

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 UMC Zorgverzekering.

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

Customer number

1 Initials  Surname prefix  Surname

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

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. Do you have a different nationality? Then please send us a copy of your residence card.

### 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  Male  Female BSN (citizen service number)  Nationality  NL  Other\*

3 Initials  Surname prefix  Surname

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

4 Initials  Surname prefix  Surname

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

5 Initials  Surname prefix  Surname

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

6 Initials  Surname prefix  Surname

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

\* 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. Do you have a different nationality? Then please send us a copy of your residence card.

### 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

Name of employer/organisation

Start date of employment with employer

Group discount number\*

Postcode and town/city of employer/organisation

Payroll number\*

\*Your employer or organisation has your group discount number or payroll number.

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

### E. Basic cover

UMC Zorgverzekering

More information on the basic cover and the excess is available from our website.

#### Excess

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

Would you like a voluntary excess?  Yes  No

If yes, please indicate your choice here. 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

Please enter the required package choice here. Please find more information on the possible choices on our website.

Do you require supplementary insurance (UMC Aanvullende verzekering)? Indicate your choice here.

	UMC Extra Zorg 1	UMC Extra Zorg 2	UMC Extra Zorg 3	UMC Extra Tand 1	UMC Extra Tand 2	UMC Extra Tand 3
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"/>

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

UMC Extra Tand 3 is subject to a qualification period of 1 calendar year for partial dental prostheses and implants, crowns and bridges.

### 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. For any amounts exceeding €220, you will receive an 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.

The premium can be withheld from your salary only if your employer offers this option. Your excess, personal contributions and any amounts paid out on claim forms that prove unjustified will not be withheld from the salary.

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

Signing this form simultaneously grants us authorisation for monthly automatic direct debits for your excess, personal contributions and any amounts paid out to you on expense forms that prove unjustified, unless you choose payment by acceptance giro (payment order form).

If you do not wish to pay the premium based on amounts withheld from your salary, please select your payment method:

direct debit

paper invoice (this is subject to a €1.50 fee for each paper invoice)

If you do not wish to pay the premium on a monthly basis, would you prefer annual payment?  yes, annual payment (this option is not possible if paying through amounts withheld from the salary)

### 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.umczorgverzekering.nl](http://www.umczorgverzekering.nl). We can send you the terms and conditions at your request. Alternatively, you can view the terms and conditions at one of our offices. Registration will be processed after we have verified that the persons to be insured fulfil the terms and conditions of the healthcare insurance policy.

If you have any questions, please visit [www.umczorgverzekering.nl](http://www.umczorgverzekering.nl)/contact. We would be happy to help you.

By taking out a healthcare insurance with NV Zorgverzekeraar UMC, 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 NV Zorgverzekeraar UMC 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.

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

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](mailto:privacy@vgz.nl). For more information about privacy, please check the Privacy page on our website.

### Details

#### UMC Zorgverzekering

Please find the details of UMC Zorgverzekering below. You can also find the collection details on your bank statement.

#### NV Zorgverzekeraar UMC

PO Box 25210  
5600 RS Eindhoven, the  
Netherlands  
The Netherlands

#### Collector ID

NL22 INGB 0000710537

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

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

Date

Town/city

Signature of policyholder

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