membercareinsurance

Applicationform

Select a package	: Basic / Standard / Select	Please circle your choice
Last name	: _____	
First name	: _____	
Gender	: Male / Female	Please circle your choice
Date of Birth (dd-mm-yyyy)	: _____ - _____ - _____	
Nationality	: _____	
Address in country of origin	: _____	
Zip / Postal code	: _____	
Name of city / town	: _____	
Country	: _____	
Contact address: same as address of origin?	: Yes / No	Please circle your choice, if 'no' please write the contactdetails in the fields following
Contact address	: _____	
Zip / postal code	: _____	
Name of city / town	: _____	
Country	: _____	
Country of destination	: _____	
Email	: _____	
Email validation	: _____	
Telephone number	: _____	+ country code, area code, phonenumber
During the last three years, have you been treated by a medical specialist	: Yes / No	If the answer is yes, we will contact you
Do you use any medicines	: Yes / No	If the answer is yes, we will contact you
Are you affected by anemia, any kind of blood disease, diabetes, kidney problems, overweight (or high level of cholesterol), hepatitis (A, B or C) or HIV / AIDS?	: Yes / No	If the answer is yes, we will contact you
Do you expect the need of a specialist shortly?	: Yes / No	If the answer is yes, we will contact you
Date to start the insurance	: _____ - _____ - _____	dd-mm-yyyy
Member of organisation	: _____	
Would you like us to renew your policy automatically?	: Yes / No	Please circle your choice
I accept the acceptation en policy conditons*	: Yes / No	Please circle your choice

* Please sign the acceptation conditions and return the signed form together with this form

After we received your payment, we will send you the policy