Group Insurance (Health Care)

Individual continuation of the collective Health cover

This document makes it possibly to apply for an individual insurance. This application does not bind you to closing an agreement.

To be filled in by the employee

Data of the employer who offered the collective cover:

Name of the employer: _____

Date on which your employer informed you of the loss of the collective cover: _____

Identity of member of personnel

Name: Date of birth: / /

First name : Gender* : M / F

Street : n°: B:

Postal Code : City:

Phone number: / Fax : /

Email (private):

Hospitalization cover

Group n°: S/Group n°: Contract n°:

Date on witch the hospitalization cover became effective? / /

Date on witch the hospitalization cover was ended? / / (This date has been communicated by your employer)

Please give an overview of all your hospitalization covers during the last 2 years? Private cover as well as cover offered by the employer:

	Beginning	Ending	Insurance Company	Employer (if any)
1	____ /____ /____	____ /____ /____		
2	____ /____ /____	____ /____ /____		
3	____ /____ /____	____ /____ /____		

The data of the members of family who were covered by the collective Insurance and wish to continue their cover on an individual basis:

Family	Name & First name	Date of birth	Gender (*)	Postal code
Spouse/ Partner		____ /____ /____	M / F	
1st child		____ /____ /____	M / F	
2nd child		____ /____ /____	M / F	
3rd child		____ /____ /____	M / F	
4th child		____ /____ /____	M / F	
5th child		____ /____ /____	M / F	

Are you affiliated to AG Care Vision or AG Care Vision Full?* ☐ **Yes: contract n°: 04/8** ☐☐☐☐☐☐

☐ **No**

Other Health Care Cover(s)

If you wish to continue an other Health Care Cover, please mention the cover: _____

The undersigned agrees for AG Insurance to process the above-mentioned data, subject to compliance with the Belgian privacy legislation, with a view to providing and managing insurance services in general, including the drawing up of statistics.
AG Insurance shall not communicate such data to third parties. However, the undersigned agrees for AG Insurance to communicate such data provided it has a statutory or contractual obligation or a legitimate interest. The person involved is entitled to consult and, where appropriate, to correct his data.
If you do not wish your data to be processed for purposes of direct marketing, you may object to it expressly, free of charge, by ticking this box: ☐

Made out in _____, on ____ /____ /_____

Signature of the affiliate,

(*)Please delete what is not appropriate

Please send your application to:	AG Insurance Employee Benefits – Health Care 1JQ5B Boulevard Emile Jacqmain 53 1000 Brussels continuation.employeebenefits@aginsurance.be FAX: 02/664 79 66

0079-8082531E-230420149