



Answer the questions in capital letters using a blue or black biro.
You can only be insured with CZ if you meet the following conditions:

- You live in the Netherlands **and**
- you are working in/ receiving benefits abroad **and**
- You have received convention form 106/109/121/S1 from your foreign healthcare insurer. (Send this form along with this application)

| | |
|---|----------------------|
| Broker information (to be completed by broker) | |
| Broker number | <input type="text"/> |
| Client number | <input type="text"/> |
| Collectivity information (to be completed by collectivity) | |
| Collectivity's number | <input type="text"/> |
| Personnel number/membership number* | <input type="text"/> |
| Bill number/business unit number *(if applicable) | <input type="text"/> |

Commencement date: (dd-mm-yyyy)

The commencement date is always equal to the commencement date stated in the convention form.

Personal Information

| | |
|------------------------------------|--|
| Initials <input type="text"/> | First Name <input type="text"/> |
| Prefix <input type="text"/> | Surname <input type="text"/> |
| Date of Birth <input type="text"/> | Sex <input type="checkbox"/> M <input type="checkbox"/> F CZ insurance no. (if known) <input type="text"/> |

Address

| | | |
|------------------------------------|---|---|
| Street <input type="text"/> | House No. <input type="text"/> | House No. suffix <input type="text"/> |
| Postal code <input type="text"/> | Place of residence <input type="text"/> | Country <input type="text"/> |
| Telnr. 1 <input type="text"/> | Telnr. 2 <input type="text"/> | Social security number <input type="text"/> |
| Email address <input type="text"/> | | |

Details of the family members to be insured

| Initials | Prefix | Surname | Date of birth | Sex | BSN / SOFI number |
|----------------------|----------------------|----------------------|----------------------|---|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="text"/> |

1 Do you or a member of your family receive income from the Netherlands?

Explanation of question 1: Income from the Netherlands is income from work (e.g. employed or self-employed work) in the Netherlands or a Dutch social security benefit (e.g. Unemployment benefit, Sickness benefit, Disability benefit, State Pension). This question applies to all family members of all ages.

Completion of these sections is mandatory, otherwise the form cannot be processed.

No

Yes, You date of birth Income

 Family member date of birth Income

 Family member date of birth Income

 Family member date of birth Income

2 Insurance details

Please let us know by filling in the table at the bottom of the page, which additional insurance you choose. Do you not like to have any additional insurance or additional dental insurance? Then please fill in the word 'none' in the blank space.

Deductible

For insured persons aged 18 and above there is a compulsory deductible of € 385 per year.

Additional insurance None, Start, Basis, Plus, Top, Jongeren, Gezinnen, 50+

The additional policies Jongeren and Gezinnen cover you for dental charges. You cannot take out additional dental insurance with this policy.

Additional dental insurance None, Tandarts, Uitgebreide tandarts

If you opt for the additional insurance Uitgebreide tandarts, CZ will need a dentist's statement for the medical assessment. You and your dentist will need to complete and sign the statement. We will send the statement to you.

| Date of birth | Additional insurance | Additional dental insurance |
|----------------------|----------------------|-----------------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

3 How would you like to pay the premium?

Clarification of question 3: With automatic debit orders, CZ will be entitled to debit your bank account (IBAN) for **all** amounts that pertain to your health insurance premium. You will need to sign a separate authorisation form for this purpose. We will send this form to you. The account number for which the authorisation is given must be the policyholder's own account number. This authorisation can always be withdrawn at a later stage. We will also use your account number for payments owed to you.

a month quarter six months year

b automatic direct debit giro collection form

c What is your bank account number (IBAN)?

What is your BIC?

**This only needs to be filled in for non-Dutch bank accounts.*

4 Who is your current health insurer? Registration number

5 Cancellation of current insurance

With this registration you give CZ permission to cancel the basic insurance and the additional insurance with your current health insurer. You also give this permission on behalf of other people named in this form. Do you not want CZ to cancel all of the insurance for all of those people? If so, indicate which policy CZ should cancel and for which people.

| Surname | Date of birth | General insurance | Additional insurance |
|----------------------|----------------------|--------------------------|--------------------------|
| <input type="text"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="text"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="text"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="text"/> | <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> |

6 Do all the persons to be insured have Dutch nationality?

Explanation of question 6: In a number of cases CZ requires additional documents for insured persons. If you are an EU or EEA national and have a BSN (citizen service number) you do not need to send any additional documents. If you are NOT an EU or EEA national or do not have a BSN (citizen service number), please send a copy of your passport and a copy of your residence permit for the country of residence.

Yes No, not the following:

| | | | |
|---------------|----------------------|-------------|----------------------|
| Date of birth | <input type="text"/> | Nationality | <input type="text"/> |
| Date of birth | <input type="text"/> | Nationality | <input type="text"/> |
| Date of birth | <input type="text"/> | Nationality | <input type="text"/> |
| Date of birth | <input type="text"/> | Nationality | <input type="text"/> |

External Reference Register (EVR) assessment

We will check your details against the External Reference Register (EVR) when you register with us. A fraud registration may have implications for your additional insurance.

Signature

The undersigned certifies that he or she has answered all of the questions in this application form correctly, fully and truthfully. This application form is the basis of the medical insurance that is being taken out with OWM Centrale Zorgverzekeraars Groep Zorgverzekeraars u.a., Chamber of Commerce no. 41095222, and of any additional insurance contacts that are being concluded with OWM Centrale Zorgverzekeraars Groep Aanvullende Verzekering Zorgverzekeraar u.a., Chamber of Commerce no. 18028752, under the conditions that apply. The undersigned confirms agreement to this.

Place Date Signature