

Received by Globality S.A.:

Date/ Person responsible

Declaration of accession to group insurance

Globality CoGenio®



Globality S.A.

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Phone: +352 270 444 3501, e-mail: service-cogenio@globality-health.com

Globality S.A.

Board of Directors: Christof Flosbach (Chairman), Anja Berner,
Jens Gruss, Dr. Rasmus Schlömer, Dr. Cornelia Röskau
Commercial Register (R.C.S. Luxembourg): B 134.471

Declaration of accession to group insurance

I herewith declare my accession to the group contract with the group contract number

and request co-insurance of the persons listed under Person 1, 2, 3, 4.

The group insurance partner is the policyholder.

A. Particulars concerning the applicant (Person 1)

First name	Surname	Title	Date of birth (DD/MM/YYYY)	Start date of insurance
Gender <input type="checkbox"/> male <input type="checkbox"/> female	Nationality	Occupation		Professional status
Building/floor	Street and house number	Postcode and town		Country and region
Mobile phone (+ country code)	Fax (+ country code and local dialling code)		E-mail	
<input type="checkbox"/> New (not yet customer of Globality S.A.)	<input type="checkbox"/> Previous or existing customer of Globality S.A. If yes, please provide insurance number/numbers.			
Correspondence address <input type="checkbox"/> Same as above <input type="checkbox"/> Other:	Building/ floor	Street and house number	Postcode and town	Country and region

B. Particulars concerning the insured persons

Person	First name	Surname	Title	Husband/Wife	Non-marital partner	Child	Date of birth	Gender m	f	Nationalities	Occupation	Start date of insurance
2				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>			
3				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>			
4				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>			

C. Further particulars concerning the insured persons

Country of future location (where you will live as an expatriate):

Home country:

Country of current location (where the application is signed):

Contractual language/ language for communication:
All the required information will be provided in this language.

German English
 French Spanish
 Dutch

D. Plan levels and geographical areas for Globality CoGenio®

Person	Plan level	Deductible*	Geographical area	Premium (monthly) in <input type="checkbox"/> € <input type="checkbox"/> \$ <input type="checkbox"/> £
1	<input type="checkbox"/> Classic <input type="checkbox"/> Plus <input type="checkbox"/> Top	<input type="checkbox"/> None <input type="checkbox"/> 250 €/ 325 \$/ 210 £ <input type="checkbox"/> 500 €/ 650 \$/ 420 £ <input type="checkbox"/> 1000 €/ 1300 \$/ 840 £	<input type="checkbox"/> None USA <input type="checkbox"/> Incl. USA	
2	<input type="checkbox"/> Classic <input type="checkbox"/> Plus <input type="checkbox"/> Top	<input type="checkbox"/> None <input type="checkbox"/> 250 €/ 325 \$/ 210 £ <input type="checkbox"/> 500 €/ 650 \$/ 420 £ <input type="checkbox"/> 1000 €/ 1300 \$/ 840 £	<input type="checkbox"/> None USA <input type="checkbox"/> Incl. USA	
3	<input type="checkbox"/> Classic <input type="checkbox"/> Plus <input type="checkbox"/> Top	<input type="checkbox"/> None <input type="checkbox"/> 250 €/ 325 \$/ 210 £ <input type="checkbox"/> 500 €/ 650 \$/ 420 £ <input type="checkbox"/> 1000 €/ 1300 \$/ 840 £	<input type="checkbox"/> None USA <input type="checkbox"/> Incl. USA	
4	<input type="checkbox"/> Classic <input type="checkbox"/> Plus <input type="checkbox"/> Top	<input type="checkbox"/> None <input type="checkbox"/> 250 €/ 325 \$/ 210 £ <input type="checkbox"/> 500 €/ 650 \$/ 420 £ <input type="checkbox"/> 1000 €/ 1300 \$/ 840 £	<input type="checkbox"/> None USA <input type="checkbox"/> Incl. USA	

*Classic level only with a deductible of 250 €/ 325 US\$/ 210 £. **Total monthly premium (for all 4 persons)**

E. Previous insurance

Do you have or have you ever had held health insurance cover in the past 5 years (including compulsory statutory/private/government insurance)?

Person	Insurer	Inpatient	Outpatient	Dental	Period (from – to/month-year)
1	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

F. Information on your state of health

Based on the answers you provide, you will be informed whether risk loadings have to be added to the premium or whether exclusions have to be applied to your insurance cover.

Important: Please note the following (refer also to "Responsibility for the information provided in the declaration of accession", page 5):

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 declaration of accession. 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.** In this case, you must indicate in the declaration of accession 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 wilfully violated – submit a new quote allowing for the increased medical risk (risk loading or exclusion of benefits) within one month of being informed of the violation. The new quote must be accepted within one month of receipt. If the quote is not accepted within this period, we will have the right to terminate the insurance cover. The insurance cover shall be null and void if our assessment of the risk is affected by a wilful 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.

Health conditions arising between signing the declaration of accession 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 declaration of accession and acceptance by us.**

If insurance cover already exists or existed 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.

	Person 1		Person 2		Person 3		Person 4	
Height and weight	in cm / in kg							
	No	Yes	No	Yes	No	Yes	No	Yes
1. Have you been admitted to a hospital, therapy centre, health cure or sanatorium during the last five years? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you undergone surgery (including outpatient surgery) at any time during the last five years? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you received psychotherapy or treatment of an addiction during the last five years? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you suffered any illnesses, disorders, consequences of an accident or other impairments of your health _____ or have you undergone any examinations/treatment either during the last three years or at present?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you require any kind of medication (e.g. tablets, ointments)? If yes, please specify which and what for. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you been advised, or are you planning, to undergo any kind of outpatient/inpatient treatment or examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been tested positive, awaiting treatments, investigations, check ups or the results of investigations for AIDS, HIV, Hepatitis B, C, D?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have impaired vision with 8 diopters or more? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have any physical/organic defect, a chronic illness, an illness or injury due to military service, any reduction in your ability to work/degree of disability? If yes, please enclose a copy of the official notice. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you pregnant? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you visited a dentist during the last five years for a treatment or a check up? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you currently receiving dental treatment (please indicate your dentist details on the box below), are dentures being produced or renewed, are you receiving treatment for periodontal disease or orthodontic treatment, or has such treatment been recommended or planned? (If yes, an up-to-date plan of treatment and costs must be enclosed.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. 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)? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you been diagnosed with periodontitis or other periodontal disease? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes to 12,13 or 14, you will be asked to submit a dental form sent to you by Globality. This dental form must be completed, signed and stamped by a dentist.

Further details: if you answered "Yes" to any of the questions above, please provide details in the table below. Please provide medical reports if available.					
Person	Question	Type of illness, drugs, injury, symptoms, examination (what was diagnosed?); diopter grade? Question 12: which treatment?	Treatment/symptoms from – to (month-year)	Name and address of doctors, hospitals; who can provide further information?	When did treatment/symptoms cease?

Please specify the name and address of your family doctor or other doctor best able to provide further information concerning your health:

G. Special agreements* and remarks

* Subject to written confirmation by Globality S.A.

H. Payment of premiums


Payment to be made by <input type="checkbox"/> Insured person <input type="checkbox"/> Policyholder	Payment frequency <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Half-yearly <input type="checkbox"/> Yearly
Payment method <input type="checkbox"/> Premium to be remitted to Globality S.A. – EURO Account BGL BNP Paribas · IBAN: LU090030309301020000 · Swift Code: BGLLLLULL <input type="checkbox"/> Premium to be remitted to Globality S.A. – USD Account BGL BNP Paribas · IBAN: LU450030309301173000 · Swift Code: BGLLLLULL <input type="checkbox"/> Premium to be remitted to Globality S.A. – GBP Account BGL BNP Paribas · IBAN: LU810030309301326000 · Swift Code: BGLLLLULL	
<input type="checkbox"/> Credit Card Together with your welcome package, you will receive a link to a special secure webpage, where you will be able to enter your credit card details in order to active your insurance cover. Please note that the following surcharges are due on the premium for the respective intervals: 0% for yearly payment, 2% for half-yearly payment, 3% for quarterly payment and 4% for monthly payment.	
<input type="checkbox"/> 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. <small>*Eurozone includes: Austria, Belgium, Cyprus, Estonia, Finland, France, Germany, Greece, Italy, Latvia, Luxembourg, Malta, Netherlands, Portugal, Republic of Ireland, Slovakia, Slovenia, Spain.</small>	

I. Reimbursements of claims

One account must be specified for reimbursements by the insurer if available.

Account holder	Name of bank
Account No.	Branch No. (BLZ)
Postcode / Town	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.

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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 ** 7

Creditor name

** 8

Creditor identifier

** 9

Street name and number

** 10

Postal code City

** 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

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

The following points are known to me:

Right of withdrawal

You may withdraw your declaration of accession to the insurance contract in writing within 14 days without stating any reasons. The time-limit begins to run on the day on which you receive your insurance policy and the General Conditions of Insurance. For compliance with this deadline, it is sufficient to send your notice of withdrawal by post, e-mail or fax before it expires. Your withdrawal should be addressed to Globality S.A., 1A, rue Gabriel Lippmann, L-5365 Munsbach. If you send your withdrawal by e-mail or fax, please send it to: service-group@globality-health.com +352 / 270 444 3599.

Consequences of withdrawal

If you validly exercise your right of withdrawal, the premiums and benefits received must be returned by the respective parties. If you have agreed to inception of the insurance cover before expiry of the period for withdrawal, we are only obliged to refund the premium corresponding to the period following the receipt of your notice of withdrawal.

Responsibility for the information provided in the declaration of accession

Before declaring my intention to access an insurance 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 cover.

Attention is drawn to the information given on page 2 with regard to the legal consequences of incorrectly answering the questions concerning your state of health.

Applicable law

Unless the application of a different law is required by national legislation or unless otherwise stipulated in the insurance contract, the insurance contract shall be governed by the law of the Grand Duchy of Luxembourg.

Supervisory authority

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.

Data Protection

In accordance with applicable data protection rules, the data subjects, including the insured person(s) and the policyholder (the "Data Subjects"), are informed that their personal data is processed by the insurer, Globality S.A. This will be done only for the purposes of the granting of the insurance cover, the performance of the insurance contract (including to provide insurance cover or to pay for a claim, to manage the risk associated to the insurance coverage through reinsurance, etc.), the provision of related assistance services, advice and support (including contacting a repatriation service provider, assisting in finding an appropriate medical services provider, etc.) and compliance with applicable legal and regulatory obligations relating to fraud detection, anti-money laundering rules and the regulatory requirements applicable to the insurance company, including the requirements of the law of 7th December 2015 on the insurance sector, as amended. Globality S.A. also processes personal data when it is necessary for the purposes of the legitimate interests it pursues, including ensuring IT security and IT operations, carrying out marketing activities, market surveys and questionnaires, and preventing and investigating punishable offenses. Supplied details may also be used by Globality S.A. to make automated decisions, pertaining in particular to the conclusion or cancellation of a contract, possible risk preclusion or benefit obligations.

Personal data that are processed include identification data and contact details, insurance and health data, bank and credit details (the "Personal Data"). The Personal Data is obtained directly from the Data Subjects or from the insurance intermediary of the Data Subjects. In the case of collective health insurance schemes entered into by an employer for the benefit of its staff, Globality S.A. may obtain identification data of the staff members concerned from the employer in order to determine whether insurance claims filed at a later stage by employees are covered. In certain cases, health data may be obtained from medical services providers and their staff and insurance data may be obtained from other insurance companies and from statutory health insurance institutions when the Data Subjects have consented to such release of information. The processing of health data is required

for the purposes of the underwriting services (i.e. evaluating the risks covered, matching to appropriate policy/premium, assessing whether the requested insurance coverage may be provided etc.) and for claims management purposes. Information relating to the Data Subjects may also be provided by credit rating companies keeping debtor and private insolvency registers in order to assess creditworthiness.

Globality S.A. may share Personal Data with Service Providers, including group companies, for the purpose of the performance of the insurance contract and the provision of assistance services, advice and support in the countries in which the insured person(s) require health insurance cover, support and assistance. The Service Providers may be located in countries that do not offer a level of protection that is equivalent to the protection afforded under Luxembourg law or any other European data protection standards. For this reason, Globality S.A. has entered into appropriate contractual arrangements with the Service Providers in order to guarantee adequate safeguards for the processing and protection of personal data. A copy of such agreements may be consulted at the registered office of Globality S.A. Information about the identity and registered office of third party data processing Service Providers is available from Globality S.A. on request at any time. Globality S.A. may also share Personal Data with other Service Providers such as its reinsurer, banks, auditors and legal advisors or with regulatory or judicial authorities.

Data Subjects have the right to request access to their Personal Data. They may require that their Personal Data is rectified in case of error. Data Subjects may also request that their Personal Data is erased or that data processing be restricted if the Personal Data may no longer be legitimately held or processed.

Data Subjects further have a right to object to processing of Personal Data for direct marketing purposes. When the processing of Personal Data is carried out by Globality S.A. on the grounds that it is necessary for the purposes of the legitimate interests pursued by Globality S.A., Data Subjects also have a right to object to such processing, on grounds relating to their particular situation.

The right to data portability is granted under the conditions laid down in the applicable data protection rules. Data Subjects may exercise their rights by writing to Globality S.A. at dataprotection@globality-health.com.

Data Subjects have the right to lodge a complaint with a supervisory authority.

Personal Data will be stored for the duration of the contractual relationship and thereafter until legal claims are barred under the statute of limitation.

The provision of the Personal Data, including health data, is required for the performance of the insurance contract and to pay for a claim. Failure to provide sufficient, accurate and up-to-date information may prevent Globality S.A. from providing cover.

Globality S.A. may be contacted by mail at its registered office indicated on its letterhead. It may also be contacted by e-mail at dataprotection@globality-health.com.

Processing of health data and consent to provide access to medical data

Data Subjects are informed that health data may be processed by Globality S.A. and its Service Providers, including group companies, as set out in the Data Protection clause above, for the purposes of providing health insurance cover and for the provision of related assistance services and support. By signing this declaration of accession, Data Subjects may explicitly consent to the processing of their health data. The withdrawal of consent will not affect the data processing carried out prior to such withdrawal.

Application and acceptance of your declaration of accession to group insurance

The declaration of accession does not bind either you or us to conclude the contract. However we will notify you within 30 days of receipt with an insurance offer. The insurance will be subjected to an inquiry or survey which could result in 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').

Start date of insurance cover

Insurance cover commences on the date specified in the insurance policy (start date of insurance). Insured events occurring before the start date of the insurance will not be indemnified. Insurance events occurring after conclusion of the insurance contract are only excluded from indemnification insofar as they occur before the start date of the insurance.

If the insurance cover is amended, the provisions of this paragraph will apply to the new, additional part of the insurance cover.

Governing documents

The insurance plan entered through this declaration of accession is governed by the General Conditions of Insurance for Globality CoGenio®.

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

Conversion:

- **General Conditions of Insurance for the Globality CoGenio®**

In cases of conversion of an insurance cover (e.g. change of plan levels), the plan features specified in the General Conditions of Insurance for Globality CoGenio® shall apply for the new plan level as from the date of conversion specified in the endorsement to the insurance certificate.

- **Right of withdrawal**

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

- **Crediting of the prior term**

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

Insurance cover may be increased during an insurance year; reductions in insurance cover are only possible with effect from the beginning of the next insurance year.

- **Insurance year**

The insurance year shall remain unchanged following conversion.

- **Surcharges for substandard risk, restrictions, exclusions**

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

Any restrictions on insurance cover and exclusions from benefits applicable in the past will continue to apply after conversion of an insurance.

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

Persons eligible for insurance

As an employee/member of the group policyholder specified on page 1, I confirm being eligible for insurance under this group contract or that I will be eligible on the start date of the insurance cover. 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 group contract; they are not co-insured automatically.

Previous insurance

Data about 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 need to be provided to Globality S.A. by the insured.

J. Final provisions

Please check that the information provided in this declaration of accession is correct and complete.

By signing this form,

- I also give my consent to the receipt, storage, processing and transmission of personal data and give mandate to provide medical information (in some jurisdictions referred to as release from the professional confidentiality duty) as detailed on pages 5 and 6. I give this consent for myself, for my insured children and for the coinsured persons I represent by law.
- I do not give mandate to professionals to provide Globality S.A. with information on my health and treatment as detailed on pages 5 and 6. 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 mandate to the specified persons or institutions to forward information to Globality S.A.

To be completed by the insurance intermediary: When answering the questions in this form, did the insured person provide information which has not been recorded in this application form? No Yes

If yes, which?

If I choose this alternative,

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.

All information and documents regarding my policy will be sent:

- to my correspondence address
 - to the policyholder
 - to the following insurance intermediary to whom I give mandate to receive them on my behalf:
-
- to whom I give mandate to receive them on my behalf.

By signing this declaration of accession, [please tick the following appropriate boxes]

- I confirm I have read and understood the General Conditions of Insurance for Globality CoGenio® and the declarations printed on pages 5 and 6 (including the declaration concerning my right of withdrawal and data protection).

Data protection

- I explicitly consent to the processing of my health data by Globality S.A. and its service providers, including group companies, as set out in the Data Protection clause above, for the purposes of providing health insurance cover and for the provision of related assistance services and support. This consent may be revoked at any time.

If I refuse to tick this box and thus to give consent to the processing of my health data by Globality S.A. and its service providers, including group companies, as set out in the Data Protection clause above, for the purposes of providing health insurance cover and for the provision of related assistance services and support, I understand that:

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 associated with my request.
2. It may take longer to investigate my claims, benefits may be reduced or Globality S.A. 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.
3. I will have to decide, in each instance, whether or not I will give consent to the specified persons or institutions to forward information to Globality S.A.

- I herewith agree that information on special offers by Globality S.A. may be sent to me in writing, in electronic form and by telephone. This consent may be revoked at any time.

All persons aged 18 years and older have to sign. For minors and incapable adults, the authorized legal representative(s) have to sign.

Place and date	Signature of the applicant	Signature of insurance intermediary
Insurance intermediary name and No.	Sub-intermediary 1 name and No.	Sub-intermediary 2 name and No.
Signature(s) of the co-insured person(s) or their legal representative(s)		