

Health Insurance Application Form



You can use this form to apply for health insurance. Please use a black or blue pen to complete this form. It is quicker to apply for health insurance on our website, averoachmea.nl/premie.

1 My details (policyholder)

Initials Infix Last name

Date of birth - - ☐ Male ☐ Female Social Security Number

Nationality ☐ Dutch ☐ Other

Street name House number Addition

Postal code City Country

Home phone number Mobile telephone no.

E-mail address

Are you applying for insurance for yourself? ☐ Yes ☐ No

Voluntarily chosen excess¹⁾ ☐ None ☐ € 100,- ☐ € 200,- ☐ € 300,- ☐ € 400,- ☐ € 500,-

Name group/company

Group collectivity number Employee or registration number

Which family member is member of, works for or receives social benefits from that organisation? (You can tick several family members.)

☐ Policyholder ☐ Insured 1 ☐ Insured 2 ☐ Insured 3 ☐ Insured 4

2 Other insured persons Who else do you want the policy to cover

Insured 1 Initials Infix Last name

Date of birth - - ☐ Male ☐ Female Social Security Number

Nationality ☐ Dutch ☐ Other Relationship to policyholder ☐ Partner ☐ Child

Voluntary chosen excess¹⁾ ☐ None ☐ € 100,- ☐ € 200,- ☐ € 300,- ☐ € 400,- ☐ € 500,-

Insured 2 Initials Infix Last name

Date of birth - - ☐ Male ☐ Female Social Security Number

Nationality ☐ Dutch ☐ Other Relationship to policyholder ☐ Partner ☐ Child

Voluntary chosen excess¹⁾ ☐ None ☐ € 100,- ☐ € 200,- ☐ € 300,- ☐ € 400,- ☐ € 500,-

Insured 3 Initials Infix Last name

Date of birth - - ☐ Male ☐ Female Social Security Number

Nationality ☐ Dutch ☐ Other Relationship to policyholder ☐ Partner ☐ Child

Voluntary chosen excess¹⁾ ☐ None ☐ € 100,- ☐ € 200,- ☐ € 300,- ☐ € 400,- ☐ € 500,-

Insured 4 Initials Infix Last name

Date of birth - - ☐ Male ☐ Female Social Security Number

Nationality ☐ Dutch ☐ Other Relationship to policyholder ☐ Partner ☐ Child

Voluntary chosen excess¹⁾ ☐ None ☐ € 100,- ☐ € 200,- ☐ € 300,- ☐ € 400,- ☐ € 500,-

3 Basic and supplementary insurance policies

		Policyholder	Insured 1	Insured 2	Insured 3	Insured 4
Basisverzekering	Zorg Plan Restitutie	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Zorg Plan Natura	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aanvullend²⁾	Intro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Start	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Royaal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aanvullend Tand³⁾	Start	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Extra	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Royaal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional question Tand Royaal en Tand Excellent (only fill in if you take out this insurance)*

Does/do the policyholder/insured persons have the most extensive dental insurance with their current healthcare insurer?

Policyholder Insured 1 Insured 2 Insured 3 Insured 4

☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

* Sometimes we need more information about your teeth. If this is the case, we will send you another application form.

4 Income (only fill in for persons of 18 and older)

	Policyholder	Insured 1	Insured 2	Insured 3	Insured 4
Do you have a personal income?	<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
I receive my income from	<input type="checkbox"/> Netherlands <input type="checkbox"/> Abroad <input type="checkbox"/> Both	<input type="checkbox"/> Netherlands <input type="checkbox"/> Abroad <input type="checkbox"/> Both	<input type="checkbox"/> Netherlands <input type="checkbox"/> Abroad <input type="checkbox"/> Both	<input type="checkbox"/> Netherlands <input type="checkbox"/> Abroad <input type="checkbox"/> Both	<input type="checkbox"/> Netherlands <input type="checkbox"/> Abroad <input type="checkbox"/> Both

5 Why are you taking out basic insurance and from which date?

<input type="checkbox"/> I am transferring from another healthcare insurer from 1 January	<input type="checkbox"/> I wish to be policyholder
<input type="checkbox"/> I have group healthcare insurance and switch group plans	<input type="checkbox"/> Because I come/am returning from abroad
<input type="checkbox"/> New entitlement to healthcare insurance has been established	<input type="checkbox"/> I am uninsured since
<input type="checkbox"/> I was insured through Menzis COA administration (MCA)	<input type="checkbox"/> Other : <input type="text"/>

Commencement date - -

Taking out healthcare insurance you authorise Avero Zorgverzekeringen N.V. Achmea Zorgverzekeringen N.V. to terminate your current healthcare insurance including possible supplementary insurances on your behalf. Should you NOT wish us to do so, please tick the box.

☐ I wish to keep my supplementary insurances with my current healthcare insurer.

6 Payment details (We also need your account number to be able to pay your claims.)

My account number (IBAN)

I pay the premium ☐ Month ☐ Quarter ☐ Half-year⁴⁾ ☐ Year⁵⁾

By signing this form you give NL 12ZZZ302086330000 Avero Achmea / Achmea Zorgverzekeringen N.V. permission to charge your insurance premium, deductible excess, statutory contribution and any other possible claims according this method of payment.

7 Policyholder signature

In signing this form, you declare that:

- all of the information you have provided is correct
- you have not concealed any important information
- you are aware that we may terminate your insurance or reject your application if you have provided false or inaccurate information
- you are aware that you are obliged to pay the premium once the policy commences.

We will use the information you have provided:

- to register you for insurance
- to improve our service
- to ensure that your details are not misused by third parties
- to send you information about other products offered by Achmea or Zilveren Kruis
- we ensure that your details are protected in accordance with the data protection regulations issued by the Dutch Data Protection Authority (College Bescherming Persoonsgegevens (CBP)).

Date - - Policyholder signature

1) Are you 18 or older? In that case you are obliged to pay a mandatory excess of € 385,- in 2018. This mandatory excess only applies to the basic insurance. You can also opt for a voluntarily chosen excess, in which case you will pay a lower premium.

2) You can only take out this insurance for persons who are 18 or older. Children under the age of 18 are automatically covered free of charge.

3) Are you 18 or older? In that case the cost of dental care is no longer reimbursed by your basic insurance. What if you want the cost of dental care to be reimbursed? In that case you can take out additional insurance that covers dental care.

4) You are entitled to a 1.25% discount.

5) You are entitled to a 3% discount.

**Send the completed and signed form to Avero Achmea, t.a.v. Serviceteam Polis, Antwoordnummer 45428, 1040 WD Amsterdam.
A stamp is not necessary.**