Received by Globality S.A.:   Date / Person responsible
Broker / Intermediary name
Broker / Intermediary No.

GLOBALITY HEALTH
premium health insurance worldwide

Globality **YouGenio® World**

Application for health insurance

Globality S.A.

13, rue Edward Steichen · L-2540 Luxembourg

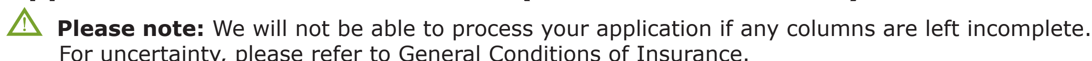
Phone: +352 270 444 3601, E-mail: service-yougenio@globality-health.com

Globality S.A.
Board of Directors: Roman Beilhack, Stephen Bishop, Wolfgang Diels
R.C.S. Luxembourg (Commercial Register): B 134471

a member of MUNICH HEALTH

10/14 E.& O.E.

Application for health insurance (individual insurance)


Please note: We will not be able to process your application if any columns are left incomplete.
For uncertainty, please refer to General Conditions of Insurance.

I hereby apply for a health insurance contract for the Globality YouGenio® World plan for the persons to be insured as listed below.

A. Policyholders personal details

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

Start date of insurance coverage (dd/mm/yyyy)		
Title	First Name	Surname
Gender ☐ M ☐ F	Date of Birth (dd/mm/yyyy)	Occupation
Correspondence Address	Building name / number	Street
	Town / city	Postal / zip / area code
	Region	Country
Contact details	Daytime number (+ country code / area code)	
	Mobile number (+ country code / area code)	
	E-mail address	

☐ New (no previous coverage with Globality S.A.)	☐ Existing customer of Globality S.A. If yes, please provide current insurance no.
Nationality	Home country
Country of current location (where the application is signed)	Country of future location (where you will live as an expatriate)

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

☐ English ☐ German ☐ French ☐ Spanish ☐ Dutch

B. Persons to be insured

Person 2

Start date of insurance coverage (dd/mm/yyyy)		
Title	First Name	Surname
Relationship to the policyholder ☐ Partner ☐ Child		
Gender ☐ M ☐ F	Date of Birth (dd/mm/yyyy)	Occupation
Correspondence Address ☐ Same address as the policyholder ☐ Different address (please enter aside)	Building name / number	Street
	Town / city	Postal / zip / area code
	Region	Country
Contact details	Daytime number (+ country code / area code)	
	Mobile number (+ country code / area code)	
	E-mail address	

☐ New (no previous coverage with Globality S.A.)	☐ Existing customer of Globality S.A. If yes, please provide current insurance no.
Nationality	Home country
Country of current location (where the application is signed)	Country of future location (where you will live as an expatriate)

Person 3

Start date of insurance coverage (dd/mm/yyyy)		
Title	First Name	Surname
Relationship to the policyholder ☐ Partner ☐ Child		
Gender ☐ M ☐ F	Date of Birth (dd/mm/yyyy)	Occupation
Correspondence Address ☐ Same address as the policyholder ☐ Different address (please enter aside)	Building name / number	Street
	Town / city	Postal / zip / area code
	Region	Country
Contact details	Daytime number (+ country code / area code)	
	Mobile number (+ country code / area code)	
	E-mail address	
☐ New (no previous coverage with Globality S.A.)	☐ Existing customer of Globality S.A. If yes, please provide current insurance no.	
Nationality	Home country	
Country of current location (where the application is signed)	Country of future location (where you will live as an expatriate)	

Person 4

Start date of insurance coverage (dd/mm/yyyy)		
Title	First Name	Surname
Relationship to the policyholder ☐ Partner ☐ Child		
Gender ☐ M ☐ F	Date of Birth (dd/mm/yyyy)	Occupation
Correspondence Address ☐ Same address as the policyholder ☐ Different address (please enter aside)	Building name / number	Street
	Town / city	Postal / zip / area code
	Region	Country
Contact details	Daytime number (+ country code / area code)	
	Mobile number (+ country code / area code)	
	E-mail address	
☐ New (no previous coverage with Globality S.A.)	☐ Existing customer of Globality S.A. If yes, please provide current insurance no.	
Nationality	Home country	
Country of current location (where the application is signed)	Country of future location (where you will live as an expatriate)	

C. Plan level and geographical area

Person	Plan level				Geographical area	Premium (monthly)
	***Essential**	**Classic**	**Plus**	**Top**		☐ € ☐ $ ☐ £
1	☐ No deductible	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/ 840 £	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/ 840 £ ☐ 2,500 €/3,250 $/ 2,100 £	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/ 840 £ ☐ 2,500 €/3,250 $/ 2,100 £	☐ Worldwide excl. USA ☐ Worldwide incl. USA	
2	☐ No deductible	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/ 840 £	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/ 840 £ ☐ 2,500 €/3,250 $/ 2,100 £	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/ 840 £ ☐ 2,500 €/3,250 $/ 2,100 £	☐ Worldwide excl. USA ☐ Worldwide incl. USA	
3	☐ No deductible	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/ 840 £	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/ 840 £ ☐ 2,500 €/3,250 $/ 2,100 £	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/ 840 £ ☐ 2,500 €/3,250 $/ 2,100 £	☐ Worldwide excl. USA ☐ Worldwide incl. USA	
4	☐ No deductible	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/ 840 £	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/ 840 £ ☐ 2,500 €/3,250 $/ 2,100 £	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/ 840 £ ☐ 2,500 €/3,250 $/ 2,100 £	☐ Worldwide excl. USA ☐ Worldwide incl. USA	
*Essential (inpatient with critical illness coverage) **Total monthly premium for all persons:**						

D. Previous coverage and doctor details

Please note: The following details (point 1. AND point 2.) are required.

1. Do you have or have you ever had health insurance coverage within the last 5 years (including compulsory statutory / private / public health insurance)?

Person	Previous Insurer	Insurance No.	Coverage	Start date (dd/mm/yyyy)	End date (dd/mm/yyyy)
1 ☐ Yes ☐ No			☐ Inpatient ☐ Outpatient ☐ Dental		
2 ☐ Yes ☐ No			☐ Inpatient ☐ Outpatient ☐ Dental		
3 ☐ Yes ☐ No			☐ Inpatient ☐ Outpatient ☐ Dental		
4 ☐ Yes ☐ No			☐ Inpatient ☐ Outpatient ☐ Dental		

2. Please specify the name and address of the doctor best able to provide further information regarding your health. If there is more then one doctor associated with the persons in this application please provide any additional information in the information box at the end of Section E or include a separate page.

Person	Doctor's name	Address of the hospital / clinic	Phone no. and E-mail address
1			
2			
3			
4			

E. Medical history

Please tick either one. In the event neither is ticked (☐) the application will go for FMU (full medical underwriting).

☐ **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 (signature date in Section G)
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.
* Conditions apply, please refer to page 11 of the application for further information on the moratorium option.

☐ **Insurance coverage including coverage for pre-existing conditions**
I understand I am required to answer the complete health questionnaire below for the persons to be insured.
In order to be covered for pre-existing conditions you are required to answer all the health questions below. Based on the answers you provide, you will be informed whether you are eligible for insurance and whether risk loadings or exclusions need to be applied.

Important: All questions must be answered in detail. Symptoms, illnesses and the consequences of an accident should be mentioned even if you consider them to be unimportant. Dashes do not qualify as an answer. ***If you need more space:*** continue on a separate sheet, specifying the number of the person concerned, and refer to that sheet in your application form. If you do not wish to reveal certain information to the intermediary, this information must be provided directly to Globality S.A. ***in writing within three days of the reception of the application form by Globality S.A..*** In this case you must indicate in the application form that the information is to be provided separately.
If the questions on this page, where of relevance for acceptance of the risk, are answered incorrectly or incompletely, we may – if the duty to provide information has not been willfully violated – terminate the contract within one month of being informed of the violation, insofar as we can prove that we would not have insured the risk in any case. The contract shall be null and void if our assessment of the risk is affected by willful violation of your duty to provide information. In this case, you are obliged to repay the insurance benefits already received. We will not refund the paid premiums. ***If insurance coverage already exists with Globality S.A.,*** it is not necessary to specify any disorders or courses of treatment during the last five years which are already fully known to Globality S.A. on account of the invoices or medical certificates presented to Globality S.A. in conjunction with the previously existing insurance contract.
Conditions arising between signing the application form and confirmation of acceptance by Globality S.A will equally be deemed to be pre-existing. ***Therefore it is necessary that you advise us immediately of any material changes to the information provided, which would occur between submission of this application and acceptance by us*** **(Please refer to "Responsibility for the information provided in the application form", page 10).**

Pre-existing conditions:

Pre-existing conditions are medical conditions for which one or more symptoms has been shown prior to the start of coverage with Globality S.A. including pregnancy, childbirth, postpartum complications and related conditions, irrespective of whether any medical treatment or advice was sought.

Any medical or dental condition or related condition for which you:
- had symptoms of or received medical treatment for;
- sought advice on or consulted any doctor for medical treatment or advice (including checkups);
- took medication (including over the counter drugs, alternative medications, special diets, injections or vitamins) or
- to the best of your knowledge were already existing upon inception of the insurance.

Pre-existing conditions may be covered under the policy following a full medical underwriting. Conditions that arise between signing the application form and confirmation of acceptance by our underwriting team are deemed to be pre-existing. Therefore, it is necessary that you advise us of any material changes to the information provided between submission of this application and acceptance. You are hereby obliged to provide any further information we might require on request.

No.	Questions	Person 1	Person 2	Person 3	Person 4
1	What is your height/weight? cm/kg	______ cm ______ kg	______ cm ______ kg	______ cm ______ kg	______ cm ______ kg
2	Have you been using tobacco products including, cigarettes, cigars, chewing tobacco or any form of tobacco in the last 12 months? If yes, average no. of cigarettes / amount per day	☐ Yes ☐ No ______	☐ Yes ☐ No ______	☐ Yes ☐ No ______	☐ Yes ☐ No ______

No.	Questions	Person 1	Person 2	Person 3	Person 4
3	How many units of alcohol do you drink per week? Alcohol: units (1 unit = 250ml beer / 100 ml wine / 25 ml spirit)	______	______	______	______
	Please note that we have given examples of conditions below, but not all conditions are listed below.				
4	**In the last 5 years have you or anyone to be insured under this policy:** **a) Seen a doctor or other healthcare professional,** **b) Had any history of, suffered from, been admitted to hospital for,** **c) Received treatment, carried out tests or investigations for the following:**				
4.1	Heart problems or circulatory disorders (e.g. high blood pressure, angina, chest pains, heart attack, heart insufficiency, abnormal heart beat, heart defects, aneurysms, varicose veins etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.2	Respiratory disorders (e.g. breathing problems, asthma, COPD, pneumonia, bronchitis, tuberculosis, allergies, septum deviation etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.3	Endocrine disorders (e.g. glandular disorders, diabetes (Type 1 or Type 2), thyroid problems, Cushing's syndrome, Addison's disease, Graves disease etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.4	Gastrointestinal disorders (e.g. stomach, intestines, liver or gall bladder problems, stomach inflammation/ulcers, irritable bowel syndrome, Crohn's disease, colitis, change in bowel habits, hemorrhoids/piles, pancreatitis, liver inflammation, cirrhosis, gall stones, hernias etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.5	Cancer, tumours or growths (e.g. polyps, benign growths, cysts, any cancers or precancerous condition etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.6	Brain & nervous system disorders (e.g. stroke, dementia, migraine, chronic headaches, multiple sclerosis, epilepsy / fits, sciatica, low muscle tone, Parkinson's disease etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.7	Skin, hair, nail problems (e.g. eczema, dermatitis, rashes, alopecia areata, psoriasis, acne, cysts, moles that itch or bleed, etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.8	Ear disorders (tinnitus, vertigo, hearing disorder, deafness)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Problems with the eyes (e.g. Glaucoma, Cataracts, corneal problems, retinal detachment, etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Do you have impaired vision with 8 diopters or more? If yes, please specify diopters: right eye (RE); left eye (LE)	☐ Yes ☐ No RE ______ LE ______	☐ Yes ☐ No RE ______ LE ______	☐ Yes ☐ No RE ______ LE ______	☐ Yes ☐ No RE ______ LE ______
4.9	Urinary & reproductive disorders (e.g. kidney failure, urinary infections, incontinence; testicular or prostate disorders, infertility, pregnancy / childbirth problems (including caesarean sections), heavy or irregular periods, fibroids, endometriosis, abnormal smears, polycystic ovaries, etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.10	Blood / infective / immune disorders (e.g. abnormal blood tests, coagulation problems, high cholesterol, anemia, malaria, autoimmune disorder, etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.11	Psychiatric / Psychological disorders (e.g. depression, medically treated stress, anxiety, mental illness, schizophrenia, compulsive or eating disorders, drug/alcohol dependency, etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.12	Muscle or skeletal problems (e.g. rheumatism, gout, arthritis, back problems, neck / shoulder problems, cartilage and ligament problems, joint replacements, fractures, osteoporosis, inflammatory conditions, disc prolapse etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

No.	Questions	Person 1	Person 2	Person 3	Person 4
5	Do you have any physical / organic defect, a chronic illness, congenital condition, an illness or injury due to military service, any reduction in your ability to work? Or a degree of disability that leads to permanent disability? If yes, please enclose a copy of the official notice of invalidity.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6	Have you ever been tested positive for HIV, Hepatitis B or C? Are you awaiting the results of such a test? (If the result is negative, having an HIV test will not, in itself, have any effect on your acceptance terms for insurance).	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No
7	Pregnancy: Are you pregnant? If yes, how many weeks?	☐ Yes ☐ No ________	☐ Yes ☐ No ________	☐ Yes ☐ No ________	☐ Yes ☐ No ________
8	Have you undergone inpatient or outpatient surgery during the last five years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9	Have you been advised, or are you planning currently undergoing any kind of outpatient / inpatient treatment or examination?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10	Do you require any kind of medication (e.g. tablets, ointments, capsules, syrups, injections, creams, suppositories, inhalers, OTC)? If yes, please specify which and what for the medication is treating.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
11	Dental a) Have you visited a dentist during the last five years? b) Are you currently receiving dental treatment, are dentures being produced or renewed, are you receiving treatment for periodontosis or orthodontic treatment, or has such treatment been recommended or planned? (If yes, please include an up-to-date plan of treatment and costs.) c) Do you have any missing teeth which have not yet been replaced (other than milk and wisdom teeth, as well as teeth for which the gaps have been filled by adjacent teeth)? If yes: number of missing teeth	a) ☐ Yes ☐ No b) ☐ Yes ☐ No c) ☐ Yes ☐ No ________	a) ☐ Yes ☐ No b) ☐ Yes ☐ No c) ☐ Yes ☐ No ________	a) ☐ Yes ☐ No b) ☐ Yes ☐ No c) ☐ Yes ☐ No ________	a) ☐ Yes ☐ No b) ☐ Yes ☐ No c) ☐ Yes ☐ No ________
12a	Have you suffered any other illnesses, disorders, consequences of an accident or other impairments of your health or stayed in hospital or have you undergone any examinations / treatments either during the last five years or at present?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
12b	Are there any other medical conditions not listed above for which you have had signs or symptoms without diagnosis, doctors visit or consultation at any time during the last 5 years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Further information:

If you answered “Yes” to any of the questions above, please provide details in the table below.
Please provide medical reports if available.

Person No.	Question No.	1. Type of illness / diagnosis, symptoms, area of body affected (right / left), treatment details, names of medications prescribed	2. Treatment / symptom start date (dd/mm/yyyy)	3. Treatment / symptom end date / ongoing (dd/mm/yyyy)	4. Name of treating doctor & address of clinic / hospital

Per-son No.	Ques-tion No.	1. Type of illness / diagnosis, symptoms, area of body affected (right / left), treatment details, names of medications prescribed	2. Treatment/ Symptom start date (dd/mm/yyyy)	3. Treatment / Symptom end date / ongoing (dd/mm/yyyy)	4. Name of treating doctor & address of clinic / hospital

Additional information and remarks:

F. Payment of premiums

a) Payment frequency

☐ monthly ☐ quarterly ☐ semi-annually ☐ annually

b) Payment method

Premium remittance

☐ **EURO Account – Premium in Euros to be remitted to Globality S.A.**
BGL BNP Paribas · IBAN: LU090030309301020000 · BIC Code: BGLLLULL

☐ **USD Account – Premium in USD to be remitted to Globality S.A.**
BGL BNP Paribas · IBAN: LU450030309301173000 · BIC Code: BGLLLULL

☐ **GBP Account – Premium in GBP to be remitted to Globality S.A.**
HSBC · IBAN: GB87MIDL40025081330713 · Swift Code: MIDLGB22 · Sort Code: 400250

☐ **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, 3% for quarterly payment and 4% for monthly payment.

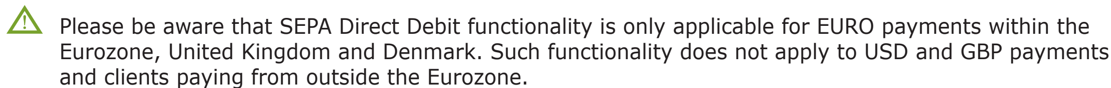
☐ **Direct debit** (applies only for Euro premiums within the Eurozone*, UK and Denmark).
Please complete the below SEPA Direct Debit Mandate and return with the application form.

*Eurozone includes: Austria, Belguim, Cyprus, Estonia, Finland, France, Germany, Greece, Italy, Latvia, Luxembourg, Malta, Netherlands, Portugal, Republic of Ireland, Slovakia, Slovenia, Spain.

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

SEPA Direct Debit Mandate



Please be aware that SEPA Direct Debit functionality is only applicable for EURO payments within the Eurozone, United Kingdom and Denmark. Such functionality does not apply to USD and GBP payments and clients paying from outside the Eurozone.

Mandate Reference – to be completed by the creditor

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

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.

Please complete all the fields marked *. **Creditor is to complete fields marked ** before supplying form to Debtor.**

Name of Debtor * 1
Name of the bank account holder

Address of Debtor * 2
Street name and number

* 3
Postal code City

* 4
Country

IBAN of Debtor * 5
Account number – IBAN (International Bank Account Number) of the Debtor

* 6
BIC/ SWIFT code

Creditor's Name ** Globality S.A. 7
Creditor name

** LU53ZZZ000000000LU22284578 8
Creditor identifier

** 13, rue Edward Steichen 9
Street name and number

** L-2540 Luxembourg 10
Postal code City

** Luxembourg 11
Country

Type of Payment * ☐ Recurrent payment ☐ One-off payment 12

Details regarding the underlying relationship between the Creditor and the Debtor – for information purposes only.

Name of Policyholder 13
First and Last Name

Policy No./Insurance No. if known 14

City or town in which you are signing* Date * 15
Location

Please sign here*

Note: Your rights regarding the above mandate are explained in a statement that you can obtain from your bank.

Signature(s)

If you are an individual client please send the completed form to:
service-yougenio@globality-health.com

If you are insured on a corporate plan please send to:
service-group@globality-health.com

Creditor's use only

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

The following points are known to me:

Right of withdrawal
You may withdraw from this insurance policy in writing within 14 calendar days, without penalty and without giving us any reason. This 14-day period begins on the day on which you receive your insurance policy and the general conditions of insurance. So that you meet this deadline, you can send your notice of withdrawal by post, email or fax before the end of the 14 days.

If you withdraw from your insurance policy within this 14-day period, we will refund any premiums you might have already paid. If you do not withdraw from your insurance policy within the 14 days, your insurance policy will become final.

Your withdrawal should be addressed to
Globality S.A.,
13, rue Edward Steichen,
L-2540 Luxembourg.

If you send your withdrawal by E-mail or fax, please send it to:
service-yougenio@globality-health.com, Fax +352 / 270 444 3699.

Consequences of withdrawal
If you exercise your right of withdrawal, the premiums and benefits received must be returned by the respective parties.

Responsibility for the information provided in the application
Before declaring my intention to conclude a contract, I must inform the insurer of all circumstances known to me and requested by the insurer, which are of importance for the insurer's decision to provide the agreed insurance coverage.

Conditions that arise between signing the application form and confirmation of acceptance by our underwriting team are deemed to be pre-existing.

Attention is drawn to the information given on pages 4 to 7 with regard to the legal consequences of incorrectly answering the questions concerning your state of health.

Applicable law
The insurance policy will be governed by the law of the Grand Duchy of Luxembourg as long as another law which applies according to national regulations does not contain conditions which are not compatible with the law of the Grand Duchy of Luxembourg.

Supervisory authority
The supervisory authority for Globality S.A. can be contacted at the following address:

Commissariat aux Assurances,
7, Boulevard Joseph II
L-1840 Luxembourg.

Complaints procedure
Complaints may be addressed to 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 the insurance sector in Luxembourg, the Commissariat aux Assurances.

Consent to the receipt, storage, processing and transmission of personal data
By signing this application for health insurance, I explicitly acknowledge and agree to the receipt, storage and processing of my personal, insurance, health data and bank details by Globality S.A., and to the transmission thereof to the relevant contracted partners of Globality S.A. (such as reinsurer, medical providers, cooperating service partners).

In this respect, Globality S.A. undertakes to collect, store, process and transmit such data and details to third parties exclusively for the purpose of the performance of the insurance contract, the granting of the insurance coverage and the provision of assistance services, advice and support.

Information concerning the identity and registered office of third parties processing my data is available from Globality S.A. on request at any time.

This consent shall continue to apply after my death, and be valid for my children to be insured and any other persons to be insured whom I represent by law.

I have a right of access and rectification to my personal data on request at any time.

Consent to provide medical information
By signing this application for health insurance, I give appropriate consent to allow doctors, nurses and other medical staff, as well as employees of hospitals, clinics, nursing homes, personal insurance companies, statutory health insurance institutions, employers liability insurance associations and public authorities who are named in the documents presented to Globality S.A. or were involved in the medical treatment, to provide Globality S.A. with information on my health and treatment in order to permit assessment of the medical risk when concluding the contract and verifcation of my rights under the insurance contract.

By signing this application for health insurance, I also give appropriate consent to allow Globality S.A. to provide information on my health and treatment or on my insurance coverage to other companies in the Münchener Rückversicherungs-Gesellschaft AG, the reinsurer group, to contracted medical providers and to partners cooperating with Globality S.A.. This consent is revocable at any time. Globality S.A. undertakes to provide such information to third parties exclusively for the purpose of the performance of the insurance contract, the granting of the insurance coverage and the provision of assistance services, advice and support.

The consent as defined above shall continue to apply after my death, and be valid for my insured children and any other insured persons whom I represent by law.

I also agree, subject to revocation at any time, that Globality S.A. 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.

Start date of insurance coverage
Insurance cover starts on the date shown in the insurance policy (start date of insurance), but not before you have paid your first premium and not before the end of the waiting periods.

We will not cover insured events which happen before the start date of the insurance. If the insurance policy is amended, this will apply to the "change of the insurance cover" as stated below.

Governing documents
The insurance contract will be governed by the insurance policy, the application form, the general conditions of insurance for Globality YouGenio® World, the special conditions and any possible additions to them.

In case of any disputes regarding the insurance, its coverage and conditions the English version of the General Conditions of Insurance and other relevant literature and documentation shall prevail.

A copy of the application form will be handed over to me as soon as I have signed it.

Change of insurance cover
Any changes in insurance cover are only possible from the beginning of the next insurance year (currency, deductible, plan level).

Depending on the agreed plan level, new waiting periods will also apply accordingly for the additional insurance coverage. 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 coverage.

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

If health related risk loadings were payable prior to the change of the insurance coverage, these premium loadings shall also be levied on the new plan premiums at the same percentage rates unless agreed otherwise. The premium loadings will change to the same extent that premiums change (e.g. due to adjustment).

The previous insurance coverage shall continue to apply if a requested change of insurance coverage does not become effective because the right of withdrawal has been exercised.

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

The insurance year shall remain unchanged following change of the insurance coverage.

Persons eligible for insurance
As someone who is temporarily living abroad for at least three months, I confirm being eligible for insurance or that I will be eligible on the start date of the insurance coverage. 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.

Previous insurance
You need to provide Globality S.A. with your previous health insurance or state healthcare system details of the past 5 years (including compulsory statutory/private/public health insurance) for inpatient, outpatient and dental coverage.

Application and acceptation of your application for health insurance
The application does not bind either you or us to conclude the contract. However, we will notify you, within 30 days of the receipt of the application form, of an insurance offer, the subjection of the insurance to an inquiry or survey, or the refusal to insure. We will provide insurance cover in good faith, assuming that you have correctly and completely answered all the relevant questions raised before the start of the insurance policy (this is known as your ‘pre-contractual duty to disclose information’).

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 or insurer does not constitute acceptance of the application.

Due payment of the first premium
The first premium installment is due as soon as we have accepted your application for insurance by sending out the insurance policy. The premium is owed by you; it is your responsibility to ensure punctual payments.

Term of the contract
The insurance contract is initially concluded for a duration of one insurance year which is automatically renewed for further periods of 12 months each on expiry of each insurance year, unless you object to the renewal not less than three months before expiry of the insurance year.

Moratorium
Instead of applying for full medical underwriting, if the insured person is 55 or younger, you may choose a ‘moratorium’.

In that case any pre-existing medical condition that an insured person has experienced during the last five years will be covered after a continuous two-year period free of medical treatment, symptoms, advice or medication relating to the pre-existing medical condition. If an insured person has any treatment, advice or medication during the first two years of cover relating to a pre-existing medical condition, the two-year period (free of any treatment, advice or medication) may start again for that pre-existing medical condition. We will cover any new and unrelated medical conditions immediately (after expiry of waiting periods if any apply).

Pre-existing medical conditions
A medical condition that has existed before the start date of health insurance cover with us. For the purpose of this definition, medical condition means any medical, dental condition or related condition for which you have received medical treatment for, had symptoms of, asked advice on, consulted any doctor for medical treatment (including check-ups), or taken medication for (including drugs, medicines, special diets or injections), or to the best of the person’s knowledge already existed at the start of the insurance; or pregnancy, childbirth, postpartum complications and related consequences.

We treat conditions arising between filling in the application form and us confirming that we accept the application as ‘pre-existing’.

☐ **I have read the above declaration and confirm that the information provided in this application is correct and complete for all persons to be insured.**

By signing this form,

☐ I give my consent to the receipt, storage, processing and transmission of personal data and give consent to provide medical information (in some jurisdictions referred to as release from the professional confidentiality duty) as detailed on pages 10 and 11. I give this consent for myself, for my children to be insured and for the persons to be insured I represent by law.

☐ I do not give consent to professionals to provide Globality S.A. with information on my health and treatment as detailed on page 10. I wish to be informed by the insurer, which persons and institutions information is required from. I will then decide in each instance whether or not I will give consent to the specified persons or institutions to forward information to Globality S.A..

If I choose this alternative I understand:

1. conclusion of the insurance contract which I have requested may be delayed or denied, if the remaining sources of information do not make it possible to investigate and assess the risk.

2. it may take longer to investigate my claims, benefits may be reduced or the insurer may be relieved from its obligation to pay benefits if the obligation to pay benefits cannot be fully 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, please give details:

All information and documents regarding my policy will be sent:

☐ to my correspondence address ☐ to the following intermediary to whom I give consent to receive them on my behalf:

I herewith agree that information on special offers by 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 all declarations printed on pages 10 and 11 (including the declaration concerning my right of withdrawal and data protection) and confirm I have read and understood the General Conditions of Insurance for Globality YouGenio® World. All persons 18 years and older have to sign. In case, policyholder and insured person are same, please sign once.

Place and date | Signature of the policyholder | Insured person 1

Insured person 2 | Insured person 3 | Insured person 4

Signature(s) of the co-insured person(s) or their legal representative(s)

Intermediary name and No. | Sub-intermediary 1 name and No.

Signature of intermediary | Sub-intermediary 2 name and No.

We will not be able to process your application if any columns are left incomplete.
Please return your fully completed application form by:

E-mail: Scan it and send it to: service-yougenio@globality-health.com

Fax: Print it and send it to: +352 270 444 3699

Alternatively you can post it to: Globality S.A., 13 rue Edward Steichen, L-2540 Luxembourg