

GROUP HEALTH INSURANCE APPLICATION FORM

ACIBADEMINSURANCE

Agency Number		Secondary Agency Number / MT Code	
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POLICY	Product /Plan	Policy Commencement Date	_/_/___	Expiry Date	_/_/___
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POLICY HOLDERS	Title				
	Address				
	Telephone		Fax	() _____	
	Tax Number			Tax Office	

INSURED PERSON	Name Surname	Date of Birth		Place of Birth	
	Communication Address				
	Communication Telephone	() _____	GSM	() _____	ID or Passport Number
	Tax Number			Tax Office	
	Social Security Number			Social Security Organization	

BANK	Please write down the information about the bank account you wish the indemnity to be paid below.				
	Bank Name	City		Branch	
	Account Number	Name of the Account Holder			

INSURED CANDIDATE AND OTHER FAMILY MEMBERS		Name Surname	Gender	Date of Birth	Place of Birth	Social Security Organization/ Number	ID or Passport Number	Tax Office/ Number
	Insured Candidate		<input type="checkbox"/> Female <input type="checkbox"/> Male	_/_/___				
	Spouse		<input type="checkbox"/> Female <input type="checkbox"/> Male	_/_/___				
	Child 1		<input type="checkbox"/> Female <input type="checkbox"/> Male	_/_/___				
	Child 2		<input type="checkbox"/> Female <input type="checkbox"/> Male	_/_/___				
	Child 3		<input type="checkbox"/> Female <input type="checkbox"/> Male	_/_/___				
	Child 4		<input type="checkbox"/> Female <input type="checkbox"/> Male	_/_/___				

PAST INSURANCE INFORMATIONS	PREVIOUS HEALTH INSURANCE INFORMATION IF THERE IS of the MEMBERS WHO WILL BE TAKEN UNDER INSURANCE COVERAGE				
	Insurance Company		Policy Number		Insurance starting/expiration
	Family Individuals Names within Scope of Coverage				
	Scope of Health Problems not within Scope of Coverage (Exempted) if There are				

DECLARATION	I commit that the information I give at the application form and the attached documents are complete and accurate. Filling this form does not necessitate an automatic acceptance of the Insurance Company. I do accept that my policy will become valid after my application is accepted by the Insurance Company and the liability to the Insurance Company does not start until initial premium is collected by the Insurance Company.				
	As the Policy Holder, I do accept to receive information regarding insurance services through SMS or E-Mail <input type="checkbox"/> SMS <input type="checkbox"/> E-Mail				

Policy Holder's Name - Surname /Signature	Agency/Customer Representative Name Surname/ Signature	Date

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GROUP HEALTH INSURANCE DECLARATION FORM

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ACIBADEMINSURANCE

This form must be filled for all members who will be within health insurance coverage, all questions must be answered.
Please attach test results related to the declared health problems at the form, detailed information related to the reports or illnesses.
Please declare all present and past health problems even you think it is not important or you do not have any complaints right now

	Insured Candidate	Spouse	Child 1	Child 2	Child 3	Child 4
Height/Weightcmkgcmkgcmkgcmkgcmkgcmkg
Blood group						
Occupation						
Working environment						

Does individual within health insurance coverage have genetic, chronic or still have any health problem tension, diabetes, allergy, gastro-intestinal system diseases, tuberculosis, epilepsy, hearth, jaundice, cancer, goiter, psychological, renal diseases and pediatric surgery, general surgery, thorax-cardiovascular surgery, neurosurgery, ear-nose-throat, orthopedics, eye diseases, gynecology and/or urology problems, having any treatment, taking medicine regularly, having any problem which need surgery? (If your answer is yes; define the name of the person who needs treatment, the diagnosis, what the surgery is, date, the name of the hospital and doctor, last situation in details. Please attach reports about the illness.

Yes No

Explanation: _____

Did individuals within health insurance coverage have serious illness before, health problem tension, diabetes, allergy, gastro-intestinal system diseases, tuberculosis, epilepsy, hearth, jaundice, cancer, goiter, psychological, renal diseases and pediatric surgery, general surgery, thorax-cardiovascular surgery, neurosurgery, ear-nose-throat, orthopedics, eye diseases, gynecology and/or urology problems, having any treatment, taking medicine regularly, having any problem which need surgery? (If your answer is yes; define the name of the person who needs treatment, the diagnosis, what the surgery is, date, the name of the hospital and doctor, last situation in details. Please attach reports about the illness.

Yes No

Explanation: _____

Did female individuals within health insurance coverage have any birth or are they pregnant now? (If your answer is yes describe how many birth does she have and/or How many months pregnant is she) Yes No

Explanation: _____

Are you completely healthy now? Do the individuals within health insurance coverage have body disability, deformity, incomplete limb or change in health status? (Please explain if your answer is yes) Yes No

Explanation: _____

I commit that the information above is complete and accurate, I declare that the Insurance Company is authorized by me to collect information about all issues related to health insurance conditions from doctors, health organizations and other related people.

Title of Policy Holder/ Insured Candidate Name Surname	Signature	Date

This part will be filled by company authoritative.

Risk Acceptance Opinion

Policy Exemption Surpremium (%.....) Rejection

Explanation:

Name Surname	Signature	Date

Company