Groupama Sigorta

FIT - HEALTH INSURANCE FOR FOREIGNERS APPLICATION FORM

AGENCY

NAME / TITLE :
CODE :

POLICY TYPE

New ☐ **Renewal** ☐

(In case of transfer, please indicate policy no and date od end of policy of the previous company)

Policy No: Expiry Date of the Policy: / /

APPLICANT

If applicant and policy owner is the same person, only this part will be filled.

NAME SURNAME :
GENDER : ☐ Female ☐ Male
DATE OF BIRTH (Day/Month/Year) / /
MARITAL STATUS : ☐ Married ☐ Single
FOREIGN ID NO/TAX NO:
NATIONALITY : COUNTRY :
HOME PHONE : 0 ( ) MOBILE : 0 ( )
E-MAIL :
COMMUNICATION ADDRESS: COUNTY:
STREET :
APARTMENT/DOOR NO :
DISTRICT : CITY : / COUNTRY:

REASONS OF STAY IN TURKEY:

POLICY OWNER

If policy owner is a different person from the applicant, he/she will fill this part.

☐ **REAL PERSON**

NAME SURNAME :
GENDER : ☐ Female ☐ Male
DATE OF BIRTH (Day/Month/Year) / /
MARITAL STATUS : ☐ Married ☐ Single
FOREIGN ID NO/TAX NO:
NATIONALITY : COUNTRY :
HOME PHONE : 0 ( ) MOBILE : 0 ( )
E-MAIL :
COMMUNICATION ADDRESS: COUNTY:
STREET :
APARTMENT/DOOR NO :
DISTRICT : CITY : / COUNTRY:

☐ **LEGAL ENTITY** TITLE :
TAX IDENTITY NO : TAX ADMIN. :
ADDRESS COUNTY:
STREET :
APARTMENT/DOOR NO :
DISTRICT : CITY : / COUNTRY:

PERSON TO BE UNDER COVERAGE

Name Surname	Relation to Insured	Date of Birth	Height/Weight	Marital Status	Gender	Identity Number	Chosen Plan	Premium of The Plans
								TL
	Spouse	...../...../.....	.....cm.....Kg					TL
	Child 1	...../...../.....	.....cm.....Kg					TL
	Child 2	...../...../.....	.....cm.....Kg					TL
	Child 3	...../...../.....	.....cm.....Kg					TL
	Child 4	...../...../.....	.....cm.....Kg					TL
							TOTAL PLAN PREMIUM	TL

PREMIUM PAYMENT METHOD AND CHANNEL

☐ Cash ☐ Credit Card

Payment in Installments ☐ Down Payment ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9

(Only for payments with Turkish credit card and maximum 9 installments)

Beginning Date of Premium Payments: At most 7 days after policy beginning date.

IF THE AMOUNT IS PAID BY CREDIT CARD :

Bank : **Credit Card Type :** ☐ VISA ☐ MASTERCARD **Expiry Date :** / /

Credit Card No :

INDEMNITY PAYMENT CHANNEL

Name / Surname of Account Owner:
Bank : **Account No :**
Branch : **IBAN No :**

21033105/06.14/01

HEALTH DECLARATION

If your answer is yes for the questions for the persons to be taken under insurance coverage, please give detailed information on the EXPLANATION TABLE by indicating the question number. If a question above is left empty, it shall be accepted as answered as no.

01) Please tick up, if the persons to be taken under coverage have ever had the diseases stated below.

- ❑ AIDS
- ❑ Mental diseases
- ❑ Allergic diseases
- ❑ Asthma bronchitis tuberculosis
- ❑ Arthralgia rheumatism with fever
- ❑ Intestine disorders
- ❑ Herniated disc cervical disc hernia
- ❑ Kidney disorders
- ❑ Spleen diseases
- ❑ Skin diseases
- ❑ Other respiratory and pulmonary illnesses
- ❑ Male genital diseases
- ❑ Ophthalmological diseases (excluding usage of eye glass)
- ❑ Goitre
- ❑ Hemorrhoid
- ❑ Hormonal disorders
- ❑ Urinary disorders
- ❑ Stroke (paralysis)
- ❑ Permanent paralysis
- ❑ Heart attack
- ❑ Cardiovascular diseases
- ❑ Blood or lymph disorders
- ❑ Inguinal and stomach hernia
- ❑ Bone, muscle, joint and other rheumatic diseases
- ❑ Cyst disorders
- ❑ Wen disorders
- ❑ Ear-nose-throat disorders (excluding influenza)
- ❑ Stomach and duodenum diseases
- ❑ Neurological diseases
- ❑ Pancreas diseases
- ❑ Psychiatric disorders
- ❑ Prostate diseases
- ❑ Uterine ovarian and other gynecologic diseases
- ❑ Breast diseases
- ❑ Gall bladder diseases
- ❑ Epilepsy
- ❑ Jaundice, cirrhosis and other liver diseases
- ❑ Digestive system diseases
- ❑ Diabetes (Insulin-dependent)
- ❑ Diabetes (Non insulin-dependent)
- ❑ Tumor, cancer
- ❑ Varicosis
- ❑ Hypertension
- ❑ Venereal diseases
- ❑ Brain and nervous system disorders
- ❑ Renal Insufficiency
- ❑ Chronic organ failure
- ❑ MS
- ❑ Alzheimer
- ❑ Parkinson
- ❑ Hepatitis C
- ❑ Motor Mental Developmental Disorder
- ❑ Sarcoidosis
- ❑ Varicosis and other vascular diseases
- ❑ Loss of organ, limb
- ❑ Other

02) Has any medical treatment been applied for an illness? ❑ Yes (Please indicate at the explanation table) ❑ No

03) Has any surgical treatment (operation) been applied for an illness? ❑ Yes (Please indicate at the explanation table) ❑ No

04) Do you have any existing disease requiring any medical or surgical treatment (operation)? ❑ Yes (Please indicate at the explanation table) ❑ No

05) Do you have any congenital disorder? Do you have any congenital or acquired physical deficiency or deformity? ❑ Yes (Please indicate at the explanation table) ❑ No

06) Has any physiotherapy, chemotherapy or radiotherapy been applied? ❑ Yes (Please indicate at the explanation table) ❑ No

07) Do you have any existing disease requiring treatment? ❑ Yes (Please indicate at the explanation table) ❑ No

08) When and why did you consult to a doctor for the last time? (please indicate date of visit) ❑ Yes (Please indicate at the explanation table) ❑ No

09) Have you recently been applied any blood tests. Have any tests gave abnormal results? ❑ Yes (Please indicate at the explanation table) ❑ No

10) Have you recently undergone any advance examinations for any illness (such as MR, Tomography, Colonoscopy, Gastroscopy…) ❑ Yes (Please indicate at the explanation table) ❑ No

11) Do you suffer from paresthesia, feeling of pain and similar symptoms in any part of your body? ❑ Yes (Please indicate at the explanation table) ❑ No

EXPLANATION TABLE

If your answer is yes to or if you tick up as yes for the questions 1 to 11 above, please indicate the question number and name of the related person in this table.

Question No	Name of The Person	Treatment Applied	Date of Treatment (Month/Year)	Operation	Operation Date (Month/Year)	Hospital of Treatment/Operation	Do you have any complaints? Please explain.

Important Note: We kindly request you to add medical reports and results of examinations related to the diseases declared above (such as operation report, pathology report, results of analysis and x rays, results of tomography/MR examinations) to the Application Form.

Please answer the questions below by indicating the names of the persons to be covered under health insurance.

12) Is there any medicine that are used regularly? ❑ Yes Name of the Medicine..... ❑ No

13) Do you smoke? (If yes, smoker's name, period of smoking and daily consumption) ❑ Yes..... ❑ No

14) Do you drink alcohol? (If yes, drinker's name, period of drinking and daily consumption) ❑ Yes..... ❑ No

15) Do you have drug addiction? (If yes, addict's name, period of addiction) ❑ Yes..... ❑ No

16) FOR FEMALES:

a) Did you give birth to a child? What is the number of live births? ❑ Yes Number..... ❑ No

b) Any current pregnancy? ❑ Yes How many months..... ❑ No

c) Last menstrual period? ❑ ..... ❑ No

17) Do you practice sports professionally? If yes, please explain. ❑ Yes..... ❑ No

I hereby declare that my statements in this form is true and complete as to my best knowledge and belief and I have not hidden any condition that Groupama Sigorta A.Ş. should know. I agree that I will comply with general and special terms and conditions of the health insurance policy, that the declarations in this form shall be the basis of insurance contract between me and Groupama Sigorta A.Ş. and that Groupama Sigorta A.Ş. shall be free to provide any insurance coverage or not. On condition that Groupama Sigorta A.Ş. has approved to provide coverage and the first premium has been paid by myself, I know and accept that the beginning of insurance period is the date of issuance of policy. I know and agree that treatments or related complications arising from illnesses or injuries occurred before the date of beginning date of insurance will be subject to related articles of Special Terms of the policy. Regarding my treatment at a hospital following a traffic accident, I have transferred and assigned all my legal rights to claim and sue concerning recovery of any invoice values higher than BUT/SUT tariffs to Groupama Sigorta A.Ş. I accept that my personal information related to my policy can be shared with Health Insurance Policy Inquiry in General (SAGMER). When the indemnity payment is transferred to the bank account that I will inform about, Groupama Sigorta A.Ş. shall be fully discharged. Following the request of the insured as indicated in the policy herein, I hereby accept, declare and commit that all information on this policy can be shared with the insured and I shall not demand material or moral indemnities due to submission of this information. I declare that the change requests on this policy will be conducted by myself or by the insured and I kindly request you to put the change requests of the insured into process as well. I allow collection of information and documents from Insurance Information and Monitoring Center (including all kinds of information and documents related to the operations paid by Private Insurance Companies and / or Social Security Institution - SSI), all kinds of private health institutions, physicians and third parties about health of me and/or my family members under insurance coverage and to submit additional information when required. ❑

The box above should be ticked. If it is left empty it shall be deemed as ticked.

AGENCY Sale	APPLICANT	POLICY OWNER
Date: / /	Date: / /	Date: / /
Signature:	Signature:	Signature: