



Application Basic and/or supplementary healthcare insurance VGZ Werkt

Use this form to request a basic or supplementary healthcare insurance, or to register a person for an existing insurance policy. Please tick what is applicable.
PLEASE COMPLETE THE FORM IN CAPITALS.

New insurance policy Registering a new insured for an existing policy

A. Personal details

The customer number is listed in Mijn VGZ.

Customer number

If you are already insured with us and you only want to register a new insured, please enter your customer number, name and date of birth. Then continue to question B.

2 Initials Surname prefix Surname

Date of birth Gender BSN (citizen service number) Nationality
 Male Female NL Other*

Street House number House number suffix

Postcode Town/city

Telephone number Mobile telephone number

Email address

Are you applying for insurance for yourself? Yes No

B. Personal details of persons to be insured

Are you applying for insurance for your family members or other persons? Yes No
 If not, please continue to question C.

2 Initials Surname prefix Surname

Date of birth Gender BSN (citizen service number) Nationality
 Male Female NL Other*

3 Initials Surname prefix Surname

Date of birth Gender BSN (citizen service number) Nationality
 Male Female NL Other*

4 Initials Surname prefix Surname

Date of birth Gender BSN (citizen service number) Nationality
 Male Female NL Other*

5 Initials Surname prefix Surname

Date of birth Gender BSN (citizen service number) Nationality
 Male Female NL Other*

6 Initials Surname prefix Surname

Date of birth Gender BSN (citizen service number) Nationality
 Male Female NL Other*

You can find your BSN on your identity document.

* Was your passport issued by an EU or EEA country, or Switzerland? Then please send us a copy of your passport or European identity card. If you have a different nationality, please send us a copy of your residence card.

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C. Income from abroad

Income includes wage, profit or other income from labour, pensions or social security. If you have any questions about your healthcare insurance relating to income earned abroad, then please visit our website for more information.

Does one of the persons for whom you are submitting this application receive any income from abroad? Yes No

If yes, to which person/persons is this applicable? Insured 1 2 3 4 5 6

D. Group insurance

* Please enquire with your employer or organisation if you need to find your group discount number, personnel number or membership number.

Are you applying for group insurance? Yes No
If not, please continue to question E.

Name of employer/organisation

Date of start employment at employer

Group discount number*

Postcode and town/city of employer/organisation

Personnel number/membership number*

We may check with your employer or organisation to verify if you are entitled to participation in a group policy.

More information on the basic insurance policy and the excess is available on our website.

E. Basic cover

Which basic cover would you like? Indicate your choice here.

| | VGZ Ruime Keuze | VGZ Eigen Keuze |
|-----------|--------------------------|--------------------------|
| Insured 1 | <input type="checkbox"/> | <input type="checkbox"/> |
| Insured 2 | <input type="checkbox"/> | <input type="checkbox"/> |
| Insured 3 | <input type="checkbox"/> | <input type="checkbox"/> |
| Insured 4 | <input type="checkbox"/> | <input type="checkbox"/> |
| Insured 5 | <input type="checkbox"/> | <input type="checkbox"/> |
| Insured 6 | <input type="checkbox"/> | <input type="checkbox"/> |

Excess

Every person age 18 and older is subject to a statutory excess on their healthcare policy. Every person age 18 and older may additionally choose a voluntary excess.

Would you like a voluntary excess? Yes No

If yes, please indicate your choice below. You do not have to make a choice for persons under age 18.

| | €100 | €200 | €300 | €400 | €500 |
|-----------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Insured 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Insured 2 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Insured 3 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Insured 4 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Insured 5 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Insured 6 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

F. Supplementary insurance

More information on the supplementary healthcare insurance policies is available on our website.

Do you require supplementary insurance? Yes No
If not, please continue to question H.

Do you require **supplementary insurance** (VGZ Werkt Goed, Beter, Best) and/or **dental insurance** (VGZ Werkt Tand Goed, Beter, Best)? Then please indicate your choice below.

You do not need to make a choice for persons under age 18. They are automatically classed in the highest supplementary insurance of one of the parents/foster parents.

VGZ Werkt Tand Best is subject to a qualification period of 1 calendar year for orthodontic care, partial dental prostheses and implants, crowns and bridges.

| | VGZ Werkt Goed | VGZ Werkt Beter | VGZ Werkt Best | VGZ Werkt Tand Goed | VGZ Werkt Tand Beter | VGZ Werkt Tand Best |
|-----------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Insured 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Insured 2 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Insured 3 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Insured 4 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Insured 5 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Insured 6 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

G. Start date and cancellation service

The start date of your healthcare insurance policy may deviate from your entry. The start date depends on the date on which we can verify that you are subject to mandatory insurance and on the termination date of your existing healthcare insurance policy.

The insurance should become effective as per

Do the persons covered by this application currently have healthcare insurance with a Dutch healthcare insurer? Yes No
If not, please complete Question 2.

1. If you request healthcare insurance, you are simultaneously giving us permission to cancel any existing healthcare insurance policies for the persons listed on this application for healthcare insurance. This permission also applies to any supplementary insurance policies. If you do not want the supplementary insurance policy/policies to be cancelled, please notify us accordingly below.

The supplementary insurance policy/policies should not be cancelled.

2. The persons covered by this application currently have no healthcare insurance with a Dutch healthcare insurer. Please state the situation that applies.

- Newborn Adopted Military insurance
 From abroad Former conscientious objector Not insured

H. Payment

If you choose payment by direct debit, the amount we automatically debit for your excess, personal contributions or reimbursements paid out that prove unjustified amounts to a maximum of €220 per month. Relating to amounts exceeding €220, you will receive a paper invoice. If we choose to send you a paper invoice, this form of payment is free of charge for you.

If you are registering a new insured for an existing policy, you do not need to complete this question. The premium payment method will not change.

What is your bank account number?

IBAN

We are unable to pay out your invoices without a bank account number.

How would you like to pay for the premiums and other amounts due?

Payment by direct debit is free. Please indicate your choice below.

- Monthly payment via direct debit Annual payment via direct debit
 Monthly payment via paper invoice (you pay €1.50 per paper invoice) Annual payment via paper invoice

Authorisation for direct debit

If you choose payment by direct debit, your authorisation is valid for payment of premiums, excess, personal contributions and any reimbursements paid out that prove unjustified. Your authorisation is valid during and, if necessary, after cancellation of the insurance contract. If a direct debit transaction cannot be executed, we will send you a paper invoice. This is subject to a fee of €1.50 per invoice.

If you disagree with a processed payment, you can have the payment reversed later. Please contact your bank within 8 weeks of processing the payment. Please ask your bank for the terms and conditions.

I. Approval and signature

By signing this form, you declare that the details completed in this form were entered fully and truthfully. You declare your approval of the application of the relevant policy terms and conditions on the insurance contract and the Healthcare Insurance Card relating to this insurance policy. You also declare that you agree with the start date, cancellation service (section G) and payment method (section H) as set out in this application form.

The terms and conditions and the Healthcare Insurance Card can be viewed at www.vgz.nl. We can send you the terms and conditions at your request. Registration will be processed after we have verified that the persons to be insured fulfil the terms and conditions of the healthcare insurance policy.

By taking out a healthcare insurance with VGZ Zorgverzekeraar N.V., the undersigned will also become a member of the cooperative society Coöperatie VGZ U.A., unless you express the desire not to do so. This cooperative society is the holder of all the shares of the VGZ Zorgverzekeraar N.V. and represents the interest of its members in the field of healthcare and other insurance. When terminating the insurance agreement/agreements, the membership will also be terminated.

We process your private data when we carry out your insurance policies. This is completed in compliance with legislation and regulations, including the General Data Protection Regulation (GDPR). Please find more details about this in the privacy statement on our website. The privacy statement also states your rights. If you conclude or change this contract, you authorise us to process your personal details and other data for the purposes as set out in the privacy statement. If you have any questions regarding processing private data, please contact our Data Protection Officer at privacy@vgz.nl. For more information about privacy, please check the Privacy page on our website.

You herewith grant VGZ permission to use your email address for sending:

- the policy schedule Yes No
- information relating to your healthcare insurance policy Yes No
notifications about your healthcare insurance, such as amendments to the premium and/or policy terms and conditions
- newsletters and offers Yes No
healthcare information such as newsletters and offers

Date

Town/city

Signature of policyholder

If you have any questions, please visit www.vgz.nl/contact. We are pleased to assist you.

Please enter the date and town or city. Have you signed the form? Then please send it to the address below:

Details VGZ

Please find below the details of Coöperatie VGZ. You can also find the collection details on your bank statement.

VGZ

PO Box 25210
5600 RS Eindhoven
The Netherlands

Collector ID

NL12ZZZ091567230000