Received by Foyer Global Health S.A.: Date / Person responsible
Broker / Intermediary name
Broker / Intermediary No.

Globality YouGenio® World

Application for health insurance

Foyer Global Health S.A.
12, rue Léon Laval · L-3372 Leudelange · Luxembourg
Phone: +352 270 444 3601, E-mail: service-yougenio@globality-health.com

Commercial Register (R.C.S. Luxembourg): B 134.471

02/24 E.& O.E.

Application for health insurance (individual insurance)

⚠ **Please note: We will not be able to process your application if any columns are left incomplete.**
For uncertainty, please refer to General Conditions of Insurance.

I hereby apply for a health insurance contract for the Globality YouGenio® World plan for the persons to be insured as listed below.

A. Policyholder's personal details

☐ I act as policyholder only and not as insured person

☐ I act as both policyholder and insured person

Start date of insurance (dd/mm/yyyy) ☐ Today (date of signature) ☐ Or specify future start date: _____		
Title	First name	Surname
Gender ☐ M ☐ F	Date of birth (dd/mm/yyyy)	Occupation and industry
Correspondence address	Building name / number	Street
	Postal / zip / area code AND town / city	Country AND region
Contact details	Mobile number (+ country code / area code)	
	E-mail address	
☐ New (no previous coverage with Foyer Global Health S.A.)	☐ Previous or existing customer of Foyer Global Health S.A. If yes, please provide insurance number/numbers.	
Nationality or nationalities		
Country where the application is signed	Country of future location (where you will live as an expatriate)	

Contractual language (all correspondence / documents will be provided in this language)

☐ English ☐ German ☐ French ☐ Spanish ☐ Dutch

⚠ **Mandatory**

B. Persons to be insured

Person 2

Start date of insurance (dd/mm/yyyy) ☐ Today (date of signature) ☐ Or specify future start date: _____		
Title	First name	Surname
Relationship to the policyholder ☐ Partner ☐ Child		
Gender ☐ M ☐ F	Date of birth (dd/mm/yyyy)	Occupation and industry
Correspondence address ☐ Same address as the policyholder ☐ Different address (please enter aside)	Building name / number	Street
	Postal / zip / area code AND town / city	Country AND region
Contact details	Mobile number (+ country code / area code)	
	E-mail address	
☐ New (no previous coverage with Foyer Global Health S.A.)	☐ Previous or existing customer of Foyer Global Health S.A. If yes, please provide insurance number/numbers.	
Nationality or nationalities		
Country where the application is signed	Country of future location (where you will live as an expatriate)	

Person 3

Start date of insurance (dd/mm/yyyy) ☐ Today (date of signature) ☐ Or specify future start date: _____		
Title	First name	Surname
Relationship to the policyholder ☐ Partner ☐ Child		
Gender ☐ M ☐ F	Date of birth (dd/mm/yyyy)	Occupation and industry
Correspondence address ☐ Same address as the policyholder ☐ Different address (please enter aside)	Building name / number	Street
	Postal / zip / area code AND town / city	Country AND region
Contact details	Mobile number (+ country code / area code)	
	E-mail address	
☐ New (no previous coverage with Foyer Global Health S.A.)	☐ Previous or existing customer of Foyer Global Health S.A. If yes, please provide insurance number/numbers.	
Nationality or nationalities		
Country where the application is signed	Country of future location (where you will live as an expatriate)	

Person 4

Start date of insurance (dd/mm/yyyy) ☐ Today (date of signature) ☐ Or specify future start date: _____		
Title	First name	Surname
Relationship to the policyholder ☐ Partner ☐ Child		
Gender ☐ M ☐ F	Date of Birth (dd/mm/yyyy)	Occupation and industry
Correspondence address ☐ Same address as the policyholder ☐ Different address (please enter aside)	Building name / number	Street
	Postal / zip / area code AND town / city	Country AND region
Contact details	Mobile number (+ country code / area code)	
	E-mail address	
☐ New (no previous coverage with Foyer Global Health S.A.)	☐ Previous or existing customer of Foyer Global Health S.A. If yes, please provide insurance number/numbers.	
Nationality or nationalities		
Country where the application is signed	Country of future location (where you will live as an expatriate)	

C. Plan level and geographical area

Person	Plan level				Geographical area
	Essential	Classic	Plus	Top	
1	☐ No deductible	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/840 £	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/840 £ ☐ 2,500 €/3,250 $/2,100 £	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/840 £ ☐ 2,500 €/3,250 $/2,100 £	☐ Worldwide excl. USA ☐ Worldwide incl. USA
2	☐ No deductible	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/840 £	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/840 £ ☐ 2,500 €/3,250 $/2,100 £	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/840 £ ☐ 2,500 €/3,250 $/2,100 £	☐ Worldwide excl. USA ☐ Worldwide incl. USA
3	☐ No deductible	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/840 £	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/840 £ ☐ 2,500 €/3,250 $/2,100 £	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/840 £ ☐ 2,500 €/3,250 $/2,100 £	☐ Worldwide excl. USA ☐ Worldwide incl. USA
4	☐ No deductible	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/840 £	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/840 £ ☐ 2,500 €/3,250 $/2,100 £	**Deductible:** ☐ None ☐ 250 €/325 $/210 £ ☐ 500 €/650 $/420 £ ☐ 1,000 €/1,300 $/840 £ ☐ 2,500 €/3,250 $/2,100 £	☐ Worldwide excl. USA ☐ Worldwide incl. USA

Contractual currency ☐ € ☐ $ ☐ £

D. Previous coverage and doctor details

⚠ **Mandatory: The following details (point 1. AND point 2.) are required.**

1. Do you have or have you ever had health insurance coverage within the last 5 years (including compulsory statutory/private health insurance)?

Person	Previous insurer	Insurance no.	Level of coverage	Start date (dd/mm/yyyy)	End date (dd/mm/yyyy)
1 ☐ Yes ☐ No			☐ Inpatient ☐ Outpatient ☐ Dental		
2 ☐ Yes ☐ No			☐ Inpatient ☐ Outpatient ☐ Dental		
3 ☐ Yes ☐ No			☐ Inpatient ☐ Outpatient ☐ Dental		
4 ☐ Yes ☐ No			☐ Inpatient ☐ Outpatient ☐ Dental		

2. Please specify the name and address of the doctor best able to provide further information regarding your health. If there is more than one doctor/clinic associated with the persons in this application please provide any additional information in the information box at the end of Section E or include a separate page.

Person	Doctor's name	Address of the hospital/clinic/doctor	Phone no. and e-mail address
1			
2			
3			
4			

E. Medical history (Health questionnaire)

⚠ Please tick only one. In the event neither is ticked (☐) the application will go for FMU (full medical underwriting).

☐ **Moratorium coverage** only available if all the persons to be insured are aged 55 or younger at the date of application (signature date in Section G). The following health questions **should not be completed** because all pre-existing medical conditions and related conditions are not covered for a qualifying period of at least 24 months. Please refer to page 12 of the application for further information on the moratorium option. ⚠ **If this is the chosen option please continue completion on Section F.**

☐ **Full medical underwriting**
To assess whether the pre-existing medical conditions can be covered from the start date of the insurance policy, all the health questions listed below must be answered correctly and to the best of the insured knowledge. The medical risk assessment may result in Foyer Global Health S.A. adding conditions to the policy, charging an extra premium, adding an exclusion or rejecting the application/an insured person.

Important: All health questions listed below must be answered in detail. Symptoms, illnesses and the consequences of an accident should be mentioned even if you consider them to be unimportant. Dashes do not qualify as an answer. **If you need more space**: continue on a separate sheet, specifying the number of the person concerned, and refer to that sheet in your application form. If you do not wish to reveal certain information to the intermediary, this information must be provided directly to Foyer Global Health S.A. **in writing within three days of the reception of the application form by Foyer Global Health S.A.**. In this case you must indicate in the application form that the information is to be provided separately.

If the health questions on this page, where of relevance for acceptance of the risk, are answered incorrectly or incompletely, we may – if the duty to provide information has not been willfully violated – terminate the contract within one month of being informed of the violation, insofar as we can prove that we would not have insured the risk in any case. The contract shall be null and void if our assessment of the risk is affected by willful violation of your duty to provide information. In this case, you are obliged to repay the insurance benefits already received. We will not refund the paid premiums.

Conditions arising between signing the application form and confirmation of acceptance by Foyer Global Health S.A. will equally be deemed to be pre-existing. **Therefore it is necessary that you advise us immediately of any material changes to the information provided, which would occur between submission of this application and acceptance by us (Please refer to "Responsibility for the information provided in the application form", page 10).**

Pre-existing conditions:
Pre-existing conditions are medical conditions for which one or more symptoms has been shown prior to the start of coverage with Foyer Global Health S.A. including pregnancy, childbirth, postpartum complications and related conditions, irrespective of whether any medical treatment or advice was sought.

Any medical or dental condition or related condition for which:
- you had symptoms of or received medical treatment for;
- you sought advice on or consulted any doctor for medical treatment or advice (including checkups);
- you took medication (including over the counter drugs, alternative medications, special diets, injections or vitamins) or
- to the best of your knowledge were already existing upon inception of the insurance.

Pre-existing conditions may be covered under the policy following a full medical underwriting. Conditions that arise between signing the application form and confirmation of acceptance by our underwriting team are deemed to be pre-existing. You are hereby obliged to provide any further information we might require on request.

If insurance cover already exists or existed with Foyer Global Health S.A., it is not necessary to specify any disorders or courses of treatment during the last five years which are already fully known to Foyer Global Health S.A. on account of the invoices or medical certificates presented to Foyer Global Health S.A. in conjunction with the previously existing insurance contract.

⚠ **If you have selected "Moratorium" in Section E above, please skip the below questionnaire and continue in Section F.**

No.	Questions	Person 1	Person 2	Person 3	Person 4
1	What is your height/weight?	_____ cm _____ kg	_____ cm _____ kg	_____ cm _____ kg	_____ cm _____ kg
2	Have you been using tobacco products including, cigarettes, cigars, chewing tobacco or any form of tobacco in the last 12 months? If yes, average no. of cigarettes / amount per day	☐ Yes ☐ No _____	☐ Yes ☐ No _____	☐ Yes ☐ No _____	☐ Yes ☐ No _____
3	How many units of alcohol do you drink per week? Alcohol: units (1 unit = 250 ml beer / 100 ml wine / 25 ml spirit)	_____	_____	_____	_____
	Please note that conditions listed below are only examples. All medical conditions should be disclosed, even if not listed. In the last 5 years have you or anyone to be insured under this policy: a) Seen a doctor or other healthcare professional, b) Had any history of, suffered from, been admitted to hospital for, c) Received treatment, carried out tests or investigations for the following:				
4.1	Heart problems or circulatory disorders (e.g. high blood pressure, angina, chest pains, heart attack, heart insufficiency, abnormal heart beat, heart defects, aneurysms, varicose veins etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.2	Respiratory disorders (e.g. breathing problems, asthma, COPD, pneumonia, bronchitis, tuberculosis, allergies, septum deviation etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.3	Endocrine disorders (e.g. glandular disorders, diabetes (Type 1 or Type 2), thyroid problems, Cushing's syndrome, Addison's disease, Graves disease etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.4	Gastrointestinal disorders (e.g. stomach, intestines, liver or gall bladder problems, stomach inflammation/ulcers, irritable bowel syndrome, Crohn's disease, colitis, change in bowel habits, hemorrhoids/piles, pancreatitis, liver inflammation, cirrhosis, gall stones, hernias etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.5	Cancer, tumours or growths (e.g. polyps, benign growths, cysts, any cancers or precancerous condition etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.6	Brain & nervous system disorders (e.g. stroke, dementia, migraine, chronic headaches, multiple sclerosis, epilepsy/ fits, sciatica, low muscle tone, Parkinson's disease etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.7	Skin, hair, nail problems (e.g. eczema, dermatitis, rashes, alopecia areata, psoriasis, acne, cysts, moles that itch or bleed, etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.8	Ear disorders (tinnitus, vertigo, hearing disorder, deafness) Problems with the eyes (e.g. glaucoma, cataracts, corneal problems, retinal detachment, etc.) Do you have impaired vision with 8 diopters or more? If yes, please specify diopters: right eye (RE); left eye (LE)	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No RE _____ LE _____	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No RE _____ LE _____	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No RE _____ LE _____	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No RE _____ LE _____
4.9	Urinary & reproductive disorders (e.g. kidney failure, urinary infections, incontinence; testicular or prostate disorders, infertility, pregnancy/ childbirth problems (including caesarean sections), heavy or irregular periods, fibroids, endometriosis, abnormal smears, polycystic ovaries, etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

No.	Questions	Person 1	Person 2	Person 3	Person 4
4.10	Blood/infective/immune disorders (e.g. abnormal blood tests, coagulation problems, high cholesterol, anemia, malaria, autoimmune disorder, etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.11	Psychiatric/Psychological disorders (e.g. depression, medically treated stress, anxiety, mental illness, schizophrenia, compulsive or eating disorders, drug/ alcohol dependency, etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.12	Muscle or skeletal problems (e.g. rheumatism, gout, arthritis, back problems, neck/shoulder problems, cartilage and ligament problems, joint replacements, fractures, osteoporosis, inflammatory conditions, disc prolapse etc.) Please indicate the side affected or spine level, if applicable.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5	Do you have any physical/organic defect, a chronic illness, congenital condition, an illness or injury due to military service or any reduction in your ability to work? Or a degree of disability that leads to permanent disability? If yes, please enclose a copy of the official notice of invalidity.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6	Have you ever been tested positive, awaiting treatments, investigations, check ups or the results of investigations for AIDS, HIV, Hepatitis B, C, D?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7	Pregnancy: Are you pregnant? If yes, how many weeks?	☐ Yes ☐ No _____	☐ Yes ☐ No _____	☐ Yes ☐ No _____	☐ Yes ☐ No _____
8	Have you undergone inpatient or outpatient surgery during the last five years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9	Have you been advised, or are you planning currently undergoing any kind of outpatient/ inpatient treatment or examination?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10	Do you require any kind of medication (e.g. tablets, ointments, capsules, syrups, injections, creams, suppositories, inhalers, OTC)? If yes, please specify which and list the medication along with diagnoses it is related to.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
11	Dental a) Have you visited a dentist during the last five years for a treatment or a check up? b) Are you currently receiving dental treatment (please indicate your dentist details on the box below), are dentures being produced or renewed, are you receiving treatment for periodontal disease or orthodontic treatment, or has such treatment been recommended or planned? (If yes, please include an up-to-date plan of treatment and costs.) c) Do you have any missing teeth which have not yet been replaced (other than milk and wisdom teeth, as well as teeth for which the gaps have been filled by adjacent teeth)? d) Have you been diagnosed with periodontitis or other periodontal disease? If yes to b, c or d, you will be asked to submit a dental form sent to you by Globality. This dental form must be completed, signed and stamped by a dentist.	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

No.	Questions	Person 1	Person 2	Person 3	Person 4
12a	Have you suffered any other illnesses, disorders, consequences of an accident or other impairments of your health (including any implant, stent or prosthesis) or stayed in hospital or have you undergone any examinations/treatments either during the last five years or at present?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
12b	Are there any other medical conditions not listed above for which you have had signs or symptoms without diagnosis at any time during the last 5 years, regardless of whether a health care professional has been consulted?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Further information:

If you answered "Yes" to any of the questions above, please provide details in the table below.
⚠ **Please provide medical reports if available.**

Person	Question no.	Type of illness/diagnosis, symptoms, area of body affected (right/left), treatment details, names of medications prescribed	Treatment/ symptom start date (dd/mm/yyyy)	Treatment/ symptom end date/ongoing (dd/mm/yyyy)	Name of treating doctor & address of clinic/hospital

Additional information and remarks:

F. Payment of premiums

a) Payment frequency

☐ monthly ☐ quarterly ☐ semi-annually ☐ annually

b) Payment method

☐ **Direct debit** (applies only for Euro premiums within the Eurozone*, UK and Denmark or where specifically supported by your bank). Please complete the below SEPA Direct Debit Mandate and return with the application form.

*Eurozone includes: Austria, Belguim, Cyprus, Estonia, Finland, France, Germany, Greece, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Portugal, Republic of Ireland, Slovakia, Slovenia, Spain.

☐ **Premium payment by bank transfer**

☐ **Credit Card**
Together with your welcome package you will receive a link to a secure webpage where you will be prompted to enter credit card details in order to activate insurance coverage.

SEPA Direct Debit Mandate

⚠ Please be aware that SEPA Direct Debit functionality is only applicable for EURO payments within the Eurozone, United Kingdom and Denmark, or where specifically supported by your bank. Such functionality does not apply to USD and GBP.

Mandate Reference – to be completed by the creditor

By signing this mandate form, you authorise (A) Foyer Global Health S.A. to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instructions from Foyer Global Health S.A.

As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited.

Please complete all the fields marked *. **Creditor is to complete fields marked ** before supplying form to Debtor.**

Name of Debtor	*	Name of the bank account holder	1
Address of Debtor	*	Street name and number	2
	*	Postal code / City	3
	*	Country	4
IBAN of Debtor	*	Account number – IBAN (International Bank Account Number) of the Debtor	5
	*	BIC/ SWIFT code	6
Creditor's Name	**	Creditor name: Foyer Global Health S.A.	7
	**	Creditor identifier: LU53ZZZ000000000LU22284578	8
	**	Street name and number: 12, rue Léon Laval	9
	**	Postal code: L-3372 / City: Leudelange	10
	**	Country: Luxembourg	11
Type of Payment	*	☐ Recurrent payment ☐ One-off payment	12

Details regarding the underlying relationship between the Creditor and the Debtor – for information purposes only.

Name of Policyholder	First and Last Name	13
Policy No./Insurance No. if known		14
City or town in which you are signing*	Location / Date *	15
Please sign here*	X Signature(s)	

Note: Your rights regarding the above mandate are explained in a statement that you can obtain from your bank.

If you are an individual client please send the completed form to: service-yougenio@globality-health.com

If you are insured on a corporate plan please send to: service-group@globality-health.com

Creditor's use only

G. Declarations by the applicant and person(s) to be co-insured

The following points are known to me:

Right of withdrawal
You may withdraw from this insurance policy in writing within 14 calendar days, without penalty and without giving us any reason. This 14-day period begins on the day on which you receive your insurance policy and the General Conditions of Insurance. So that you meet this deadline, you can send your notice of withdrawal by post, email or fax before the end of the 14 days.

If you withdraw from your insurance policy within this 14-day period, we will refund any premiums you might have already paid. If you do not withdraw from your insurance policy within the 14 days, your insurance policy will become final.

Your withdrawal should be addressed to
Foyer Global Health S.A.
12, rue Léon Laval
L-3372 Leudelange
Luxembourg

If you send your withdrawal by e-mail or fax, please send it to: service-yougenio@globality-health.com, Fax +352 / 270 444 3699.

Consequences of withdrawal
If you exercise your right of withdrawal, the premiums and benefits received must be returned by the respective parties.

Responsibility for the information provided in the application
Before declaring my intention to conclude a contract, I must inform the insurer of all circumstances known to me and requested by the insurer, which are of importance for the insurer's decision to provide the agreed insurance coverage.

Conditions that arise between signing the application form and confirmation of acceptance by our underwriting team are deemed to be pre-existing.

Attention is drawn to the information given on pages 4 to 8 with regard to the legal consequences of incorrectly answering the questions concerning your state of health.

Applicable law
The insurance policy will be governed by the law of the Grand Duchy of Luxembourg as long as another law which applies according to national regulations does not contain conditions which are not compatible with the law of the Grand Duchy of Luxembourg.

Supervisory authority
The supervisory authority for Foyer Global Health S.A. can be contacted at the following address:
Commissariat aux Assurances,
11, rue Robert Stumper
L-2557 Luxembourg.

Complaints procedure
Complaints may be addressed to Foyer Global Health S.A. or to the Ombudsman for insurance companies (A.C.A. – Association des Compagnies d'Assurance – in collaboration with the U.L.C. – Union Luxembourgeoise des Consommateurs) or to the supervisory authority for the insurance sector in Luxembourg, the Commissariat aux Assurances.

Outsourcing and Consent to the transfer of Personal Data
The policyholder understands that for the purpose of the provision of the insurance cover and related assistance services, Foyer Global Health S.A. will outsource tasks, functions and/or services relating to the performance of the contract, including claims and complaints handling, payments and data collection (the "Outsourced Services"). This outsourcing will only be done to third party providers (the "Service Providers") established in countries where FATF* doesn't identify specific risks for jurisdiction monitoring (the "Countries of Outsourcing").

*FATF (The Financial Action Task Force) is an accepted inter-governmental body to set standards for the international financial system. For excluded countries see: http://www.fatf-gafi.org/countries/#high-risk

In this context, the policyholder consents that Foyer Global Health S.A. transfers or makes available to the Service Providers in the Countries of Outsourcing, personal data including identification data, contact details, insurance and health data, bank, and credit and asset details pertaining to the policyholder, the insured and/or the beneficiaries of the insurance contract (the "Personal Data").

Health data shall only be transferred by Foyer Global Health S.A. in compliance with specific medical secrecy and related provisions. Information regarding the Service Providers is available on Foyer Global Health S.A.'s website and at Foyer Global Health S.A.'s head office. The policyholder accepts that the Personal Data, Countries of Outsourcing, Outsourced Services and Service Providers be updated or amended from time to time. The policyholder will be informed of such updates or amendments according to the information arrangements provided by the terms and conditions of the insurance.

The above consent may be revoked by the policyholder by either addressing a letter to the Data Protection Officer of Foyer Global Health S.A. at 12, rue Léon Laval, L-3372 Leudelange or by e-mail at dataprotection@globality-health.com. Such revocation shall be equivalent to an immediate termination of the insurance policy on the policyholder's initiative.

Data Protection
In accordance with applicable data protection rules, the data subjects, including the insured person(s) and the policy holder (the "Data Subjects"), are informed that their personal data is processed by the insurer, Foyer Global Health S.A.. This will be done only for the purposes of the granting of the insurance cover, the performance of the insurance contract (including to provide insurance cover or to pay for a claim, to manage the risk associated to the insurance coverage through reinsurance, etc.), the provision of related assistance services, advice and support (including contacting a repatriation service provider, assisting in finding an appropriate medical services provider, etc.) and compliance with applicable legal and regulatory obligations relating to fraud detection, anti-money laundering rules and the regulatory requirements applicable to the insurance company, including the requirements of the law of 7th December 2015 on the insurance sector, as amended. Foyer Global Health S.A. also processes personal data when it is necessary for the purposes of the legitimate interests it pursues, including ensuring IT security and IT operations, carrying out marketing activities, market surveys and questionnaires, and preventing and investigating punishable offenses. Supplied details may also be used by Foyer Global Health S.A. to make automated decisions, pertaining in particular to the conclusion or cancellation of a contract, possible risk preclusion or benefit obligations.

Personal data that are processed include identification data and contact details, insurance and health data, bank and credit details (the "Personal Data"). The Personal Data is obtained directly from the Data Subjects or from the insurance intermediary of the Data Subjects. In certain cases, health data may be obtained from medical services providers and their staff and insurance data may be obtained from other insurance companies and from statutory health insurance institutions when the Data Subjects have consented to such release of information. The processing of health data is required for the purposes of the underwriting services (i.e. evaluating the risks covered, matching to appropriate policy/premium, assessing whether the requested insurance coverage may be provided etc.) and for claims management purposes. Information relating to the Data Subjects may also be provided by credit rating companies keeping debtor and private insolvency registers in order to assess creditworthiness.

Foyer Global Health S.A. may share Personal Data with Service Providers, including group companies, for the purpose of the performance of the insurance contract and the provision of assistance services, advice and support in the countries in which the insured person(s) require health insurance cover, support and assistance. The Service Providers may be located in countries that do not offer a level of protection that is equivalent to the protection afforded under Luxembourg law or any other European data protection standards. For this reason, Foyer Global Health S.A. has entered into appropriate contractual arrangements with the Service Providers in order to guarantee adequate safeguards for the processing and protection of personal data. A copy of such agreements may be consulted at the registered office of Foyer Global Health S.A. Information about the identity and registered office of third party data processing Service Providers is available from Foyer Global Health S.A. on request at any time. Foyer Global Health S.A. may also share Personal Data with other Service Providers such as its reinsurer, banks, auditors and legal advisors or with regulatory or judicial authorities.

Data Subjects have the right to request access to their Personal Data. They may require that their Personal Data is rectified in case of error. Data Subjects may also request that their Personal Data is erased or that data processing be restricted if the Personal Data may no longer be legitimately held or processed.

Data Subjects further have a right to object to processing of Personal Data for direct marketing purposes. When the processing of Personal Data is carried out by Foyer Global Health S.A. on the grounds that it is necessary for the purposes of the legitimate interests pursued by Foyer Global Health S.A., Data Subjects also have a right to object to such processing, on grounds relating to their particular situation.

The right to data portability is granted under the conditions laid down in the applicable data protection rules. Data Subjects may exercise their rights by writing to Foyer Global Health S.A. at dataprotection@globality-health.com.

Data Subjects have the right to lodge a complaint with a supervisory authority.

Personal Data will be stored for the duration of the contractual relationship and thereafter until legal claims are barred under the statute of limitation.

The provision of the Personal Data, including health data, is required for the performance of the insurance contract and to pay for a claim. Failure to provide sufficient, accurate and up-to-date information may prevent Foyer Global Health S.A. from providing cover.

Foyer Global Health S.A. may be contacted by mail at its registered office indicated on its letterhead. It may also be contacted by e-mail at dataprotection@globality-health.com.

Processing of health data and consent to provide access to medical data

Data Subjects are informed that health data may be processed by Foyer Global Health S.A. and its Service Providers, including group companies, as set out in the Data Protection clause above, for the purposes of providing health insurance cover and for the provision of related assistance services and support. By signing this application form, Data Subjects may explicitly consent to the processing of their health data. The withdrawal of consent will not affect the data processing carried out prior to such withdrawal.

Consent to provide medical information

By signing this application for health insurance, I give appropriate consent to allow doctors, nurses and other medical staff, as well as employees of hospitals, clinics, nursing homes, private insurance companies, statutory health insurance institutions, employers liability insurance associations and public authorities who are named in the documents presented to Foyer Global Health S.A. or were involved in the medical treatment, to provide Foyer Global Health S.A. with information on my health and treatment (including the cause of death) in order to permit assessment of the medical risk when concluding the contract and verification of my rights under the insurance contract.

By signing this application for health insurance, I also give appropriate consent to allow Foyer Global Health S.A. to provide information on my health and treatment or on my insurance coverage to other companies in the reinsurer group, to contracted medical providers and to partners cooperating with Foyer Global Health S.A.

This consent is revocable at any time either addressing a letter to the Data Protection Officer of Foyer Global Health S.A. at 12, rue Léon Laval, L-3372 Leudelange or by e-mail at dataprotection@globality-health.com.

Foyer Global Health S.A. undertakes to provide such information to third parties exclusively for the purpose of the performance of the insurance contract, the granting of the insurance coverage and the provision of assistance services, advice and support. The consent as defined above shall continue to apply after my death, and be valid for my children to be insured and any other persons to be insured whom I represent by law.

I also agree, subject to revocation at any time, that Foyer Global Health S.A. may obtain information from the Register of Companies, the Register of Debtors and the Register of Private Insolvencies, either directly or through credit reporting agencies, in order to assess my creditworthiness.

Start date of insurance coverage

Insurance cover starts on the date shown in the insurance policy (start date of insurance), but not before you have paid your first premium and not before the end of the waiting periods.

We will not cover insured events which happen before the start date of the insurance. If the insurance policy is amended, this will apply to the "change of the insurance cover" as stated below.

Governing documents

The insurance contract will be governed by the insurance policy, the application form, the General Conditions of Insurance for Globality YouGenio® World, the special conditions and any possible additions to them.

In case of any disputes regarding the insurance, its coverage and conditions, the English version of the General Conditions of Insurance and other relevant literature and documentation shall prevail.

A copy of the application form will be handed over to me as soon as I have signed it.

Change of insurance cover
Any changes in insurance cover are only possible from the beginning of the next insurance year (currency, deductible, plan level), and if we agree.

Depending on the agreed plan level, new waiting periods will also apply accordingly for the additional insurance coverage. Illnesses and their consequences, as well as the consequences of accidents which have occurred during the previous insurance term and which constitute an increased risk according to medical findings may be excluded from the higher insurance coverage. This also includes the treatment and delivery associated with an existing pregnancy.

If health related risk loadings were payable prior to the change of the insurance coverage, these premium loadings shall also be levied on the new plan premiums at the same percentage rates unless agreed otherwise. The premium loadings will change to the same extent that premiums change (e.g. due to adjustment).

The previous insurance coverage shall continue to apply if a requested change of insurance coverage does not become effective because the right of withdrawal has been exercised.

The term of the prior insurance shall be credited to the new insurance following the change of plan.

The insurance year shall remain unchanged following change of the insurance coverage.

Persons eligible for insurance
As someone who is temporarily living abroad for at least three months, I confirm being eligible for insurance or that I will be eligible on the start date of the insurance coverage. I am aware that family members/my non-marital partner can only be coinsured to the extent that they are eligible for insurance under the provisions of the General Conditions of Insurance; they are not co-insured automatically.

Previous insurance
Data about previous health insurance or state healthcare system details of the past 5 years (including compulsory statutory/private/public health insurance) for inpatient, outpatient and dental coverage need to be provided to Foyer Global Health S.A. by the insured.

Application and acceptation of your application for health insurance
The application does not bind either you or us to conclude the contract. However, we will notify you, within 30 days of the receipt of the application form, of an insurance offer, the subjection of the insurance to an inquiry or survey, or the refusal to insure. We will provide insurance cover in good faith, assuming that you have correctly and completely answered all the relevant questions raised before the start of the insurance policy (this is known as your 'pre-contractual duty to disclose information').

The insurance contract is only valid when the application has been accepted by the insurer in writing and the insurance policy has been issued. Payment of the first premium to the intermediary or insurer does not constitute acceptance of the application.

Due payment of the first premium
The first premium installment is due as soon as we have accepted your application for insurance by sending out the insurance policy. The premium is owed by you; it is your responsibility to ensure punctual payments.

Term of the contract
The insurance contract is initially concluded for a duration of one insurance year which is automatically renewed for further periods of 12 months each on expiry of each insurance year, unless you object to the renewal not less than three months before expiry of the insurance year.

Moratorium
Instead of applying for full medical underwriting, if the insured person is 55 or younger, you may choose a 'moratorium'.

In that case any pre-existing medical condition that an insured person has experienced during the last five years will be covered after a continuous two-year period free of medical treatment, symptoms, advice or medication relating to the pre-existing medical condition. If an insured person has any treatment, advice or medication during the first two years of cover relating to a pre-existing medical condition, the two-year period (free of any treatment, advice or medication) may start again for that pre-existing medical condition. We will cover any new and unrelated medical conditions immediately (after expiry of waiting periods if any apply).

Pre-existing medical conditions
A medical condition that has existed before the start date of health insurance cover with us. For the purpose of this definition, medical condition means any medical, dental condition or related condition for which you have received medical treatment for, had symptoms of, asked advice on, consulted any doctor for medical treatment (including check-ups), or taken medication for (including drugs, medicines, special diets or injections), or to the best of the person's knowledge already existed at the start of the insurance; or pregnancy, childbirth, postpartum complications and related consequences.

We treat conditions arising between filling in the application form and us confirming that we accept the application as 'pre-existing'.

☐ **I have read the above declaration and by signing this form I confirm that the information provided in this application is correct and complete for all persons to be insured. I confirm I have read and understood the General Conditions of Insurance for Globality YouGenio® World and the declarations printed on pages 10, 11 and 12 (including the declaration concerning my right of withdrawal and data protection).**

Medical secrecy lift

By signing this form,

☐ I give consent to professionals to provide Foyer Global Health S.A. with information on my health and treatment as detailed on pages 10 and 11.

If I do not give this consent I understand:

1. I will have to decide, in each instance, whether or not I will give consent to the specified persons or institutions to forward informationto Foyer Global Health S.A.
2. it may take longer to investigate my claims, benefits may be reduced or the insurer may be relieved from its obligation to pay benefits if the obligation to pay benefits cannot be fully established on the basis of the remaining sources of information.

To be completed by the insurance intermediary:	If yes, please give details:
When answering the questions in this form, did the applicant provide information which has not been recorded in this application form? ☐ No ☐ Yes	

All information and documents regarding my policy will be sent:

☐ to my correspondence address ☐ to the following insurance intermediary to whom I give consent to receive them on my behalf:

Data protection

☐ I explicitly consent to the processing of my health data by Foyer Global Health S.A. and its service providers, including group companies, as set out in the Data Protection clause above, for the purposes of providing health insurance cover and for the provision of related assistance services and support. This consent may be revoked at any time.

If I refuse to tick this box and thus to give consent to the processing of my health data by Foyer Global Health S.A. and its service providers, including group companies, as set out in the Data Protection clause above, for the purposes of providing health insurance cover and for the provision of related assistance services and support, I understand that:
Conclusion of the insurance contract which I have requested may be delayed or denied, if the remaining sources of information do not make it possible to investigate and assess the risk associated with my request.

Direct marketing

☐ I herewith agree that information on special offers by Foyer Global Health S.A. may be sent to me in writing, in electronic form and by telephone. This consent may be revoked at any time.

All persons aged 18 years and older have to sign. For minors and incapable adults, the authorized legal representative(s) have to sign.
In case policyholder and insured person are same, please sign once.

Place and date	Signature of the policyholder	Insured person 1 (if different to policyholder)
Insured person 2	Insured person 3	Insured person 4

Signature(s) of the co-insured person(s) or their legal representative(s)

Insurance intermediary name and No.	Sub-intermediary 1 name and No.
Signature of insurance intermediary	Sub-intermediary 2 name and No.

We will not be able to process your application if any fields are left incomplete.

Please return your fully completed application form by:
E-mail: Scan it and send it to: service-yougenio@globality-health.com
Fax: Print it and send it to: +352 270 444 3699

Alternatively you can post it to: Foyer Global Health S.A., 12, rue Léon Laval, L-3372 Leudelange, Luxembourg