

Please fill in all the details using a blue or black pen

1 My details (= policyholder)

Initial(s) Surname Sex Male Female

Date of birth - - Nationality*

National insurance number/Public service number

Street name House number Additional address details

Postcode Place of residence Country

Telephone number (during the day) Telephone number mobile

E-mail address

* If you or one of the people to be insured do not have the Dutch nationality, please enclose a copy of the relevant alien's identity card. In the case of nationals of a country within the EU or EER, a copy of the person's passport will suffice.

2 As policyholder, I wish to register the following people for the OZF Zorgpolis

Policyholder. I do not need to provide any personal details below.

	Initial(s)	Surname	Date of birth	National Insurance Number/ Public service number	Nationality	Sex
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F

3 Home address of the people to be insured (fill in details if different to your own address)

Street name House number Additional address details

Postcode Place of residence Country

Which insured party/parties live at this address Insured party 1 Insured party 2 Insured party 3 Insured party 4

4 My relationship with the people I am registering is (for example: partner, parent, guardian, etc.)

1 2 3 4

5 Participation in group insurance

I wish to participate in a group insurance yes No Name of group insurance

Contract number Registration number

6 Payment of premium and receipt of reimbursements

My bank account number is I wish to pay via: direct debit* accept giro form

I wish to pay the premium each Month Quarter Six months Year

* I hereby authorize OZF Achmea to deduct the amounts payable from my account until further notice.

7 I am applying for this insurance in connection with

An entitlement to basic healthcare insurance as of Uninsured since

Transfer from another insurer, namely

Policy number of policyholder

Policy numbers of insured parties 1 2

3 4

What is the reason for the transfer

By signing this form I authorise OZF Achmea to terminate the present health care insurances as mentioned above. I do not need to take further actions.

8 Deductible excess (to be filled in only for people aged 18 and over)

	Policyholder	Insured party 1	Insured party 2	Insured party 3	Insured party 4
€ 0,-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
€ 100,-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
€ 200,-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
€ 300,-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
€ 400,-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
€ 500,-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9 Supplementary insurance policies

	Policyholder	Insured party 1	Insured party 2	Insured party 3	Insured party 4
AV Royaal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AV Compact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tand Royaal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tand Compact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AV Top Collectief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10 Additional questions relating to the AV Royaal, Tand Royaal en AV Top

(fill in only if you are applying for one of these policies)

	Policyholder	Insured party 1	Insured party 2	Insured party 3	Insured party 4
Have the people to be insured been to the dentist for a check-up in the past 13 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do any of the people to be insured have the most extensive dental insurance with their current insurer*?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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* If you are applying for the AV Royaal or AV Top and you answer this last question with 'no' we will send you an additional application form

11 Insurance obligation assessment (to be filled in only for people aged 18 and over)

	Policyholder	Insured party 1	Insured party 2	Insured party 3	Insured party 4
Do you have a personal income? If no, please proceed to the signature section.	<input type="checkbox"/> yes <input type="checkbox"/> No	<input type="checkbox"/> yes <input type="checkbox"/> No	<input type="checkbox"/> yes <input type="checkbox"/> No	<input type="checkbox"/> yes <input type="checkbox"/> No	<input type="checkbox"/> yes <input type="checkbox"/> No
If yes, please state the type of income	<input type="checkbox"/> Employment <input type="checkbox"/> Pension <input type="checkbox"/> Benefit <input type="checkbox"/> Other	<input type="checkbox"/> Employment <input type="checkbox"/> Pension <input type="checkbox"/> Benefit <input type="checkbox"/> Other	<input type="checkbox"/> Employment <input type="checkbox"/> Pension <input type="checkbox"/> Benefit <input type="checkbox"/> Other	<input type="checkbox"/> Employment <input type="checkbox"/> Pension <input type="checkbox"/> Benefit <input type="checkbox"/> Other	<input type="checkbox"/> Employment <input type="checkbox"/> Pension <input type="checkbox"/> Benefit <input type="checkbox"/> Other
Are you liable to pay tax in the Netherlands?	<input type="checkbox"/> yes <input type="checkbox"/> No	<input type="checkbox"/> yes <input type="checkbox"/> No	<input type="checkbox"/> yes <input type="checkbox"/> No	<input type="checkbox"/> yes <input type="checkbox"/> No	<input type="checkbox"/> yes <input type="checkbox"/> No
Do you receive your personal income from:	<input type="checkbox"/> The Netherlands <input type="checkbox"/> A foreign country <input type="checkbox"/> Both	<input type="checkbox"/> The Netherlands <input type="checkbox"/> A foreign country <input type="checkbox"/> Both	<input type="checkbox"/> The Netherlands <input type="checkbox"/> A foreign country <input type="checkbox"/> Both	<input type="checkbox"/> The Netherlands <input type="checkbox"/> A foreign country <input type="checkbox"/> Both	<input type="checkbox"/> The Netherlands <input type="checkbox"/> A foreign country <input type="checkbox"/> Both

12 Insured party

I declare that I have answered the questions truthfully. I am aware that if I fill in this form incorrectly/incompletely, or withhold facts which are important for the insurance policy/policies, the agreement can be declared null and void. By signing this form I give OZF Achmea permission to request, as necessary, the claims and medical details from my previous insurer in order to determine the level of the no-claim.

Applying for an insurance policy involves the submission of personal details. We use these details within Achmea to enter into and implement agreements, to comply with statutory obligations and to inform you about relevant products and services. Achmea can access your details via the Stichting CIS (Central Information System Foundation) in Zeist. The aim is to manage the information risks and combat insurance fraud. The foundation's privacy regulations apply.

Date

Signature of
policyholder:

Send the fully completed and signed form to OZF Achmea, afdeling Polisadministratie,
Antwoordnummer 1038, 7550 VB Hengelo. No stamp required.