

ALLIANZ CARE & HEALTH

INDIVIDUAL QUOTATION REQUEST FORM



INSURED PERSON

First Name : Last Name : Date of birth :/...../..... Nationality : Gender (M/F) :
 Residential address⁽¹⁾ : ZIP Code : City : Country :
 Email : Tel. : Cell phone :
 Correspondence Address (if different from the home address) : ZIP Code : City : Country :
 Professional status :

DEPENDANTS TO BE INCLUDED IN THE PLAN

Relationship	Last Name	First Name	Date of birth	Gender (M/F)	Country of usual residence ⁽¹⁾
_____	_____	_____	____/____/____	____/____	_____
_____	_____	_____	____/____/____	____/____	_____
_____	_____	_____	____/____/____	____/____	_____
_____	_____	_____	____/____/____	____/____	_____

(1) Country in which you and beneficiaries are living at least 6 months a year.

PAYMENT

How would you like to pay your premium (payment in dollars) ?

- Annually
 Semi-annually
 Quarterly

(Semi-annual and Quarterly premiums are subject to a 3%).

EFFECTIVE DATE OF COVERAGE

___/___/___

CHOOSE YOUR AREA OF COVERAGE

- Area 1**
Brazil, China, Hong Kong, Macau, Switzerland + countries in areas 2, 3, 4 et 5.
- Area 2**
Argentina, Australia, Belarus, Bosnia, Canada, Colombia, Spain, Ireland, Israel, Italy, Japan, Mexico, Monaco, United Kingdom, Russia, Singapore, South Korea, Venezuela + countries in Areas 3, 4, and 5.
- Area 3**
South Africa, Germany, Belgium, Chile, Denmark, Finland, France, Greece, Hungary, Iceland, New Caledonia, New Zealand, Portugal, Rest of Latin America, Rest of Europe, Sweden + countries in areas 4, and 5.
- Area 4**
Saudi Arabia, Bahrain, Egypt, United Arab Emirates, Iran, Iraq, Jordan, Kuwait, Lebanon, Oman, Qatar, Rest of Middle East, Syria, Turkey, Yemen + countries in area 5.
- Area 5**
Rest of Africa, Rest of Asia (Bangladesh, Cambodia, North Korea, India, Indonesia, Laos, Malaysia, Mongolia, Myanmar, Philippines, Sri Lanka, Vietnam, etc.).

CHOOSE YOUR PLAN

- Primary
 Vitality
 Prestige

1 Choose your Maximum Annual Limit :

- US\$ 25,000
 US\$ 50,000
 US\$ 200,000
 US\$ 300,000
 US\$ 500,000
 US\$ 4,500,000

2 Choose your level of coverage for Outpatient benefits :

(it will also apply to Maternity, Dental & Vision of chosen)

- 80% of usual benefits
 90% of usual benefits
 100% of usual benefits

L'assistance rapatriement et évacuation médicale d'urgence est incluse.

CHOOSE YOUR OPTIONS

Maternity

Dental

Vision

Only available if Dental is also chosen