ACIBADEMSIGORTA
HEALTH INSURANCE APPLICATION FORM

Please fill the form with capital letters.

This section will be filled by the intermadiary

Agency Number		Selected Product, Plan		Policy Start Date	__ __ /__ __ /__ __ __ __
Customer Representetive		☐ New		Policy End Date	__ __ /__ __ /__ __ __ __

POLICY OWNER

Name, Last Name/Title		Nationality	
Place/Date of Birth		Identity No/Passport No:	
Address ☐ Home ☐ Work		Tax Office/No	/
		Cell Phone	( )
		Telephone No	( )
Postal Code		E-Mail	_____@_____

INSURANCE CANDIDATE

	Oneself	Spouse	Child	Child	Child
Name					
Lastname					
Gender	☐ F ☐ M	☐ F ☐ M	☐ F ☐ M	☐ F ☐ M	☐ F ☐ M
Identity No					
Date of Birth	__ __ /__ __ /__ __ __ __	__ __ /__ __ /__ __ __ __	__ __ /__ __ /__ __ __ __	__ __ /__ __ /__ __ __ __	__ __ /__ __ /__ __ __ __
Marital Status	☐ Married ☐ Single				
Number of Children					
Profession					
Height/Weight	____ cm / ___ kg	____ cm / ___ kg	____ cm / ___ kg	____ cm / ___ kg	____ cm / ___ kg

This section will be filled by agency

Tariff Premium (TL)					
Additional Premium (%)					
Discount (%)					
Premium Amount of the Insured					
The Total Amount of the Policy Premium					

BANK ACCOUNT INFORMATİON

Owner of the Account	IBAN NO
	☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐

CREDIT CARD INFORMATION (The policy owner and the credit card owner has to be the same person)

Credit Card Owner		Type of The Card	☐Visa ☐Master
Credit Card Number	__ __ __ __/__ __ __ __/__ __ __ __/__ __ __ __	CVV	__ __ __
Name of the Bank		Expiry Date	__ __ / __ __ __ __

PAYMENT TYPE

Premium payment type	☐ Credit card	☐ Wire Transfer

PAYMENT PLAN

☐ 2 Equal Installments	☐ 6 Equal Installments	☐ ____ Equal Installments	Which day of the month would you like to make your payments?
☐ 4 Equal Installments	☐ 8 Equal Installments	☐ Cash	

Do you want to receive the receipt of payment?	☐ Yes	☐ No	☐ E-Mail	☐ Post

DECLARATION OF THE POLICY OWNER

- I authorize Acıbadem Sağlık ve Hayat Sigorta A.Ş. for the renewal of this and the future policies and for the premiums, which are to be calculated, to be paid with the same credit card, under the same conditions unless otherwise is started in written by me as the policy owner.
- I accept that all the information that I have started above is complete and accurate, and according to this information, the insurance premium can be obtained from my credit card, until the second directive, in the case of not being able to obtain the premium payment, my policy may be adeemed by force of Health Insurance Special and General Conditions.
- The premium calculated above is prepared by assuming that the applicants are healthy and all the family members are insured whitin the same policy. I know that the premium and the policy conditions can be changed after the results of the considerations made according to Application Form, attached documents, reports, company records and other information.
- I commit that all the information given on the application form and attached documents are complete and accurate.
- I, applicant, accept to receive SMS and/or E-Mail form Acıbadem Sağlık ve Hayat Sigorta A.Ş. ☐ SMS ☐ E-posta

Name, Last Name of the Policy Owner	Signature of the Policy Owner	Name, Last Name of the Agency/Customer Representative, Signature, Date
		__ __ /__ __ /__ __ __ __

ACIBADEM SAĞLIK VE HAYAT SİGORTA A.Ş.
Aydınevler Mh. Efendioğlu Sk. No: 7 Küçükyalı 34854 İstanbul Tel: (216) 571 55 55 Faks: (216) 571 55 56 Müşteri İletişim Merkezi (216) 571 5 571
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ACIBADEMSİGORTA
HEALTH ACCOUNT FORM

Please answer the questions below for all who will be covered under this insurance.

If a false, incomplete or wrong declaration is determined about one's health situation or if one uses the insurance benefits maliciously, due to the Health Insurance General ond Special Conditions, exemptions or additional premiums can be applied to one's policy, payments of the treatments can be recoursed and the policy can be cancelled.

1- OTHER INSURANCE COMPANY INFORMATION

Do you have a health and/or life insurance policy within another insurance company which continues or is cancelled ? ☐ Yes ☐ No		
Name of the Insurance Company	Name of the Product	Number of the Policy

2- HEALTH INFORMATION

For each of the YES answers to the questions below in the 3rd clause, explanations section, please state your existing complaints, diagnosis realated to examined or treated diseases, name of the doctor/hospital that the examination/treatment received and your current situation. Please attach a copy of all the doctor, surgery, epicrisis reports, test and if any, pathology results to the application form for all the questions that you have stated YES.

Explain the questions that you have answered as "yes" below					
1	Cardiouscular Diseases (coronary failure, cholestrol, blood presure)	☐Y ☐N	12	Gastroin Testinal System (mouth, esophous, stomach, intestive)	☐Y ☐N
2	Diabetes	☐Y ☐N	13	Genitourinary System Diseases (ovary, womb, bladder...etc.)	☐Y ☐N
3	Cancer	☐Y ☐N	14	Back, Waist, Neck Diseases	☐Y ☐N
4	Mascular Disorsders	☐Y ☐N	15	Knee Diseases	☐Y ☐N
5	Neruous System Diseases	☐Y ☐N	16	Intellingence Disorders	☐Y ☐N
6	Multiple Sclerosis	☐Y ☐N	17	Psychological / Psychiatric Diseases	☐Y ☐N
7	Paralysis	☐Y ☐N	18	AIDS	☐Y ☐N
8	Blood Diseases	☐Y ☐N	19	Have you ever had any surgecy / Have you ever stayed in a hospital?	☐Y ☐N
9	Lung Diseases	☐Y ☐N	20	Are you on medication?	☐Y ☐N
10	Kidney Diseases	☐Y ☐N	21	Do you have any complaints, ailments or illnesses that is known even though you haven't been to a doctor?	☐Y ☐N
11	Liver Diseases	☐Y ☐N			

3- EXPLANATİONS

Insurance Candidate Number	Number of the Question	Complaint, Name of the Disease	Name of the Doctor, Hospital
Attached Document			

4- IMMEDIATE FAMİLY

Do your immediate family (mother, father and siblings) have any of the diseases stated below?

1	Cardiouscular Diseases (Coronary Failure,Cholestrol, Blood Presure)	☐Y ☐N	3	Cancer	☐Y ☐N
2	Diabetes	☐Y ☐N	4	Others	☐Y ☐N
Explanations					

5- HABITUATES

	Oneself	Spouse	Child	Child	Other
Do you have any family member who drinks alcohol?	(.....glass/week .....years.)	(.....glass/week .....years.)	(.....glass/week .....years.)	(.....glass/week .....years.)	(.....glass/week .....years.)
Do you have any family member who smokes?	(.....piece/day .....years)	(.....piece/day .....years)	(.....piece/day .....years)	(.....piece/day .....years)	(.....piece/day .....years)

6- DECLORATION OF THE POLICY OWNER

- I declare that I authorize Acıbadem Sağlık ve Hayat Sigorta A.Ş. to obtain any information, which is a concern about my health insurance coverage, from doctor, health institutions and other concerned, and to provide information to SAGMER (Health Insurance Information Center)
- I declare that I read and accepted the Health Insurance General and Special Condition.
- I commit that all the information that I provided above is complete and accurate.
- I accept and declare that I transfer irreavacable and alienate all prices belong to examinations and treatments and other health expenses, that should be paid by Social Security Institution (SSI)

Name, Lastname of the Policy Owner	Signature of the Policy Owner	Date
		__/__/____

Opinion of the Underwriting Department (This section will be filled by the Insurance Company)

Number of the Insured	
Explanation	

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