ACIBADEM SİGORTA

GROUP HEALTH INSURANCE APPLICATION FORM

Please fill in all fields of the Application Form applicable to you in capital letters in readable form. This form does not partage of affer.

Group Name / Policy Holder		Inception Date Of The Day	___/___/___
Step Plan		Expiry Date Of The Day	___/___/___

POLICY HOLDER APPLICANT INFORMATIONS

	(1. Candidate) Himself / Herself	(2. Candidate) Spouse	(3. Candidate) Child	(4. Candidate) Child	(5. Candidate) Child
Name Last Name					
Date of Birth	__/__/___	__/__/___	__/__/___	__/__/___	__/__/___
Gender	☐F ☐M	☐F ☐M	☐F ☐M	☐F ☐M	☐F ☐M
Turkish ID NO/Passp./ Foreign ID NO					
Actual Working Place					
Department Code					
Register No					
Date of Recruitment					
Profession / Title					
Height / Weight	___cm___kg	___cm___kg	___cm___kg	___cm___kg	___cm___kg
Birth Week			___week	___week	___week

POLICY HOLDER APPLICANT CONTACT INFORMATIONS (Contact informations must be on dear own for insurees.

	(1. Candidate) Himself / Herself	(2. Candidate) Spouse	(3. Candidate) Child	(4. Candidate) Child	(5. Candidate) Child
Phone No	(___)________	(___)________	(___)________	(___)________	(___)________
GSM No					
E-mail					
Address					

BANK ACCOUNT DATA INFORMATION (Bank account informations for repayment for non aggrement institutions medical expenses.) (Bank account informations must be on their own for insurees ove the age of 18)

	Account Holder	IBAN NO
(1. Candidate) Himself / Herself		
(2. Candidate) Spouse		
(3. Candidate) Child		
(4. Candidate) Child		
(5. Candidate) Child		

Name, Last Name, Signature, Stamp of the Policy Holder and the Date	Name, Last Name, Signature, Stamp of the Policy Insured and the Date

Küçükbakkalköy Mah. Başar Sok. No:20 34750 Ataşehir - İstanbul Tel: +90 216 571 55 55 Faks: +90 216 571 55 56 MERSİS No: 0153003619800017
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Please answer the following questions for all of the persons to be included in this insurance.

During the establishment of the contract or in other cases due to the insurer's request, regarding the health status of individuals to be covered by insurance, the questions located in the Declaration Form must be answered fully and correctly. In case if the respective declaration contrary to the facts or under-declare and declaration obligations are not discharged due to the contract, in accordance with the Health Insurance General and Special Conditions of the policy, the Insurance Contract will be rearranged as of the stated date. Exception, deductible or additional premium may be applied to the policy as of the date of discovery or healthcare expenses paid for you may be recovered from you or your policy may be cancelled.

DECLARATION OF THE POLICY HOLDER

- The assumption of all individuals written on application form will be insurer, as a result of the evaluation of an application Form, Health Declaration Form, attached documents, reports, company records and other information prepared in parallel with the selected product, I know and accept the premium and the conditions of policy may change.
- E-mail addresses and other contact information written in the relevant sections of the Application Form belong to myself and Insured Candidates. By Acibadem Health and Life Insurance Company, for all the information related to insurance contracts preliminary negotiations and agreements, declarations and the delivery of the policy, I agree to the use of the Information in this communication by SMS and / or by e-mail as the use of these contact details for notification and delivery of the policy etc.
- Regarding to the information, this Application Form is filled by myself.

Name, Last Name, Signature, Stamp of the Policy Holder and the Date	Name, Last Name, Signature, Stamp of the Policy Insured and the Date

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GROUP HEALTH INSURANCE DECLARATION FORM

INFORMATION ABOUT THE OTHER INSURANCE, IF ANY

Do you have any Health and/or Life Policy purchased from another insurer which has expird or is still in effect?	☐ Yes ☐ No

Name of the Insurance Company :	Name of the Product :	Policy Number:

HEALTH INFORMATION

“For all YES answers you have given to the following questions regarding diseases or conditions, please state in the remarks section by stating insuree candidate and disease or the condition number; currently complaints diagnose of treatment or condition number; currently contlaints, diagnose treatment of ailment, name of attending physician, name of the hospital where the treatment is provided, your final status. In respect of the disease and/or condition which you have marked as YES, please attach the copies of all the physician, surgery and hospital discharge reports, test and pathology results, if any, to the application form.

Please State Below the Details of the Questions You Have Answered as Yes

No	Question	Answer
1	Cardiovascular diseases (Blood pressure, cholesterol, cardiac valve disease, cardiac failure, varicase, venous, statis etc.)	Y ☐ N ☐
2	Diabetes	Y ☐ N ☐
3	Cancer, Cyst, Tumour	Y ☐ N ☐
4	Nervous System Diseases (Multiple Sclerosis, stroke etc.)	Y ☐ N ☐
5	Blood Diseases	Y ☐ N ☐
6	Muculoskeletal System	Y ☐ N ☐
7	Back, Belly, Neck Disorders	Y ☐ N ☐
8	Knee Disorders	Y ☐ N ☐
9	Respirotary System Diseases (Pulmonary, Trechea, Larynx etc.)	Y ☐ N ☐
10	Otorhinolaryngology (Ear/Nose/Throat)	Y ☐ N ☐
11	Urinary System Diseases (Kidney, Bladdder)	Y ☐ N ☐
12	Endocrine (Hormonal) Diseases (Thyroid, Hyrophysis, cushing etc.)	Y ☐ N ☐
13	Gastrointestinal Diseases (Mouth, Esophagus, Stomach, Intestines, etc.)	Y ☐ N ☐
14	Liver Diseases	Y ☐ N ☐
15	Genital System Diseases (Ovary, Womb, Prostate, Testicles etc.)	Y ☐ N ☐
16	Breast Disease (Cyst, Adenoma, Tumour etc.)	Y ☐ N ☐
17	Psychological/Psychiatric Disorders	Y ☐ N ☐
18	Do You Have Any Diseases or Accidenta / occupations which is not stated above?	Y ☐ N ☐
19	Have You Ever Undergone Surgical Opeteion / hospitalized?	Y ☐ N ☐
20	Are You Taking Any Medicine?	Y ☐ N ☐
21	Are You Pregnant? (If Yes Please Indicate The Week?)	Y ☐ N ☐
22	Do you have any known disorder, complaint, disease, even if you have not been examined by a physician?	Y ☐ N ☐

REMARKS

Candidate Intsured No	Question No	Complaint, Disease, Pain	Name of Physician, Hospital

Attached Documents:

Name, Last Name, Signature, Stamp of the Policy Holder and the Date	Name, Last Name, Signature, Stamp of the Policy Insured and the Date

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DECLARATION OF THE POLICY HOLDER

- Insurer and insurant both agree and declare that during the insurance agreement period and contract time, Insurance Information and Supervision Center can share any kinds of information or document, collect or share personal information (including wrong insurance conditions) of all insurants and insurer to/from doctors, medical centers, insurance companies, reassurance firms, and other concerned individuals or firms directly or indirectly for all kinds of issues related to the content of medical insurance contract (reinsurance, valuation of risk and indemnity, payment of indemnity, etc.) after the application of insurance. I authorize Acıbadem Sağlık ve Hayat Sigorta A.fi. and Policy Holder to get information from physicians, healthcare institutions and other concerned persons and give information to the Health Insurance Information Center (SAGMER) regarding all matters concerning this health insurance.
- I authorized and accepted given information for myself and my dependants in thisn application and health decleration form are full ande true for usas a member of group of insurance policy. I authorized and accepted sharing and be viewed with group for policy decision as (deductions) limits, extra premium, participation, waiting period etc.)
- I have read and accepted the Special Conditions of the Policy and the General Conditions of Health Insurance relevant with the insurance contract for this application.
- I authorized and accepted given in this application form and the attached documents is full and true for the candidate individuals of insurance.

Name, Last Name, Signature, Stamp of the Policy Holder and the Date	Name, Last Name, Signature, Stamp of the Policy Insured and the Date

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- In accordance with ''Private health insurance regulations'' published in the Official Gazette as number of 28800 10.23.2013. Insurer and insurant both agree and declare that during the insurance agreement period and contract time, Insurance Information and Supervision Center can share any kinds of information or document, collector share personal information (including wrong insurance conditions) of all insurants and insurer to/from doctors, medical centers, insurance companies, reassurance firms, and other concerned individuals or firms directly or indirectly for all kinds of issues related to the content of medical insurance contract (reinsurance, valuation of risk and indemnity, payment of indemnity, etc.) after the application of insurance. I authorize Acıbadem Sağlık ve Hayat Sigorta A.fi. and Policy Holder to get information from physicians, healthcare institutions and other concerned persons and give information to the Health Insurance Information Center (SAGMER) regarding all matters concerning this health insurance.

- I authorized and accepted given information for myself and my dependants in thisn application and health decleration form are full ande true for usas a member of group of insurance policy. I authorized and accepted sharing and be viewed with group for policy decision as (deductions) limits, extra premium, participation, waiting period etc.)

Insured Turkish ID Number :
Insured Name Last Name :
Insured Sign :
Date :

Spouse Turkish ID Number :
Insured Name Last Name :
Insured Sign :
Date :

Child +18 Turkish ID Number :
Insured Name Last Name :
Insured Sign :
Date :

Child +18 Turkish ID Number :
Insured Name Last Name :
Insured Sign :
Date :

Child +18 Turkish ID Number :
Insured Name Last Name :
Insured Sign :
Date :

Child +18 Turkish ID Number :
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