COSMOS insurance — Always by your side.

# Cyprus Choice

## MEDICAL INSURANCE APPLICATION FORM

**Important Note:**
Please ensure that you disclose all material facts in this Application Form to the best of your knowledge, which shall form the basis of contract, otherwise the issued policy may be void. A material fact is one which may influence the assessment or acceptance of the risk to be insured by Cosmos Insurance Company Public Ltd. ('Cosmos'). If you are in doubt whether a fact is material, please disclose it on the Application Form.

1. Please complete this Application Form in BLOCK LETTERS in BLACK/BLUE PEN. Any corrections should be signed /initialised by the form signatory or you should complete a new form. Corrective fluid should not be used.
2. All applications are subject to underwriting.
3. Please tick the appropriate box and delete whichever is inappropriate.

### Choice of Plan

Please refer to the Member Guide and Table of Benefits for full details.

| **Geographical area:** | Worldwide including USA ☐ | Worldwide excluding USA ☐ | Cyprus, Europe & Israel ☐ |
|---|---|---|---|

| **Core cover:** | Basic ☐ | Select ☐ | Classic ☐ | Premier ☐ |
|---|---|---|---|---|
| **Outpatient cover:** | Basic ☐ | Select ☐ | Classic ☐ | Premier ☐ |

### Optional Packages

| **Vision and Dental:** | Option 1 ☐ | Option 2 ☐ |
|---|---|---|
| **Vision, Dental and Maternity:** | Option 1 ☐ | Option 2 ☐ |

| **Deductible Amount*:** | €85 ☐ | €150 ☐ | €300 ☐ | €500 ☐ | €1.000 ☐ | €2.000 ☐ |
|---|---|---|---|---|---|---|

*Note: There is a mandatory deductible per insured member per period of cover of €50. Higher deductibles are available that, if selected, provide premium discount. If no selection is made the €50 deductible will apply.

| **Co-insurance:** | 80% reimbursement on in-patient (Core benefits) ☐ | 20% co-insurance on out-patient (out-patient benefits) ☐ |
|---|---|---|

### Policyholder's Details

| Full name / Company Name | | | |
|---|---|---|---|
| Identification Number / Passport No. / Company's Registration No. | | | |
| Nationality | | Date of Birth (dd/mm/yyyy) | |
| Address of Residence | | | |
| Postcode | Town | Telephone | Mobile Phone |
| Email Address | | | |
| Correspondence Address (if different) | | | |
| Postcode | | Town | |

Please turn over to complete form

## Main Insured's Details

| 1. Title (Mr./Mrs./Ms.) | 2. First Name(s) | | 3. Surname | |
|---|---|---|---|---|
| 4a. Passport/Company Reg. No. | | 4b. National ID Number | | |
| 5. Date of Birth (dd/mm/yyyy) | 6. Sex (M/F) | | 7. Height (cm) | |
| 8. Weight (Kg) | 9. Nationality | | 10. Country of residence | |
| 11. Marital Status | Single ☐ | Married ☐ | Widowed ☐ | Divorced ☐ |
| 12. Residential address | | | Postcode | |
| 13. Correspondence address (if different) | | | Postcode | |
| 14. Email address | | | 15. Home phone | 16. Office phone |
| 17. Mobile | 18. Occupation | | | |

**Dependant's details**

| | Surname | Name | Sex (M/F) | Nationality | National ID/ Passport/ Birth Certificate No. | Date of Birth (dd/mm/yyyy) | Height (cm) | Weight (kg) |
|---|---|---|---|---|---|---|---|---|
| Spouse | | | | | | | | |
| Child | | | | | | | | |
| Child | | | | | | | | |
| Child | | | | | | | | |

**Questions 19-25 must be completed for each person applying for cover**
For any positive answer please provide additional information in section 24 below.

| | YES | NO |
|---|---|---|
| 19. Including work permit exams and annual physicals, **within the past 5 years, has the main insured or eligible dependant:**<br>a. Consulted or received any treatment by a doctor, therapist, counsellor, dentist or other health care professional? | | |
| b. Been admitted to any hospital, clinic, day care or other treatment facility? | | |
| 20. Has the main insured or any eligible dependant taken any medications, prescribed or otherwise, or received treatment or therapy of any kind in the past 5 years, or at the present time? | | |
| 21. Is the main insured or any eligible dependant currently pregnant? If yes, provide expected date of delivery below. | | |
| 22. Is there any known or likely need for the main insured or any eligible dependant to seek advice, treatment or investigations from a health care professional? (This includes symptoms you are aware of, even if undiagnosed or untreated) | | |

**23. Has the main insured or any eligible dependant ever experienced symptoms of, or received treatment or investigations for any of the following?**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| a. AIDS, AIDS-related complex (ARC), HIV diagnosis | | | k. High blood pressure, raised cholesterol, other blood disorder | | |
| b. Alcohol dependency and/or drug abuse | | | l. Ears, eyes, nose or throat problem | | |
| c. Arthritis, back, bone, joint, muscle or nerve problem | | | m. Irregular periods, fibroids, other pelvic disorder | | |
| d. Asthma, bronchitis, other respiratory problem | | | n. Injury, syndrome or physical defect/deformity | | |
| e. Cancer, tumour, growth or cyst | | | o. Skin problems | | |
| f. Dental problem or gum disease | | | p. Stomach, bowel, liver, kidney or gall-bladder problem | | |
| g. Depression, stress, anxiety, other psychological disorder | | | q. Varicose veins, circulation problem | | |
| h. Diabetes, thyroid, other hormonal disorder | | | r. Prostate or reproductive organ disorders or abnormal smears | | |
| i. Epilepsy, seizures, dizziness or fainting spells | | | s. Any other disorder or condition (acute or chronic) not listed above | | |
| j. Heart disease, stroke, other heart problem | | | | | |

**24. If the answer to any of the above is 'YES' please provide the following details for each symptom/condition**
(please use additional paper if necessary)

| Item No. | Name of person(s) this relates to | Symptom / Nature of disorder / Infected Areas / Diagnosis | Date(s) of treatment / tests / onset | Treatment received and/or Medication taken | Status: stable / ongoing / full recovery |
|---|---|---|---|---|---|
| | | | | | |
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| | | | | | |

**25. Previous Insurance**

| | YES | NO |
|---|---|---|
| Has the main insured or any eligible dependant ever been denied any other insurance cover, or offered coverage with any exclusions?<br>If YES, please provide applicant name and details: | | |
| Have you, or has the main insured or any eligible dependant ever applied for medical coverage with Cosmos?<br>If YES, please provide previous policy number: | | |

**26. Premium payment method**
The premium must be paid by the Policyholder. Otherwise, please provide supporting documents to prove the relationship between the payer and the Applicant/ Policyholder. Cosmos reserves the right not to accept the premium paid by a third party.

| Frequency of payment: | Monthly* | Quarterly | Semi-Annually | Annually |
|---|---|---|---|---|

*Note: This method is only available with Direct Debit or with automatic VISA transactions.

| Cheque payable to “Cosmos Insurance Company Public Ltd.” | VISA | Direct Debit | Cash |
|---|---|---|---|
| Name of the Card Issuer:<br>(to be completed only if ‘VISA’ is the preferred method of payment) | | | |
| Credit Card No: | | Expiry Date: | |
| Cardholder’s Full Name<br><br>I hereby authorise Cosmos Insurance Company Public Ltd. to charge my above credit card for the insurance premiums of this insurance policy. | | | |
| **Cardholder’s Signature** | | **Date** D D M M Y Y | |

**27. How we handle your personal data**
In order for us to provide quotes, insurance policies or deal with any claims in connection with the insurance arrangements that you have with us, we need to collect and process personal data about you, including:

- individual details, such as name, address and date of birth;
- risk details, which is information we need to collect in order to assess the risk to be insured and provide a quote.

This may include data relating to your health;

- current and past claims details, which may also include data relating to your health.

We might collect your personal data from various sources, including your insurance intermediary (if any) and medical experts appointed to treat you in the event of a claim. We will keep your personal data only for so long as is necessary and for the purpose for which it was originally collected.

The provision of insurance involves the sharing of personal data between different insurance market participants, including brokers, insurers and reinsurers, and third parties who provide services in connection with the insurance, such as medical experts, each of whom may be located outside of your country of residence.

If you have any questions in relation to the use of your or your dependant’s personal data visit **www.cosmosinsurance.com.cy/terms**

**When we need your consent**
In order to provide insurance cover and deal with insurance claims, we may need to process categories of personal data which have additional protection under data protection law, such as your health data.
Your consent to this processing may be necessary for us to achieve this.
Your consent may be withdrawn at any time. However, if consent is withdrawn this will impact our ability to provide insurance or pay claims.

**28. Authorisation**

I, the undersigned declare that I have carefully read all the questions. I fully understood them and that all my answers are complete and truthful and I accept this proposal of mine to form the basis of the contract which shall be issued and shall come into force from the date of its issuance and received by me, provided that the first premium shall have been fully paid and the state of health as well as the rest of the conditions affecting the insurability of the insured person and of the insured dependants shall remain as they have been declared in the proposal.

I have been informed in accordance with the provisions of the Law 125(I) 2018, which I have fully understood and following that by providing my consent to the processing of my sensitive personal data and I will enable COSMOS INSURANCE COMPANY PUBLIC LTD and/or its agents to provide me with a custom made insurance proposal suitable for the needs of myself and my dependants, therefore:

| | YES | NO |
|---|---|---|
| I consent for COSMOS INSURANCE COMPANY PUBLIC LTD and or its agents to process my sensitive personal data provided through the present application for the purpose of providing me with a custom made medical insurance | ☐ | ☐ |
| I consent for COSMOS INSURANCE COMPANY PUBLIC LTD and or its agents to process the sensitive personal data of my dependants provided through the present application for the purpose of providing them with a custom made medical insurance | ☐ | ☐ |
| I consent for COSMOS INSURANCE COMPANY PUBLIC LTD and its agents to process my personal data for the purpose of promoting otherinsurance products | ☐ | ☐ |
| Furthermore and for the aim of the proper evaluation of my application I hereby authorize any medical practitioner, hospital, clinic, insurance company or other organization, institution having data or knowledge about myself or about my health, as well as about any proposed dependant with me person, to give COSMOS INSURANCE COMPANY PUBLIC LTD every information that may be required for the purpose of providing me with a custom made medical insurance. | ☐ | ☐ |

| **Policyholder's Signature** (and Stamp in case of company) | **Date** (dd/mm/yyyy) | **Signed at** |
|---|---|---|
| | | |

| **Main Insured's Signature** | **Spouse's Signature** (Spouse must sign when spouse coverage is requested) |
|---|---|
| **Date** D D M M Y Y | **Date** D D M M Y Y |

| **Adult Dependant Signature** | **Adult Dependant Signature** |
|---|---|
| **Date** D D M M Y Y | **Date** D D M M Y Y |

Please return this completed and signed form to your Agent / Broker.

| **Agent's Signature** | **Agent / Broker Code** | **Agent / Broker Contact Tel No.** |
|---|---|---|
| | | |

**Date** D D M M Y Y

**Declaration of Continued Good Health**

(to be completed if cover is not approved within 90 days from the date original application is signed)

Since the date the original Health Insurance Application was signed, has the main insured or any eligible dependant:

| | YES | NO |
|---|---|---|
| 1. Experienced any symptoms of any new health problem or condition? | ☐ | ☐ |
| 2. Received any advice, treatment or investigations from any health professional or hospital facility? | ☐ | ☐ |
| 3. Any intention/need to seek advice, treatment or investigations from a health professional or hospital in future? | ☐ | ☐ |

**If the answer is YES to any of the above, please provide applicant name and full details on Page 1**

It is understood and agreed that the above statements and answers are true and complete to the best of my knowledge.
It is understood that additional information or examination by a physician may be required.

| **Signature** | **Date** D D M M Y Y |
|---|---|
| | |