Insured by

BULGARIA Insurance Company

Re-insured by

AXA PPP HEALTHCARE
redefining / healthcare

For official use only.
Date received

Bulgaria Insurance Use Only.
Membership Number

Bulgaria Insurance Use Only. Effective Date

D	D	M	M	Y	Y	Y	Y

Insurance Intermediary's Signature _____

Print name _____

Insurance Intermediary's Code _____

Application Form

Bulgaria Insurance

HEALTH WITHOUT BORDERS

International Healthcare Plans

Company stamp:
(When applying for corporate membership).

Group number:

Please complete this form using Block Capitals and by ticking the relevant boxes. It is important that you provide the following information so that we can properly assess your application. If, therefore, you do not answer the questions we shall take that failure to answer to mean that you have nothing to disclose. *This application must be completed by you or your parent/legal guardian in your/their own handwriting. If you need to make a correction, please initial the change.*

1. Your personal details (please keep us informed of any change of your address)

Title _____ *Surname* _____

Full forenames _____ *Date of birth* D D M M Y Y Y Y

Address _____

Postal address (if different from official address) _____

Personal ID OR Passport No. (delete as appropriate) _____ *Personal No.* _____

Telephone No. _____ *Mobile No.* _____ *E-mail* _____

Occupation _____ *Name of company/employer* _____

Nationality _____ *Country, in which you live for most of the year (180 days)* _____

2. Your choice of plan

☐ Plan A ☐ Plan B
☐ Plan C ☐ Additional Screening Benefits

Cover will commence only when we have received your written acceptance of any underwriting terms and your premium has reached our bank account.

3. Existing or any previous membership number

If you have ever been a member, or applied for membership of a Bulgaria Insurance or AXA health insurance scheme, you must declare it.

☐ *Bulgaria Insurance* ☐ *AXA Health Insurance*

Number:

Scheme name: *Date:*

4. Additional family members to be covered

1

Title *First name and other initials* *Surname* *Nationality*

Relationship to you (Spouse, partner, son/daughter) *Date of birth* D D M M Y Y Y Y *ID/Passport No.* *Personal No.* *Residing in:*

2

Title *First name and other initials* *Surname* *Nationality*

Relationship to you (Spouse, partner, son/daughter) *Date of birth* D D M M Y Y Y Y *ID/Passport No.* *Personal No.* *Residing in:*

3

Title *First name and other initials* *Surname* *Nationality*

Relationship to you (Spouse, partner, son/daughter) *Date of birth* D D M M Y Y Y Y *ID/Passport No.* *Personal No.* *Residing in:*

5. Frequency of payment

☐ *Annually* ☐ *Monthly*

If the above details are different for any additional persons please list on a separate sheet.

6. Medical practitioner(s) most frequently used in the last 5 years

Name _____

Address _____

PB55075

Insured by
Bulgaria Insurance Company limited.
83A Bulgaria Blvd., 1404 Sofia, Bulgaria.
Tel: +359 (0) 700 13 555; www.zadbg.bg
Authorized by the Financial Supervision Commission,
License № 432-03/14.06.2013

Re-insured by
AXA PPP healthcare limited.
Registered office: 5 Old Broad Street, London, EC2N 1AD, United Kingdom. Registered in England No. 3148119.
Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.

7. Confidential medical history (Declarations must be made in writing on this application. Verbal declarations WILL NOT be accepted)

Please Note: (i) NO LIABILITY WILL BE ACCEPTED FOR ANY MEDICAL CONDITION WHICH ORIGINATED BEFORE THE DATE OF ENROLMENT OR WHICH WAS FORESEEABLE AT THE TIME OF APPLICATION unless such medical condition has been declared to and accepted by Bulgaria Insurance in writing. (ii) Failure to notify Bulgaria Insurance of a medical condition may result in claims for benefit being refused or cover withdrawn. If you are in any doubt you should disclose the medical condition.

Please ensure that you fully disclose any known or suspected conditions and symptoms experienced by anybody included in this application. This applies even if professional advice has not yet been sought. Typical examples are varicose veins, allergies, backache, foot disorders (e.g. bunions), piles, gynaecological problems (including any irregularities of menstruation), complications of pregnancy (e.g. caesarian section), digestive irregularities, skin problems, trouble with heart, limbs, eyes, 'nerves' etc any ear, nose or throat problems or any pains, swellings, lumps or fever.

Part A You must declare your medical history even if you have been insured with us or anyone else before.

Please consider the following five questions as they apply to each of the people named. Answer each question by clearly ticking one of the corresponding Yes/No boxes.	Applicant *Name*		1st family member *Name*		2nd family member *Name*		3rd family member *Name*	
1. Has any in-patient stay in a hospital or nursing home taken place within the last five years?	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
2. Has any specialist/medical practitioner been consulted within the last five years?	☐	☐	☐	☐	☐	☐	☐	☐
3. Have you experienced any symptoms but not consulted a medical practitioner in the last five years?	☐	☐	☐	☐	☐	☐	☐	☐
4. Has any medical practitioner been consulted and/or provided prescriptions for any drugs or medication within the last two years?	☐	☐	☐	☐	☐	☐	☐	☐
5. Does any chronic/long-term medical or dental condition exist or has there been any other known disability, abnormality or recurrent illness or injury during the last five years?	☐	☐	☐	☐	☐	☐	☐	☐
6. Is there any known or foreseeable need to consult any doctor or other health professional?	☐	☐	☐	☐	☐	☐	☐	☐
7. Is there any major condition falling outside the 5 year period mentioned above that we should know about? In good faith you must declare it.	☐	☐	☐	☐	☐	☐	☐	☐

Part B (Please continue on a separate sheet if necessary. And if you do so, please identify the applicant by name, sign and date the additional sheet.)

This part applies if you have indicated 'Yes' replies in Part A. Please disclose all medical conditions (or undiagnosed symptoms) to which these replies are intended to apply. Use column 3 to list them separately and give the further detailed information required by columns 4 to 6.

1. Name of patient	2. Question number from Part A	3. Nature of illness/disability and treatment received	4. When was treatment received			5. Need for any further treatment or consultation	6. Present state of health in this respect
			Month	Year	Duration		

8. Your Signature and Declaration

Declaration: I declare that to the best of my knowledge and belief, the statements on both sides of and any attachments to this application form are full, true and correct. I understand that Bulgaria Insurance will send me an Offer of Insurance including the terms and conditions applicable to my policy in advance of the policy being issued. I will read that Offer of Insurance and either sign to accept those the terms and conditions or indicate that I do not wish to proceed with the insurance. I will confirm my acceptance within the validity period of the Offer for Insurance or Bulgaria Insurance will assume that I do not wish to proceed. I agree that Bulgaria Insurance and/or AXA PPP healthcare may contact my/our medical practitioner(s) and/or any previous insurer for further details of my/our medical history and authorise such practitioner(s)/entities to release any information Bulgaria Insurance and/or AXA PPP healthcare may require. Full policy terms and conditions can be found on our website www.zadbg.bg.

Signature: X _____ *Print Name:* X _____ *Date:* X _____

Please note: You are advised to keep a record of all information supplied in connection with this application, including any letters you send to us in connection with it. If you would like a copy of this application please let us know within 90 days. After completing this application form and signing the Declaration, please return to:

Bulgaria Insurance, Health Insurance Department, 83A Bulgaria Blvd., 1404 Sofia, Bulgaria. Tel: +359 (0) 700 13 555

For Bulgaria Insurance use only

(Underwriting terms pertaining to this application)	*Underwriter's signature*