Individual continuation of the corporated sponsored health cover

To be filled in by the employer

Information provided by the employer to the employee.

Important notice: the information contained in this document shall be provided to the insured staff member at the latest 30 days after forfeiture of the benefit under the corporated sponsored health cover together with the request form 'Request for individual continuation of the corporated sponsored health cover'.

Information on the employer:

Name of the employer: _____

Date on which the employee has been informed of the entitlement to individual continuation of a corporated sponsored policy:
_____ /_____ / _____

Information on the employee:

Name & first name: _____

Street: _____ N° : _____

Postal code: _____ City: _____

Data concerning the plans (*):

Group n°: ☐☐☐☐ S/Groupe n°: ☐☐☐☐ Contract n° : ☐☐☐☐☐☐☐☐

You are entitled, under the conditions of article 208 of the law of 4 april 2014 on Insurance, to continue the corporate sponsored health cover agreement (**)

☐ health care
☐ guaranteed income

on an individual basis. In order to be eligible, you must have been insured with a private insurer for an uninterrupted period during the last 2 years.

The entitlement to continuation also applies for family members, if they were affiliates at the time of forfeiture of the corporate sponsored policy.

Affiliation to the corporate sponsored health cover agreement (health care/guaranteed income) terminated on _____ /_____ /_____

In order to continue this (these) corporate sponsored insurance(s) on an individual basis, the attached document must be forwarded, fully completed, to AG Insurance at the address under reference within **30 days after receipt of this letter**.You are entitled to further extend this term for a supplementary period of 30 days provided you inform AG Insurance thereof by letter or by email.
This information is provided to the employer as stipulated in article 208 of the law of 4 april 2014 on insurance of the above-mentioned law.

Made out in _____ ,on _____ /_____ /_____

Signature of the employee, Signature of the employer,

(*) If the employee is affiliated to various health covers, would you please mention any of the reference numbers, preferably the hospitalization insurance.
(**)Please cross your choice

0079-8070632E-30092016

Group Insurance (Health Care)

Individual continuation of the corporated sponsored 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 corporate sponsored health cover:

Name of the employer: _____

Date on which your employer informed you of the loss of the corporate sponsored health 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 which the hospitalization cover became effective? / /

Date on which 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@aginsurance.be FAX: 02/664 79 66

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