | Nationality

Home country *(for which you have a passport)*

Country for which this cover is required *(where you will be spending most of you time)*?

How long have you been resident in your country of residence *(years/months)*?

2 Cover required

Date upon which annual cover to commence, or the date on which your proposal is accepted by insurers, whichever is the later

Choose your geographical area of cover	Europe ◯	Worldwide excluding USA, China, Singapore & Hong Kong ◯	Worldwide excluding USA ◯	Worldwide ◯

Choose your level of cover: Standard ◯ Standard Plus ◯ Comprehensive ◯ Premium ◯ Elite ◯

2 Cover required — continued

Please select the annual excess you wish to apply to your policy

Nil ◯ 100 ◯ 250 ◯ 500 ◯ 1000 ◯
2500 ◯ 5000 ◯ 7500 ◯ 10000 ◯

In addition you may select a co-insurance applicable to out-patient claims only. In effect this is a percentage of each out-patient claim for which you are responsible.

Nil co-insurance ◯ 10% co-insurance ◯ 20% co-insurance ◯

N.B. This option is not applicable to the Standard level of cover as there are no out-patient benefits on Standard.

Home country evacuation module (120 adult/75 child) ☐

Please specify the currency in which you wish to pay premiums and receive benefits — US Dollar $ ◯ Sterling £ ◯ Euro € ◯

Do you or any of the persons to be included in this proposal, have existing health insurance? Yes ◯ No ◯

If yes, which provider?

To avoid any delays and ensure that we can process your application swiftly and efficiently - Please ensure that you include the following items with your application:

- Copy of passport

Have you or any of the people to be included in the proposal, ever been refused cover by an insurance company or been accepted on special terms? *(If yes provide details on a separate sheet)* Yes ◯ No ◯

3 Dependants to be included

	Full name of dependants	Relationship to proposer	D.O.B	Nationality	Gender	Height	Weight	Occupation
Spouse								
Dep. 1								
Dep. 2								

Please provide us with the name and address of your regular personal or family doctor/physician. If you do not have a regular doctor, please give the last doctor you visited and approximate date. - If there is a different doctor for each applicant, please provide all details and indicate which physician applies to each applicant.

NB. This must be supplied for us to be able to process your application

4 Payment method

Please specify how you would like to pay

- Annually by credit/debit card ◯
- Semi annual by credit/debit card ◯
- Quarterly by credit/debit card ◯
- Monthly by credit/debit card ◯
- Annually by bank transfer *- details supplied on request* ◯
- Monthly by direct debit *- only available in the EU on Euro policies only* ◯

Service fees - credit/debit card & SEPA Direct Debits

Annual payment	0%
Semi annual payments	+4%
Quarterly payments	+5%
Monthly payments	+8%

- If paying by credit/debit card please complete attached payment form

Service fees - bank transfer

Annual bank transfer £10/€15/$30

The bank transfer fee does not need to be included as long as the payee selects to pay all charges.

5 Declaration

For the purpose of this declaration, ("I/We") means any insured person intended to benefit from insurance cover as per the policy wording.

a. I/We have been provided with a copy and read the EVOLUTION HEALTH POLICY (Germany - 2023) and IPID and I/we understand it to be part of the contract of insurance. In particular I/We have read, understandand accept the definitions, benefits and exclusions of the policy.
b. I/We have read, understand and accept Section 6 of this application form on data protection.
c. I/We am consenting for my/our insurance broker to act on my behalf for the purposes of transferring sensitive data.
d. To the best of my/our knowledge and belief the information given in connection with this application form, whether in my hand or not, is true and I/we have answered all questions asked in this application form honestly and fully. I/We also understand that I/we must tell the insurer straight away if anything that I/we have already told the insurer changes. I/we understand that non-disclosure or misrepresentation of any facts may entitle the insurer to void the insurance. This application form and the information provided contains statements upon which the Insurer will rely in deciding whether to accept this insurance and in determining the terms and conditions of such acceptance.
e. I/We understand that the signing of this application form does not bind me/us to complete, or the insurer to accept this insurance.
f. If I/we have elected to pay our premium by instalments using credit or debit cards and Morgan Price have agreed to this, I/we authorise Morgan Price to continue to deduct such instalments as and when they become due unless I/we cancel this credit/debit card authorisation by giving at least 14 days notice in writing. I/we understand that if I/we have made a claim, no refund will be due and I/we will have to pay any outstanding instalments due in the current period of cover.
g. I/We am authorised to sign this application form on behalf of all my/our dependents declared at Section 3 of this Application Form.
h. I/We consent to communicate with Insurers in the English language in respect of this Application Form including all subsequent communications.

Signature of primary applicant ✗ _____ Date _____

6 Data Protection & Professional Secrecy

Data Protection

SI Insurance (Europe), SA part of the Sompo International [1] group, records and holds data in accordance with data protection legislation and for more detail about how Sompo International uses your personal information can be found within the policy wording and on its website at https://www.sompo-intl.com/privacy-policies/.

[1] The term "Sompo International" refers to and includes each and every subsidiary of Sompo International Holdings Ltd., a Bermuda exempted company ("SIHL"). To the extent, however, that an affiliate of SIHL that is not a subsidiary of SIHL receives or uses personal information that is covered by this Policy and requires protection under the Data Protection Legislation, then such affiliate is included within "Sompo International" for purposes of protecting the data that such affiliate receives or uses. For a list of Sompo International offices, please see https://www.sompo-intl.com/location/corporate. For a list of affiliates that are included in the Sompo Group, please see https://www.sompo-hd.com/en/group/group_list/.

Luxembourg Professional Secrecy

Sompo International has chosen SI Insurance (Europe), SA, a Luxembourg based and wholly owned subsidiary of Sompo International Holdings Ltd., to insure the risks located in the EEA. As such, this proposal/insurance policy will be subject to the Luxembourg professional secrecy rules. All insurance industry professionals in Luxembourg are required to maintain the confidentiality of the information entrusted to them during the exercise of their mandate or as part of their professional duties. By way of derogation, SI Insurance (Europe), SA may transfer this information to the entities in charge of the provision of outsourced services on behalf of the insurer. The service providers are subject to an obligation of professional secrecy or bound by a confidentiality agreement.

By signing the application form for (re)insurance or the (re)insurance contract, or the payment of the policy premium, the policyholder accepts the sharing of the information covered by Luxembourg professional secrecy with SI Insurance (Europe), SA's service providers to the extent it is needed for the service outsourcing. More details can be found on http://www.sompo-intl.com/locations/luxembourg"www.sompo-intl.com/locations/luxembourg.

FOR OFFICE USE ONLY!

Policy No. _____

Surname: _____

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7. Confidential medical declaration

Part B

Please answer the following health questions completely and correctly and also state what you consider to be unimportant circumstances. If you answer one or more of these questions incompletely or incorrectly, SI Insurance (Europe), SA depending on the degree of fault may withdraw from the contract or terminate it, adjust it or refuse to perform it. Please also see the detailed instructions before the signature line.

Important: You and the persons applying for cover under this policy must declare to us any and all known pre-existing medical conditions. If you do not tell us, your policy may be cancelled and any claim you make may not be paid.

		Policyholder	Spouse	Dep. 1	Dep. 2
1.	Are any medical/surgical/dental consultations and/or procedures (including x-ray, lab or other testing) recommended, scheduled or contemplated for any applicant?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
	Additional information MUST be provided here if "Yes" is answered.				
2.	Has any applicant ever been refused medical or dental insurance, or ever had a policy postponed, rated or accepted on special terms?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
	Additional information MUST be provided here if "Yes" is answered.				
3.	Has any applicant been examined by, consulted with, or received medical treatment from a medical professional in the last 12 months?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
	Additional information MUST be provided here if "Yes" is answered.				
4.	Has any applicant been examined by, consulted with, or received medical treatment from a medical specialist or consultant in the last 5 years?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
	Additional information MUST be provided here if "Yes" is answered.				
5.	Has any applicant been confined (stayed overnight) in a hospital, clinic, sanatorium, or other treatment facility in the last 5 years?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
	Additional information MUST be provided here if "Yes" is answered.				

6. Has any applicant had any disease or impairment of or suffered any symptoms or required any medication, treatment or hospital consultation(s) for the following? - *Please answer all questions.*
Please note that if you answer yes to any of these questions, you MUST provide further details in the additional information section.

6.1.	AIDS/ARC/HIV	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.2.	Alcohol dependency or drug/substance abuse	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯

		Policyholder	Spouse	Dep. 1	Dep. 2
6.3.	Anaemia or any blood disorder	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.4.	Arthritis, or any disorder of any muscles or joints	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.5.	Asthma, bronchitis or any other respiratory disorder	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.6.	Back/spine/neck	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.7.	Blood pressure/hypertension *If yes, please complete our hypertension questionnaire*	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.8.	Blood vessels/clots/circulatory system	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.9.	Bones (including fractures)	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.10.	Brain/head	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.11.	Cancer, tumour, growth or cyst *If yes, please complete our cancer questionnaire*	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.12.	Carpal tunnel syndrome	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.13.	Cerebrovascular disease/disorder or stroke	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.14.	Chest pains, palpitations, heart murmur, angina, heart attack or any other heart disorder	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.15.	Cholesterol/Hypercholesterolemia *If yes, please complete our cholesterol questionnaire*	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.16.	Cystic fibrosis	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.17.	Dental/gum disease	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.18.	Diabetes (including where under control by medication) *If yes, please complete our diabetes questionnaire*	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.19.	Ears, eyes, nose or throat	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.20.	Epilepsy, convulsions, seizures, fits	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.21.	Gastrointestinal disorder (stomach/intestines)	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.22.	Gout	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.23.	Hernia	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
	If yes, please state the type of hernia i.e inguinal				
6.24.	Immune system disorder	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.25.	Injury, operation, physical defect or deformity	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯

		Policyholder	Spouse	Dep. 1	Dep. 2
6.26.	Kidney/bladder/urinary tract	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.27.	Liver, gall-bladder, pancreas or spleen	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.28.	Lungs/breathing	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.29.	Mental/nervous disorder	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.30.	Neurological/nervous system	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.31.	Paralysis	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.32.	Prostate	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.33.	Rheumatic fever	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.34.	Reproductive disorder or infertility	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.35.	Skin	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.36.	Sleep disorder	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.37.	Stroke	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.38.	Surgical operation	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.39.	Ulcer	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.40.	Thyroid (including where under control by medication) *If yes, please complete our thyroid questionnaire*	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.41.	Urinary abnormality	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.42.	Other medical condition not listed	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.43.	Are you currently undergoing or been advised to undergo any dental treatment?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.44.	Have you smoked, used tobacco or nicotine replacements in the last 12 months? If so, how many per day?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.45.	Do you have any known allergies, including food allergies?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.46.	Have you suffered any symptoms for which you have not sought medical advice?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.47.	Do you have any known check-ups or doctor appointments pending now or in the future?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.48.	Are you currently under the care of any specialist? (e.g. a cardiologist or oncologist)	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
6.49.	Are you currently pregnant?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯

Additional information

If you answered "Yes" to any of the questions in Section 7, you MUST complete the additional information below. If you require additional space, please continue on a separate sheet.

	Question no.	Name of illness/medical condition*	Dates (to and from)	What medical treatment was provided?	Current medication name and daily dose	Have you had any hospital stay in relation to this condition?	What is the current status of the condition?**
Policyholder							
Spouse							
Dep. 1							
Dep. 2							

*Where applicable, please state the area of the body affected (e.g. left or right arm)
**Please enter either Complete Recovery, Ongoing or Recurrent (or likely to recur)

8 Notification of breach of the duty to disclose in accordance with Sec. 19 Para. 5 Insurance Contract Act (Versicherungsvertragsgesetz – VVG)

The above health questions must be answered correctly and completely (duty of disclosure).

If you answer the questions incorrectly or incompletely, SI Insurance (Europe), SA can withdraw from the contract and be exempt from benefits in the event of intentional or grossly negligent breach of the duty of disclosure. If the breach of the duty of disclosure is neither intentional nor grossly negligent, the insurer can terminate the contract or continue it under changed conditions.

9 Instruction pursuant to Sec 19 para. 5 VVG on the consequences of a breach of the statutory duty of disclosure

What are the pre-contractual duties of disclosure?
Until you submit your contract declaration, you are obliged to truthfully and completely disclose all risk-related circumstances known to you about which you are asked in text form. If the insurer asks you in text form about risk-related circumstances after your contract declaration but before contract acceptance, you are also obliged to provide truthful and complete information in this respect.

What consequences can arise if a pre-contractual duty of disclosure is breached?

1. **Withdrawal and lapse of insurance cover**
   If you breach the pre-contractual duty of disclosure, the insurer may withdraw from the contract. This does not apply if you prove that there was neither intent nor gross negligence. In the event of a grossly negligent breach of the duty of disclosure, the insurer has no right of withdrawal if it would have concluded the contract even if it had known of the non-disclosed circumstances, albeit under different conditions. In the event of withdrawal, there is no insurance cover. If the insurer declares withdrawal after the occurrence of the insured event, it shall nevertheless remain obliged to pay benefits if you prove that the circumstance not or incorrectly disclosed was not the cause
   neither for the occurrence nor the determination of the insured event
   nor for the determination or the scope of the insurer's duty to indemnify.

   However, the obligation to pay benefits does not apply if you have fraudulently breached the duty of disclosure. In the event of a withdrawal, the insurer is entitled to that part of the premium which corresponds to the contract period which has expired by the time the declaration of withdrawal becomes effective.

2. **Termination**
   If the insurer cannot withdraw from the contract because you have only breached the pre-contractual duty of disclosure through simple negligence or without fault, the insurer may terminate the contract by giving one month's notice. The right of cancellation is excluded if the insurer would have concluded the contract even if it had known about the non-disclosed circumstances, albeit under different conditions.

3. **Contract amendment/adjustment**
   If the insurer cannot withdraw from or terminate the contract of the duty of disclosure because he would have concluded the contract even if he had known about the non-disclosed risk circumstances, albeit under different conditions, the other conditions become part of the contract at its request. If you have negligently breached the duty of disclosure, the other conditions shall retroactively become part of the contract. If the premium increases by more than 10% as a result of the contract amendment or if the insurer excludes the risk coverage for the non-disclosed circumstance, you may terminate the contract without notice within one month after receipt of the insurer's notification of the contract amendment. You will be informed of this right in the insurer's notification.

4. **Exercise of rights by the insurer**
   The insurer may only assert its rights to withdraw, terminate or amend the contract in writing within one month. The period shall commence at the time when the insurer becomes aware of the breach of the duty of disclosure giving rise to the right they are asserting. When exercising their rights, the insurer must state the circumstances on which it bases its declaration. The insurer may subsequently state further circumstances to substantiate the claim if the time limit in accordance with sentence 1 has not elapsed for these. The insurer may not invoke the rights of withdrawal, termination or contract amendment if it was aware of the undisclosed risk circumstance or the incorrectness of the disclosure. The rights to withdraw from the contract, to terminate the contract and to amend the contract expire five years after conclusion of the contract. This does not apply to insured events that occurred before the expiry of this period. The period is ten years if you have intentionally or fraudulently breached the duty of disclosure.

5. **Representation by another person**
   If you are represented by another person when concluding the contract, the knowledge and fraudulent intent of your representative as well as your own knowledge and fraudulent intent must be taken into account with regard to the duty of disclosure, withdrawal, termination, amendment of the contract and the preclusion period for exercising the insurer's rights. You can only rely on the fact that the duty of disclosure was not breached intentionally or through gross negligence if neither your representative nor you are guilty of intent or gross negligence.