

Welcome to Zorg en Zekerheid. Please help us deal with your insurance application as swiftly as possible by completing this form as much as you can. Please do not forget to fill in the back page. You can also register with us at zorgzekerheid.nl.

1. Applicant

Initials and last name m f

Address House number

Postal code City/town

Date of birth Citizen Service Number (BSN)

Telephone Nationality

E-mailaddress

Do not keep me informed of new information or special offers by email.

Yes, I would like to receive my policy schedule in digital format. You can find it in MijnZZ.

Please check MijnZZ for your right email address.

No, I would like to receive my policy schedule by regular mail.

2. Claims payment, required premium payment and voluntary and mandatory excess.

Applicant's IBAN (bank account number)

I wish to pay my premium as follows:

Payment by direct debit per month 3 months half year year. I hereby authorize Zorg en Zekerheid to direct debit my account for the due amount(s).

Monthly payment by giro collection form.

If you authorize us to direct debit your account half-yearly or annually, you will receive a 1% or 2% reduction, respectively, on your premium.

I wish to pay my voluntary and mandatory excess as follows:

Payment by direct debit. I hereby authorize Zorg en Zekerheid to direct debit my account.

Payment by giro collection form.

I will arrange everything related to my insurance on the internet and will receive a 2% internet discount on my supplementary insurance*.

3. I apply for:

Group insurance via an employer, sports club or other association, health clubs, health centre or other organisation.

Provide the details of the organisation concerned:

Name Division (at employer's)

Address Zipcode and city

The GeZZinspakket.

Group insurance for students.

Group insurance for singles.

Group insurance for couples.

Group insurance via a home care organisation in my area.

An individual insurance.

4. Family members to be included in the insurance

	Initials	Family name and/or birth name	M/F	Date of birth	Citizen Service Number (BSN)	Nationality
Partner			m/f			
First child			m/f			
Second child			m/f			
Third child			m/f			
Fourth child			m/f			

* Read the conditions of mijnZZ at zorgzekerheid/mijnzz

** Read the conditions of AV-Delen at zorgzekerheid/delen

5. Share dental coverage**

Sharing of dental coverage is possible for two insured persons older than 18 years on the same policy with the same supplementary insurance. Do you wish to share your dental coverage?

- Yes (choose the supplementary insurance in the row of AV-Delen you would like to have covered at point 6).
- No (continue to point 6).

6. Type of basic insurance, voluntary excess and supplementary insurance required

Children under 18 are insured under the highest supplementary insurance taken out by their parent/carer.

	Basic insurance			Voluntary excess (on top of compulsory excess of € 385,00)					Supplementary insurance						AV-Delen									
	Zorg Zeker Polis	Zorg Vrij Polis	Zorg Gemak Polis*	€ 0	€ 100	€ 200	€ 300	€ 400	€ 500	AV-Sure	AV-GeZZin	AV-GeZZin Compact	AV-Plus	AV-Basis	AV-Standaard	AV-Top	AV-Gemak	AV-Sure delen	AV-GeZZin delen	AV-GeZZin Compact delen	AV-Plus delen	AV-Standaard delen	AV-Top delen	
Applicant																								
Partner																								
First child																								
Second child																								
Third child																								
Fourth child																								

* The Zorg Gemak Polis only knows one amount for voluntary excess, € 500,00.

7. Requested start date for your new insurance with Zorg en Zekerheid:

□□-□□-□□□□

8. Do you come from another country?

- No
- Yes, as from □□-□□-□□□□

Or your partner?

- No
- Yes, as from □□-□□-□□□□

Or your children?

- No
- Yes, as from □□-□□-□□□□

Have you (and/or your family members) come from a non-EU country?
If so, please add a copy of both sides of the residence permit or electronic W-document..

9. Cancellation service

By applying for healthcare insurance, you grant us permission to cancel your old healthcare insurance (and that of your family members) on your behalf. We will also assume this to include permission to cancel all supplementary insurance with your old insurer on your behalf (and that of your family members). Please tick the box below if this is not the case.

- I do not want you to cancel the supplementary health care insurance on my behalf (or my partner/the rest of my family).

You can use the switch service but you cannot switch retroactively. Subsequently you can only use the switch service:

1. If you are co-insured as a relative and you want to take out your own health insurance, for instance because you are getting divorced or because you reach the age of 18.
2. If in the course of this year you will change employer through whom you are collectively insured and you will be collectively insured through your new employer at Zorg en Zekerheid.

10. Signature

The undersigned declares to have filled in this form truthfully. The undersigned has also taken note of the fact that:
The undersigned declares to have filled out this form truthfully. The undersigned has taken note that:

- I. If no options are selected in the sections relating to the basic insurance, excess, payment method and/or frequency, Zorg en Zekerheid will proceed on the basis of the Zorg Zeker Policy, a preferred voluntary excess of €0.00 and monthly payment via direct debit.
- II. In the event of any incorrect representation of events, Zorg en Zekerheid will be entitled to claim back all costs already paid and terminate the insurance.
- III. In the event the contract commences on a date other than 1 January, the contract will be valid for the current year. With effect from the following 1 January, the insurance will be tacitly renewed for the duration of one year.
- IV. If you have indicated that you wish to take out group insurance, Zorg en Zekerheid will exchange your data with the relevant organisation.
- V. I agree to the policy conditions applicable to this insurance. These conditions are listed under the heading 'Service en contact' at zorgenzekerheid.nl. A free paper copy of these is also available on request.

City: _____ Date: □□-□□-□□□□

Signature applicant:

What to do with completed forms Please send this application to Zorg en Zekerheid at Postbus 400, 2300 AK, LEIDEN. We have an obligation to verify that you are resident in the Netherlands. Your data will be stored in order to send you updates about our products and services. OWM Zorgverzekeraar Zorg en Zekerheid u.a. will process your personal data for the purpose of concluding and performing the (insurance) contract, administration and all activities arising from this. Zorg en Zekerheid subscribes to the Code of Conduct for the processing of personal details by financial institutions (Gedragscode verwerking persoonsgegevens financiële instellingen).