

Received by DKV Globality S.A.:

Date/ Person responsible



Application for health insurance

Globality YouGenio®

**DKV Globality S.A.**

13, rue Edward Steichen · L-2540 Luxembourg

Phone: +352 270 444 3602, e-mail: [service-yougenio@dkv-globality.com](mailto:service-yougenio@dkv-globality.com)

**DKV Globality S.A.**

Board of Management: Thomas Merten, Wolfgang Diels, Horst Weber  
Register of Companies: B 134471

## Application for health insurance (individual insurance)

I herewith apply for conclusion of a health insurance contract in accordance with Globality YouGenio® for the persons listed under Person 1, 2, 3, 4.

### A. Particulars concerning the applicant

First name(s) / Surname		Title	Date of birth (DD/MM/YYYY)	Inception of insurance
Sex <input type="checkbox"/> male <input type="checkbox"/> female	Nationality	Occupation		Professional status
Building/floor	Street and house number	Postcode and town		Country and region
Mobile phone (+ country code)		Fax (+ country code and local dialling code)		E-mail
<input type="checkbox"/> New (not yet customer of DKV Globality S.A.)		<input type="checkbox"/> Existing customer of DKV Globality S.A. / Insurance No.		Completion of risk assessment based on medical history required (cf. F.) <input type="checkbox"/> Yes <input type="checkbox"/> No

### B. Particulars concerning the insured persons

Person	First name(s) / Surname	Title	Hus-band/Wife	Non-marital partner	Child	Applicant	Date of birth	Sex		Nationality	Occupation	Inception of insurance
								m	f			
1			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>			
2			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>			
3			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>			
4			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>			

### C. Further particulars concerning the insured persons

Country of future residence:

Home country:

Contractual language / language for communication:

All the required information will be provided in this language.

- German  
 English  
 French  
 Spanish

### D. Plan levels and geographical areas for Globality YouGenio®

Person	Plan level	Deductible in €*	Geographical area	Premium in €
1	<input type="checkbox"/> Classic <input type="checkbox"/> Plus <input type="checkbox"/> Top	<input type="checkbox"/> None <input type="checkbox"/> 250 <input type="checkbox"/> 500 <input type="checkbox"/> 1.000	<input type="checkbox"/> None USA <input type="checkbox"/> Incl. USA	
2	<input type="checkbox"/> Classic <input type="checkbox"/> Plus <input type="checkbox"/> Top	<input type="checkbox"/> None <input type="checkbox"/> 250 <input type="checkbox"/> 500 <input type="checkbox"/> 1.000	<input type="checkbox"/> None USA <input type="checkbox"/> Incl. USA	
3	<input type="checkbox"/> Classic <input type="checkbox"/> Plus <input type="checkbox"/> Top	<input type="checkbox"/> None <input type="checkbox"/> 250 <input type="checkbox"/> 500 <input type="checkbox"/> 1.000	<input type="checkbox"/> None USA <input type="checkbox"/> Incl. USA	
4	<input type="checkbox"/> Classic <input type="checkbox"/> Plus <input type="checkbox"/> Top	<input type="checkbox"/> None <input type="checkbox"/> 250 <input type="checkbox"/> 500 <input type="checkbox"/> 1.000	<input type="checkbox"/> None USA <input type="checkbox"/> Incl. USA	
*Classic level only with a deductible of € 250.				Total premium:

### E. Miscellaneous information

Do you have or have you ever had health insurance cover elsewhere?

Person	Insurer	Period (from – to)
1 <input type="checkbox"/> No <input type="checkbox"/> Yes		
2 <input type="checkbox"/> No <input type="checkbox"/> Yes		
3 <input type="checkbox"/> No <input type="checkbox"/> Yes		
4 <input type="checkbox"/> No <input type="checkbox"/> Yes		



## H. Payment of premiums

<b>Payment to be made by</b> <input type="checkbox"/> Applicant	<b>Premiums to be paid</b> <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Half-yearly <input type="checkbox"/> Yearly
<b>Premium to be remitted to DKV Globality S.A.</b> BGL Luxembourg · IBAN: LU090030309301020000 · WL BIC Code BGLLLULL	

Credit card	<input type="checkbox"/> Premium debit <input type="checkbox"/> Credit payments	<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express				
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; padding: 2px;">Card No.</td> <td style="padding: 2px;">Valid thru</td> </tr> <tr> <td style="width: 30%; padding: 2px;">Card check code</td> <td style="padding: 2px;">Name of card holder as stated on credit card</td> </tr> </table>		Card No.	Valid thru	Card check code	Name of card holder as stated on credit card
	Card No.	Valid thru				
	Card check code	Name of card holder as stated on credit card				
<b>Direct debit order</b> I herewith authorize DKV Globality S.A., 13, rue Edward Steichen, L-2540 Luxembourg, to debit the premiums when due and to pay reimbursements in conjunction with my health insurance via my credit card account until further notice. I will inform DKV Globality S.A. of the new credit card number and/or new validity period, as well as of any changes in the card check code, in good time before expiry of the aforementioned credit card. I am aware that the following surcharges are due on the monthly premium for the respective intervals: 0% for yearly payment, 2% for half-yearly payment, 3% for quarterly payment and 4% for monthly payment. If I have any doubts, objections or queries concerning the reason for or amount of a premium to be debited or a reimbursement to be credited, I must contact DKV Globality S.A. at the following service number / e-mail address to clarify the matter: <b>Tel.: +352 / 270 444 3602, service-yougenio@dkv-globality.com</b>						
<b>Consent clause / Payment by credit card</b> By signing below, I authorize DKV Globality S.A. to forward to the relevant banks and credit card processors my insurance contract number (Policy No.), the name of the credit card company, my credit card No. with card check code, month and year of expiry, as well as the amount of premium to be debited and the corresponding currency, for the purposes of debiting premiums and crediting reimbursements – in conjunction with my existing insurance contract – by credit card. This authorization may be revoked at any time. I confirm that the information I have provided is true and correct.						
_____ Place, date, signature of the card holder (first name and surname, unless identical with the applicant)						

At least one account must be specified for reimbursements by the insurer.

Account holder (if not identical with applicant / insured person)	Name of bank
Account No.	Branch No. (BLZ)
Postcode / Town	Country
BIC	IBAN

## I. Concluding provisions

**Please check that the information provided in this application form is correct and complete.**

- By signing this form, I also give my consent to the declaration printed on page 4 releasing medical and other staff from their duty to maintain professional confidentiality. This also applies in my (our) capacity as co-insured person(s).
- I do not wish to make the declaration printed on page 4 releasing medical and other staff from their duty to maintain professional confidentiality. I wish to be informed by the insurer of the persons and institutions requiring information. I will then decide in each instance whether or not I will release the specified persons or institutions from their duty to maintain professional confidentiality.  
 If I choose this alternative,
  1. conclusion of the insurance contract which I have requested may at least be delayed, if the remaining sources of information do not make it possible to investigate and appraise the risk.
  2. it may take longer to investigate my claims, benefits may be reduced or the insurer relieved from its obligation to pay benefits if the obligation to pay benefits cannot be established or can only be partially established on the basis of the remaining sources of information.

To be completed by the intermediary:  
 When answering the questions in this form, did the applicant provide information which has not been recorded in this application form?

No     Yes

If yes, which?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I herewith agree that information by DKV Globality S.A. may be sent to me in writing and by telephone.

Yes     No    This consent may be revoked at any time.

**By signing this form, I also give my consent to the declarations printed on pages 4 and 5 (including the declaration concerning my right of revocation and the declaration on data protection).**

<div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> Place and date	<div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> Signature of the applicant	<div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> Signature of intermediary
<div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> Signature(s) of the co-insured person(s) or their legal representative(s)	<div style="border: 1px solid black; height: 20px; margin-bottom: 5px;"></div> Agency No.	

## Declarations by the applicant and person(s) to be co-insured

### The following points are known to me:

#### **Right of revocation**

You may revoke your declaration of concluding a contract in writing within 14 days without stating any reasons. The time-limit begins to run on the day on which you receive your insurance policy / certificate and the General Conditions of Insurance. It is sufficient to send off your revocation in good time by surface mail, e-mail or fax in order to comply with the deadline for revocation. Your revocation should be addressed to DKV Globality S.A., 13, rue Edward Steichen, L-2540 Luxembourg. If you send your revocation by e-mail or fax, please send it to: service-yougenio@dkv-globality.com +352 / 270 444 3699.

#### **Consequences of revocation**

If you validly exercise your right of revocation, the premiums and benefits received must be returned by the respective parties. If you have agreed to inception of the insurance cover before expiry of the period for revocation, we are only obliged to refund the premium applicable to the period after receiving your notice of revocation, within 30 days.

#### **Responsibility for the information provided in the application**

Before declaring my intention to conclude a contract, I must inform the insurer of all hazard circumstances known to me and requested by the insurer in text form, which are of importance for the insurer's decision to conclude a contract with the agreed content.

Attention is drawn to the information in conjunction with the health questions on page 3 with regard to the legal consequences of incorrectly answering the questions concerning your state of health.

#### **Applicable law**

Unless the application of a different law is required by national legislation, the insurance agreement shall be governed by the law of the Grand Duchy of Luxembourg.

#### **Supervisory authority**

Complaints may be addressed to DKV Globality S.A. or to the ombudsman for insurance companies (A.C.A. – Association des Compagnies d'Assurance – in collaboration with the U.L.C. – Union Luxembourgeoise des Consommateurs) or to the supervisory authority for all private health insurers in Luxembourg, the Commissariat aux Assurances.

#### **Release from the duty to maintain professional confidentiality**

##### **1. Assessment of the risk on conclusion of contract, insofar as existing medical conditions are to be included in the cover**

We will verify the information which you have provided with regard to your state of health before concluding the contract, insofar as this is necessary to assess the risk to be insured and insofar as your information gives cause for such verification.

To permit assessment of the risk, I herewith release doctors, nursing staff, members of staff in hospitals, nursing homes, personal insurance companies, statutory health insurance institutions, employers' liability insurance associations and public authorities who have examined, advised or treated me, or with whom I was insured or from whom I requested/applied for insurance at any time during the last ten years before filing the application, from their duty to maintain professional confidentiality.

The above release from the duty to maintain professional confidentiality shall also apply for up to ten years after conclusion of the contract if, after concluding the contract, the insurer has specific cause to suspect that the information provided when filing the application was incomplete or incorrect, thus influencing the insurer's assessment of the risk. This declaration shall remain valid even after my death.

I also release the members of the insurer's own staff from their duty to maintain professional confidentiality insofar as the requested health data are forwarded to external or medical experts consulted by the insurer, to the extent necessary for assessment of the risk.

Before requesting information in accordance with the above paragraphs, you will be informed accordingly and instructed that you may object to such information being provided.

The declaration releasing persons from their duty to maintain professional confidentiality depends on its legal admissibility in the country in which the required information is to be obtained.

##### **2. Verification of the obligation to pay benefits**

In order to establish our obligation to pay benefits, it may be necessary to verify the information which you have provided in justification of your claims or which is contained in the documents presented (e.g. medical findings, certificates, expertises) or in the reports by hospitals or doctors, for example. This verification of your health data will only be made insofar as we have cause to do so (e.g. queries concerning the diagnosis or course of treatment).

To permit verification of the obligation to pay benefits, I herewith release the doctors, nursing staff, members of staff in hospitals, other clinics, nursing homes, personal insurance companies, statutory health insurance institutions, employers' liability insurance associations and public authorities who have been named in the aforementioned documents or were involved in the treatment from their duty to maintain professional confidentiality.

I also release the members of the insurer's own staff from their duty to maintain professional confidentiality insofar as the requested health data are forwarded to external or medical experts consulted by the insurer, to the extent necessary for verifying the insurer's obligation to pay benefits.

This declaration in conjunction with verification of the insurer's obligation to pay benefits shall also remain valid even after my death.

Before requesting information in accordance with the above paragraphs, you will be informed accordingly and instructed that you may object to such information being provided.

The declaration releasing persons from their duty to maintain professional confidentiality depends on its legal admissibility in the country in which the required information is to be obtained.

##### **Declarations on behalf of co-insured persons**

The above declarations are also made on behalf of my co-insured children, as well as on behalf of those co-insured persons who cannot themselves judge the significance of this declaration and of whom I am the legal representative.

##### **Declaration of consent with regard to data protection**

I herewith agree that the insurer may, to the extent necessary, forward data obtained from the application forms or in conjunction with execution of the contract (premiums, insured events, changes in risk / contractual terms) to re-insurers for the purpose of assessing the risk and handling the reinsurance, as well as to other insurers for the purpose of assessing the risk and claims, and to external or medical experts consulted by the insurer. This consent shall also apply regardless of whether or not a contract is concluded, as well as for corresponding reviews in conjunction with other applications for insurance cover and future applications. Health data may only be forwarded to personal insurers and re-insurers; they may only be forwarded to intermediaries to the extent necessary for drawing up the insurance contract.

I also agree, subject to revocation at any time, that the insurer may obtain information from the Register of Companies, the Register of Debtors and the Register of Private Insolvencies, either directly or through credit reporting agencies, in order to assess my creditworthiness.

##### **Authorization of external service providers**

I herewith irrevocably authorize the external service providers cooperating with the insurer to accept information from the insurer for data processing and management purposes. I can obtain information on the identity and head office of the service provider processing my data from the insurer at any time.

##### **Inception of insurance cover**

Insurance cover commences on the date specified in the insurance policy / certificate (inception of insurance) and not before expiry of any qualifying periods. Benefits will not be paid for insured events occurring before inception of the insurance cover. Benefits for insured events occurring after conclusion of the insurance contract will not be paid for the period before inception of the insurance. If the contract is amended, the rulings set out in this paragraph will apply accordingly for the additional insurance cover.

**Contractual foundations**

The plan levels entered in this application form are governed by the General Conditions of Insurance for Globality YouGenio®. A copy of the application form will be handed over to me as soon as I have signed it.

**Validity of the contract**

The insurance contract is only valid when the application has been accepted by the insurer in writing and the insurance policy has been issued. Payment of the first premium to the intermediary does not constitute acceptance of the application.

**Due payment of the first premium**

The first premium or premium instalment is due as soon as we have accepted your application for insurance.

**Term of the contract**

The insurance contract is concluded for a term of one year which is renewed for further periods of 12 months each on expiry each year, unless the policyholder objects to the renewal not less than three months before expiry of the insurance year.

**Moratorium**

The moratorium is defined as a qualifying period of 24 months for treatment costs attributable to an existing medical condition and its consequences. After a continuous insurance period of 24 months, we will reimburse the eligible expenses incurred for existing medical conditions and their consequences if the insured person did not suffer any symptoms and did not require treatment, did not consult a doctor and did not receive or require any medication during this 24-month period. The moratorium may be extended beyond the 24 months for those disorders which were not without symptoms or treatment during the first 24 months.

**Conversion:**

- **General Conditions of Insurance for Globality YouGenio®**

In cases of conversion of a health insurance contract (e.g. change of plan levels), the plan features specified in the General Conditions of Insurance for the Globality YouGenio® shall apply for the new plan level as from the date of conversion specified in the endorsement to the insurance policy. Depending on the agreed plan level, the qualifying periods will also apply accordingly for the additional insurance cover.

- **Right of revocation**

The previous insurance cover shall continue to apply if a requested conversion does not become effective because the statutory right of revocation has been exercised.

- **Crediting of the prior term**

The term of the prior insurance shall be credited to the new insurance following conversion.

Insurance cover may be increased during an insurance year; reductions in insurance cover are only possible with effect

from the beginning of the next insurance year.

- **Insurance year**

The insurance year shall remain unchanged following conversion.

- **Surcharges for substandard risk, restrictions, exclusions**

If surcharges were payable for substandard risk prior to conversion of the insurance, these surcharges shall also be levied on the new plan premiums at the same percentage rates unless agreed otherwise. The surcharges will change to the same extent that premiums change (e.g. due to adjustment except when changing to the next age group).

Any restrictions on insurance cover and exclusions from benefits applicable in the past will continue to apply after conversion of an insurance.

Illnesses and their consequences, as well as the consequences of accidents which have occurred during the previous insurance term and which constitute an increased risk according to medical findings may be excluded from the higher insurance cover.

This also includes the treatment and delivery associated with an existing pregnancy.

**Persons eligible for insurance**

As someone who is temporarily living abroad for at least three months, I belong to the group of people eligible for insurance as from inception of the insurance cover. I am aware that family members / my non-marital partner can only be co-insured to the extent that they are eligible for insurance under the provisions of the General Conditions of Insurance; they are not co-insured automatically.

**Prior insurance**

Insofar as one of the persons to be insured did not have private or statutory health insurance cover for outpatient, dental and inpatient treatment during the last six months before applying for insurance, that person must now undergo medical examination. For this purpose, DKV Globality S.A. will send me a form to be completed by the doctor, which I must return within 14 days of receiving the duly completed form. The costs incurred for this medical examination will be borne by the applicant. The examination report shall in all cases become the property of DKV Globality S.A..