globalhealth
Foyer Group

Application for health insurance

DIA DEUTSCHE IM AUSLAND e.V.

Insurer: Foyer Santé S.A., a Luxembourg health insurance company having its corporate seat at 12, rue Léon Laval, L-3372 Leudelange, Luxembourg, registered under N° B72153 in the Luxembourg Trade and Companies' register, supervised by the Commissariat aux Assurances (7, boulevard Joseph II, L-1840 Luxembourg; +352226911-1; caa@caa.lu)

- [ ] New client
- [ ] Existing client of the insurer (If yes, please indicate the client reference)
- [ ] Individual
- [x] Group, group contract partner DR-WALTER Versicherungsmakler GmbH

Application for a health insurance policy

Please note: This Application Form cannot be processed if any fields are left blank.

Please refer to the General Terms and Conditions of the Insurer (Foyer Global Health Conditions), the Special Conditions and the Terms and Conditions for Medical Assistance Services and Additional Services before completing this form. Capitalised terms used herein and not otherwise defined shall have the meaning attributed to them in the Glossary appended to the General Terms and Conditions and in the Special Conditions.

Having read and understood the General Terms and Conditions, the Special Conditions and the Terms and Conditions for Medical Assistance Services and Additional Services, I hereby apply for a health insurance policy for the Insured Parties listed below.

1 Policyholder personal details

☐ I act only as Policyholder (I am not an Insured Party) ☐ I act as both Policyholder and Insured Party (I am Insured Party 1)

Desired start date of insurance coverage (dd/mm/yyyy) __ /__ /____

Title | First name | Surname

Gender ☐ M ☐ F | Date of Birth (dd/mm/yyyy) __ /__ /____ | Occupation

Address | Correspondence Address

Contact details + | ✉

Nationality / Nationalities

Country of current location

Country of expatriation | Location

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

☐ English ☐ French ☐ German

2 Insured Parties' personal details

Insured Party 2

If different than person 1: Desired start date of insurance coverage (dd/mm/yyyy) __ /__ /____

Title | First name | Surname

Gender ☐ M ☐ F | Date of Birth (dd/mm/yyyy) __ /__ /____ | Occupation

Adresse ☐ Same as Person 1 | Correspondence Address ☐ Same as Person 1

Contact details ☐ Same as Person 1 + | ✉

Nationality / Nationalities

Country of current location

Country of expatriation | Location

Insured Party 3

If different than person 1: Desired start date of insurance coverage (dd/mm/yyyy) __ /__ /____

Title | First name | Surname

Gender ☐ M ☐ F | Date of Birth (dd/mm/yyyy) __ /__ /____ | Occupation

Adresse ☐ Same as Person 1 | Correspondence Address ☐ Same as Person 1

Contact details ☐ Same as Person 1 | + | ✉

Nationality / Nationalities

Country of current location

Country of expatriation | Location

Insured Party 4

If different than person 1: Desired start date of insurance coverage (dd/mm/yyyy) __ /__ /____

Title | First name | Surname

Gender ☐ M ☐ F | Date of Birth (dd/mm/yyyy) __ /__ /____ | Occupation

Adresse ☐ Same as Person 1 | Correspondence Address ☐ Same as Person 1

Contact details ☐ Same as Person 1 | + | ✉

Nationality / Nationalities

Country of current location

Country of expatriation | Location

3 Plan level and region

Person	Plan Level (Essential, Special and Exclusive)	Additional Medical Assitance Services*	Region	Premium (monthly)
1	☐ Essential ☐ Special ☐ Exclusive **Deductible:** ☐ None ☐ 250€ ☐ 500€ ☐ 1000€	☐ YES ☐ NO	☐ Worldwide ☐ Worldwide excl.USA	_____ EUR
2	☐ Essential ☐ Special ☐ Exclusive **Deductible:** ☐ None ☐ 250€ ☐ 500€ ☐ 1000€	☐ YES ☐ NO	☐ Worldwide ☐ Worldwide excl.USA	_____ EUR
3	☐ Essential ☐ Special ☐ Exclusive **Deductible:** ☐ None ☐ 250€ ☐ 500€ ☐ 1000€	☐ YES ☐ NO	☐ Worldwide ☐ Worldwide excl.USA	_____ EUR
4	☐ Essential ☐ Special ☐ Exclusive **Deductible:** ☐ None ☐ 250€ ☐ 500€ ☐ 1000€	☐ YES ☐ NO	☐ Worldwide ☐ Worldwide excl.USA	_____ EUR

Total amount ** for all insured Parties: _____ EUR

* As defined in the Special Conditions. The monthly premium for the additional assistance package amounts to 5 Euros. Please add this amount to your premium amount if you are including additional assistance in your coverage.

** I am informed that depending on the country of expatriation taxes and fees might be added to the premium.

4 Data concerning the Insured Party's state of health

☐ Moratorium (coverage only available if all the Insured Parties are aged 55 or younger at the date of the signature of the present Application Form).

I am not required to fill in the health questions below and understand that Pre-Existing Conditions and related conditions may not be covered under the Insurance Policy or may only be covered subject to a Waiting Period of at least 24 months.

If there is not enough space for your answers, please use the fillable table in the next page.

	1	2	3	4
4.1 Please indicate your height and weight?	cm kg	cm kg	cm kg	cm kg
4.2 Do you currently have any afflictions, Diseases or health problems?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
4.3 Do you regularly take medication? If yes, please indicate on the following page.	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
4.4 Do you have a disability and/or total or temporary Incapacity to work? If yes, please specify the degree.	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
4.5 Do you have any handicaps, birth defects, prostheses or implants?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
4.6 Have you stayed in a hospital, a sanatorium or another medical institution in the last 5 years?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
4.7 Have you had any afflictions, Diseases or health problems following an accident over the last 3 years (even if never treated)	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no

4.8 Have you undergone any medical treatments in the last 3 years, due to illness, accident or mental health problems? (Please do not indicate preventive medical check-ups).	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
4. 9 Do you plan or have you been advised to undergo any necessary treatments, Medical Treatments or surgery (including dental treatments, dental prostheses or orthodontic treatments)?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
4.10 Are you currently pregnant? If yes, what is the estimated due date?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
4.11 Have you been diagnosed with HIV infection?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
4.12 Do you use any vision aids (glasses or contact lenses)? • Dioptre on the right: • Dioptre on the left:	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
4.13 Are you missing any teeth (with the exception of wisdom teeth) that have not been replaced? Number of missing teeth:	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no

Please give further details concerning the questions to which you answered "yes". For each one, please also answer the following questions:

- What is/was the diagnosis? When was it diagnosed? During what period was it treated, is it ongoing?
- Please give the name and address of the treating health care provider.
- What medication or medical treatment is/was necessary?

If there is not enough space for your answers, please use a separate sheet of paper and attach it to this Application Form.
Separate sheet attached?

☐ Yes ☐ No

Person	Question N°	Type of Disease, health problem, affliction (please state the exact diagnosis); name of prescribed Medication or Medical Treatment (if known)	Duration of the treatment	Treating doctor, hospital (name and address)	Are any other treatments planned?
			From __/__ /____ Until __/__ /____		☐ yes ☐ no
			From __/__ /____ Until __/__ /____		☐ yes ☐ no
			From __/__ /____ Until __/__ /____		☐ yes ☐ no
			From __/__ /____ Until __/__ /____		☐ yes ☐ no
			From __/__ /____ Until __/__ /____		☐ yes ☐ no
			From __/__ /____ Until __/__ /____		☐ yes ☐ no
			From __/__ /____ Until __/__ /____		☐ yes ☐ no

5 Did or does a statutory or private health insurance policy exist with another insurer, or have you applied for health coverage elsewhere?

Please provide insurance information for the past **3 years** (private or **public**)

	1	2	3	4
	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Name and address of the company				
Duration	From __/__ /____ Until __/__ /____	From __/__ /____ Until __/__ /____	From __/__ /____ Until __/__ /____	From __/__ /____ Until __/__ /____

6 Payment of premiums

A 2% discount applies to semi-annual payments and a 3% discount applies to annual payments.

A) Payment frequency

☐ monthly (only possible for direct debit and credit card payment) ☐ quarterly ☐ semi-annually ☐ annually

B) Payment method

☐ Bank Transfer (only possible for quarterly, semi-annual or annual payments)

☐ Credit Card
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 your insurance cover.

☐ Direct debit SEPA
Please complete the SEPA Direct Debit Mandate (page 7) and return it with the Application Form.

7 Reimbursement account

A bank account must be specified for reimbursements to the Policyholder.

Account holder **Name of bank**

Account No. **Branch No.**

Address (Postal / zip / area code / town / city and country)

Swift code **Currency**

IBAN

8 Special agreements (subject to the written approval of the Insurer)

9 Broker

- Broker name: DR-WALTER Versicherungsmakler GmbH
- Broker number: 3861

10 Basis of the Insurance Policy and declaration of the Policyholder and the Insured Parties

This Application Form commits neither the Policyholder nor the Insurer to conclude the Insurance Policy, and the signature of the Application Form does not cause the insurance cover and related Benefits to enter into force or take effect. Within 30 days of receipt of the Application Form, the Insurer is obliged, under penalty of paying damages, to notify the Policyholder either of an offer to conclude the Insurance Policy, or of the Insurer's decision to subject the conclusion of the Insurance Policy to further enquiries (notably in the form of additional medical controls), or of the Insurer's refusal to conclude the Insurance Policy.

This Application Form and the medical information given in response to the integrated health questionnaire and provided to the Insurer serve as a basis of the Insurance Policy and will form a part thereof.

The Policyholder and the Insured Parties are required to reply honestly, carefully and thoroughly to all the questions included in this Application Form. Any changes to the information provided in this Application Form and, in particular, any changes in the state of health, that may occur between the signature of this Application Form and the conclusion of the Insurance Policy, as well as any Medical Treatments, consultations or exams that may be prescribed or administered between the signature of this Application Form and the conclusion of the Insurance Policy (including those that were intended or recommended at the date of the signature of the Application Form), and any change in the Policyholder's and Insured Party's professional activity, must immediately be declared in writing to the Insurer.

In order to enable the Insurer to provide customer service, assess and accept the insured risks, pay out the Benefits and perform any other action pertaining to the execution, administration or management of the Insurance Policy, the Insured Parties (or the legal representatives of any minors who are Insured Parties) expressly authorise and instruct the Insurer to obtain, at any time, from the Medical Authorities advising or treating the Insured Party, further information regarding any Diseases, Bodily Injuries or previous and existing afflictions of the Insured Party that may occur, for as long as the Insurance Policy remains in force and effect. Such authorisation and instruction remain effective beyond the death of the Insured Party.

11 Explicit consent for processing health data

By signing this Application Form, the Policyholder and/or, as the case may be, the Insured Party ("you" or the "Data Subjects") expressly give their explicit consent, in accordance with the provisions of the EU Regulation No. 2016/679 of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (the "GDPR") and any applicable data protection laws, including but not limited to the law of 1 August 2018 governing the organisation of the National Commission for Data Protection and the implementation of the GDPR, as may be amended or replaced (collectively "Data Protection Law"), to the Insurer's processing of the health data provided by them on this Application Form and in the course of the performance of the Insurance Policy (the "Health Data").

The Health Data may also be processed by the Data Controller's data recipients (the "Recipients") which, in the context of the aforementioned purposes, may refer to the entities mentioned in the list you can find under the following link: https://www.foyerglobalhealth.com/general-and-special-conditions-of-our-products/.

You may, at your discretion, refuse to communicate the Health Data to the Data Controller. In this event, however, you may not be able to benefit from the Insurance Policy if such Health Data is necessary for the purpose of entering into the Insurance Policy, and/or the performance of the insurance services may be impaired if the Health Data is necessary for the purpose of the executing or performing the Insurance Policy.
The Health Data may also be processed by the Data Controller's data recipients (the "Recipients") which, in the context of the aforementioned purposes, may refer to [reinsurers as well as any other third party supporting the activities of the Data Controller]. The Recipients may, under their own responsibility, disclose the Health Data to their agents and/or delegates (the "Sub-Recipients"), which shall process the Health Data for the sole purposes of assisting the Recipients in providing their services to the Data Controller and/or assisting the Recipients in fulfilling their own legal obligations. The Recipients and Sub-Recipients shall be located inside the European Economic Area (the "EEA").

The Recipients and Sub-Recipients may, as the case may be, process the Health Data as data processors (when processing the Health Data on behalf and on the instruction of the Data Controller and/or the Recipients), or as distinct controllers (when processing the Health Data for their own purposes, in particular to meet their own legal obligations).

You have the right to withdraw your consent at any time. In this event, however, you may be required to withdraw from the Insurance Policy. You also have the right to (i) access your Health Data, (ii) correct your Health Data where it is inaccurate or incomplete, (iii) object to the processing of your Health Data, (iv) restrict the use of your Health Data, (v) ask for erasure of your Health Data and (vi) ask for Health Data portability. You may exercise the above rights by writing to the registered office of the Data Controller at the following email address: dataprotectionofficer@foyer.lu. You also have the right to lodge a complaint with the Commission Nationale pour la Protection des Données or with any competent data protection supervisory authority of your EU Member State of residence.

By signing this Application Form, the Policyholder and/or, as the case may be, the Insured Party ("you" or the "Data Subjects") expressly give their explicit consent, to the attached data protection document.

12 Signature(s)

Date and location

...../...../..... in .....

Signature of the Policyholder (full name)

Signature of Insured Party 1, if not the policyholder (full name), their legal representative (if applicable)

Signature of Insured Party 2, if not the policyholder (full name), their legal representative (if applicable)

Signature of Insured party 3, if not the policyholder (full name), their legal representative (if applicable)

Signature of Insured Party 4, if not the policyholder (full name), their legal representative (if applicable)

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Core Mandate

European Direct Debit / SEPA Direct Debit

Please return to:
policy@foyerglobalhealth.com
Foyer Santé S.A., Comptabilité Clients
12 rue Léon Laval; L-3372 LEUDELANGE

Mandate Reference

FGH -

Identification of the creditor (A)

Creditor Identifier	LU73ZZZ000000000639002008
Name of the creditor	FOYER SANTE S.A.
Address	12, RUE LEON LAVAL, L-3372 LEUDELANGE
Type of payment	Recurring payment

Identification of the account holder (B)

Policyholder name	
Address	
Account holder name	
Address (If it's different from the policyholder)	
Account number - IBAN	
Swift BIC	

Debtor's details. Full address only if different from the account holder: if the account holder is making a payment in respect of an arrangement between the creditor and another person (e.g. where the account holder is paying that other person's bill) please include the other person's address here.

Debtor name	
Address	

SIGNATURE(S)

Date and location

...../...../..... in .....

By signing this mandate form, the account holder authorises (A) the creditor to send instructions to the account holder's bank in order to debit the account holder's account indicated above, and (B) the account holder's bank to debit the account holder's account in accordance with instructions from the creditor.
The account holder has the right to a refund from the account holder's bank under the terms and conditions of the account holder's agreement with their bank. A refund must be claimed within 8 weeks starting from the date on which the account holder's account was debited.

Data protection

1) Data protection

In accordance with Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data and in accordance with the Act of 1 August 2018 on the organisation of the National Data Protection Commission and the implementation of Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, Foyer Santé S.A. respectively collect, record and process the data that the policyholder and the insured person(s) have sent to them, as well as those that they will provide them with subsequently, with a view to assessing the risks, preparing, drawing up, managing and performing the insurance policy(ies), settling any claims that may arise and preventing any fraud.

The special categories of personal data concerning health are processed by Foyer Santé S.A. within the strict framework of the purpose of Article 9 paragraph (2) g) of the GDPR or on the basis of your prior and explicit consent unless there are legal exceptions such as the protection of vital interests or the safeguarding of a legitimate interest.

No personal data will be processed for commercial prospecting purposes. The processing of data for commercial prospecting purposes will always be done with the express consent of the data subject, who retains the right to withdraw their consent.

The data controller is Foyer Santé S.A..

The data controller is entitled to provide data to third parties, in particular the reinsurer, medical officer, lawyers or other service providers, as well as within the framework of legal obligations. This transmission of data will be made in accordance with the terms and conditions set out under article 300 of the amended Law of 7 December 2015 on the insurance sector.

In the event that your personal data is transferred, recorded, and stored on a cloud server managed by a third-party host located in the EU, this transfer will be made in accordance with the terms and conditions set out under the GDPR.

In the event that personal data is transferred outside the EU, all the protection measures provided by the GDPR will be required, planned, and observed in accordance with this regulation and, more specifically, Chapter V on the transfer to third countries.

All obligations arising from Article 35 on the data protection impact assessment will be complied with.

When a Luxembourg-based insurance agent or insurance broker is the insurance intermediary in charge of the contractual management between Foyer Assurances and the policyholder, the data are provided in accordance with the terms and conditions set out in Article 300 of the amended Insurance Sector Law of 7 December 2015.

When the intermediation is provided by a non-Luxembourg-based insurance broker, the policyholder expressly authorizes Foyer Santé S.A. to communicate to the insurance intermediary any information relating to the contract. The policyholder may revoke this communication mandate by sending his request, by registered mail with acknowledgement of receipt to Foyer Santé S.A..

In the event that the policyholder seeks advice on insurance distribution from an insurance agent who is a member of the distribution network of Foyer Santé S.A. without being an insurance intermediary for the policyholder, the policyholder authorizes Foyer Santé S.A. to communicate to this insurance agent the identification data (surname, first name, address, date of birth, bank details and, where appropriate, data relating to persons habitually living in the policyholder's household) necessary to enable the policyholder to serve him and to advise him usefully in his new requests. The policyholder may also revoke this communication mandate by sending his request by registered mail with acknowledgement of receipt to Foyer Santé S.A..

The policyholder has a right of access, limitation, erasure within the legal limits, rectification and portability concerning his data which can be exercised by sending a written request to the address of the data controller.

The duration of the storage is limited to the term of the policy and to the period during which the storage of the data is necessary to enable Foyer Santé S.A. to comply with its obligations according to the limitation periods or other legal obligations.

Foyer Santé S.A. has appointed a Data Protection Officer who may be contacted by post at the address of the data controller or by email at dataprotectionofficer@foyer.lu.

2) Professional secrecy, sub-contracting, and sub-contracting to cloud computing service providers

Foyer Santé S.A. attaches great importance to respecting the professional secrecy and the confidentiality of its customer's data and undertakes at all times to implement all necessary and required measures to ensure the confidentiality of data according with the highest quality standards and in compliance with the regulations in force.

To guarantee a high level of quality of services and to provide the most advanced technologies to its customers, Foyer Santé S.A. may use service providers, sub-contractors and technologies using cloud computing. In any case, the data communicated will be protected according to high quality standards and in compliance with the regulations including those provided by the GDPR.

When the communication of data protected by professional secrecy in insurance matters takes place within the framework of sub-contracting and technologies using cloud computing is set up at the initiative of Foyer Santé S.A., within the meaning of Article 2bis paragraph 2 of Article 300 of the amended law of 7 December 2015 with a third-party service provider other than those referred to in this Article 300, the policyholder expressly consents to any subcontracting, including cloud computing.

The policyholder can access the details of these sub-contracting (sub-contracting table) at any time under the link https://www.foyer.lu/en/transparency. The policyholder can also request a hard copy of the sub-contracting table.
The policyholder will find on the sub-contracting table, the existence of current sub-contracts, the type of information that is transmitted and the country of establishment of the service provider(s). Should this service provider not be subject to an obligation of professional secrecy to that of Foyer Santé S.A. commits to enter into a confidentiality agreement with the service provider in order to require it to comply with such a confidentiality obligation as part of the sub-contracting concerned.

In the event of a change in the sub-contracting table (examples: addition of a sub-contractor, use of cloud computing... non-exhaustive list), the policyholder will be validly informed of the change by email and/or his client area and/or any other appropriate means (example: due date notice).

If within two months of a change in the sub-contracting table the policyholder has not objected in writing, the policyholder shall be deemed to have irrevocably accepted the subcontracting in question. In case of an objection by the policyholder, this must be notified to the insurer by registered letter. This will be valid as a cancellation at the next expiry of the contract only.

As an exception, if your insurance contract cannot be cancelled annually, your consent shall be valid for the entire duration of the insurance contract, including any subsequent modifications.

The policyholder shall be duly informed that:

- If he objects a change in the sub-contracting table, this objection will have consequences on an optimal management of the insurance contract(s) and on the level of service provided, and therefore the opposition is valid as a cancellation on the next due date.
- If he holds several insurance contracts with Foyer Santé S.A., it is required for the policyholder to notify one objection per insurance contract.