HEALTH INSURANCE APPLICATION AND STATEMENT FORM (A6 RESIDENCE PERMIT)

Please fill out all fields in the Application Form in legible uppercase letters. This form is not a proposal.

Agency / KRY No		Policy Start Date	
Full Name of the Technical Personnel		Policy End Date	
Policy No			

Coverage does not begin until either the entire premium amount or the first installment is paid. Accordingly, policy start date cannot be different from the date on which the entire premium or the first installment has been paid.

POLICY HOLDER

Name, Surname and Title		Tax Office No	
Place/Date of Birth	_ _ / _ _ / _ _ _ _	GSM No	(0)
T.R. ID/Pass./ Foreign ID No.		Phone	(0)
Gender/Nationality		E-mail	
Address Home		Preffered Mode of Correspondence Home ☐	
Work		Work ☐	

CANDIDATE INSUREDS

	1. Candidate (him/herself)	2. Candidate (partner)	3. Candidate (children)	4. Candidate (children)	5. Candidate (children)
Name					
Surname					
Gender	☐ F ☐ M	☐ F ☐ M	☐ F ☐ M	☐ F ☐ M	☐ F ☐ M
Foreign ID No. / Pass. No					
Nationality					
Date of Birth	_ _ / _ _ / _ _ _ _	_ _ / _ _ / _ _ _ _	_ _ / _ _ / _ _ _ _	_ _ / _ _ / _ _ _ _	_ _ / _ _ / _ _ _ _
GSM No					
E-mail					
Occupation					
Height / Weight	___ cm / ___ kg	___ cm / ___ kg	___ cm / ___ kg	___ cm / ___ kg	___ cm / ___ kg
Delivery Week			___ week	___ week	___ week

PREMIUM INFORMATION (to be filled out by the Sales Channel)

Insured Premium Amount	
Total Policy Premium Amount	

Important Note: This form is not a proposal. The Premium amount indicated above, which has been calculated based on certain criteria and according to relevant legislation, is only intended as an example for candidate insureds. The actual Premium amount will be determined following risk assessment by the insurer.

TYPE OF PAYMENT

Premium Payment Tools	☐ Credit Card	☐ Blocked	☐ Unblocked	☐ Bank Transfer

Policy Holder Title, Stamp/Name, Surname, Signature, Date	Sales Channel Title, Stamp/Name, Surname, Signature, Date
_ _ / _ _ / _ _ _ _	_ _ / _ _ / _ _ _ _

Küçükbakkalköy Mah. Başar Sok. No:20 34750 Ataşehir - İstanbul Tel: +90 216 571 55 55 Faks: +90 216 571 55 56 Central Registration No: 0153003619800017
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CREDIT CARD DETAILS (The Policy Holder and the credit card owner must be the same person.)

Please choose the product you wish to purchase with your credit card: ☐ Health

Credit Card Owner		Card Type	☐ Visa ☐ Master
Credit Card No	_____*****_____	Name of the Bank	

* Blocked type of collections can be processed only from Bonus and World branded credit cards.

PREMIUM PAYMENT SCHEDULE

☐ 2 Equal Installments	☐ 6 Equal Installments	☐ ___ Equal Installments	On which day of each month will installments be paid? _____
☐ 4 Equal Installments	☐ 8 Equal Installments	☐ In Cash	

POLICY HOLDER STATEMENT

1. I accept as a Policy Holder if I do not inform the Insurer with written instructions to the contrary, for all the insured given information that I have given in the Application Form for now and then of the policy period, within the same insurance plan without a new bid requirement Insurers could re-issued policy, the premiums can be charged to the credit I have given the above information to be calculated as authorized Bupa Acıbadem Sigorta A.Ş. in this matter I agree that this declaration.

2. In the direction of these information, until any further notice, I commit that insurance premiums would be collected from my credit card, in case of any not collection from card, even if the policy delivery has been done, I know and undertake that Insurer's responsibility will not start and during agreement and upon Insurer requests, the individuals' who would be covered, information is complete and accurate.

3. Premium installments agreed to by the Policy Holder and the Insurer are immutable. Policy Holders missing their installment payments fall into a payment default and make themselves liable as per article 1434 of the Turkish Code of Commerce. Other rights of the insurer arising from the Turkish Code of Obligations due to the default of the policy holder shall be reserved.

4. I hereby acknowledge that the Premium amount indicated above has been calculated according to the insurance product chosen by candidate policy holders, whose information have been provided in the Application Form, and that policy terms and premiums amounts may vary depending on the outcome of the assessment of the Application Form, Health Declaration Form, attached documents, reports, company records and other information. I agree that in the event that the premium is changed as a result of the evaluation of the Application Form, Health Declaration Form, attached documents, reports, company records and other information, I agree that if the above calculated premium increases up to a maximum of 50 TRY, the premiums to be calculated without re-approval may be collected from my credit card I hereby this declaration authorizes Bupa Acıbadem Sigorta A.Ş.

5. I hereby acknowledge that the email addresses and other contact information written in the Application Form belong to me and the other candidate insureds and that Bupa Acıbadem Sigorta A.Ş. shall use these contact details for all notifications regarding the insurance policy as well as for its delivery to the insured and that all SMS and/ or email notifications to be made by the Insurer shall be made using these details.

6. I hereby declare that I have been informed that I may withdraw from the policy, subject to me having made a cancellation request within 30 days following the policy start date, provided that no indemnity claims have been made until the request date.

7. This Application Form has been filled out by myself to apply for the chosen insurance product after having been fully informed of available products.

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Please bear in mind all individuals to be covered by the policy when answering the following questions.
All questions in the Health Declaration Form regarding the medical condition of all individuals to be covered by the insurance policy must be answered fully and correctly. The policy shall be redrawn as per General Conditions of the Health Insurance Policy and Policy Special Terms in case of inaccurate or misleading statements and/ or in case of non-fulfilment of the statement obligation, in which case unwarranted compensation payouts shall be returned by the customer and contract terms may be redefined by the Insurer (exemption, additional premiums, limit etc.) and the contract may be annulled.

DETAILS OF THE PREVIOUS INSURANCE COMPANY

Have you any ongoing/ expired Health Insurance Contracts with other insurance companies? ☐ Yes ☐ No

Title of the Insurance Company	Policy End Date	Policy Number
	_ _ / _ _ / _ _ _ _	

MEDICAL INFORMATION

For each medical condition / disease you have ticked “YES”, please enter in the remarks section name of the candidate policy holder and disease / case no., what the current complaints are, the diagnoses or treatment options of the complaint, name of the doctor and hospital where treatment was received and the final situation. Please attach to the Statement Form any copies of medical reports, surgery notes, epicrisis reports, tests and other pathological results for each medical conditional / disease you have ticked “YES”.

Please write down below more detailed answers to questions you have answered as "YES".

1	Cardiovascular diseases (Heart failure, hypertension, cholesterol, heart valve diseases, varicose veins, venous insufficiency etc.)	☐ Y ☐ N	12	Endocrine (Hormonal) diseases (Thyroid, hypophysis, cushing etc.)	☐ Y ☐ N
2	Diabetes (Diabetes mellitus)	☐ Y ☐ N	13	Gastrointestinal Diseases (Mouth, esophagus stomach, intestines etc.)	☐ Y ☐ N
3	Cancer, Cysts, Tumors	☐ Y ☐ N	14	Liver Diseases	☐ Y ☐ N
4	Nervous System Diseases (Multiple Sclerosis, stroke, epilepsy etc.)	☐ Y ☐ N	15	Reproductive System Diseases (Ovaries, uterus, prostate, testicles etc.)	☐ Y ☐ N
5	Blood Diseases	☐ Y ☐ N	16	Breast Diseases (Cyst , adenoma, tumors etc.)	☐ Y ☐ N
6	Musculoskeletal System Diseases	☐ Y ☐ N	17	Psychological and Psychiatric Disorders	☐ Y ☐ N
7	Did you have an operation/Did you have to stay at the hospital?	☐ Y ☐ N	18	Other (diseases other than those mentioned above please indicate all kinds of diseases and accidents)	☐ Y ☐ N
8	Knee Disorders	☐ Y ☐ N	19	Back, Waist, Neck Diseases	☐ Y ☐ N
9	Respiratory Diseases (Lung, trachea larynx, etc.)	☐ Y ☐ N	20	Are you on medication? (Please specify.)	☐ Y ☐ N
10	Ear, Nose, and Throat Disorders	☐ Y ☐ N	21	Have you any medical complaints/disorders/ diseases, including those not necessarily examined by a doctor?	☐ Y ☐ N
11	Urinary Tract Diseases (kidney, bladder etc.)	☐ Y ☐ N			

REMARKS

Candidate Insured No.	Question No.	Complaint, Name of the Disease	Doctor, Hospital Name
Attached Documents			

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_ _ / _ _ / _ _ _ _	_ _ / _ _ / _ _ _ _

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POLICY HOLDER STATEMENT

1. I hereby agree and acknowledge that details such as warranty, additional terms (exemption, limit, additional Premium, contribution, standby period etc.) pertaining to the insurance policy of applicants may be shared with me and that each applicant has given their oral consent to their information being viewed online by each other and that I will submit the deed of consent, a sample of which is in the attachment, to the Insurer within the withdrawal period and that otherwise I accept responsibility for all legal consequences.

2. Risk measurement within the scope of policies and compensation payments organized for your company, evaluation of compensation claims, the use of rights arising from the insurance contract and fulfillment of obligations, planning and statistical studies within the scope of insurance transactions and insurance transactions, and for the development of special opportunities; I acknowledge and accept that my personal data, including my health data, must be processed.

I give consent to the provision of information and documents about me with my given health information as well as the relevant legal regulations from Türkiye Sigorta Birliği (Turkish Insurance Association) Sosyal Güvenlik Kurumu(Social Security Institution), Sağlık Bakanlığı (Ministry of Health), all health institutions and organizations, other insurance companies and public institutions and organizations, private sector organizations such as the T.C. Hazine ve Maliye Bakanlığı (Ministry of Treasury and Finance of Turkey), Sigorta Bilgi ve Gözetim Merkezi (SBGM) (Insurance Information and Surveillance Center) and public health institutions, pharmacies, laboratories, physicians and other relevant third party. All such data shall be retained by the Insurer on matters which may be obtained, stored, retained, disclosed, provided that the legislation permits it, transferred to third parties or otherwise processed, I declare that I am informed and gave it approval. My personal data, for the relevant insurance proposals / policies during the effective date and the retention periods stipulated in the legislation; I understand and agree that it may be retained in writing or electronic media.

I acknowledge that I have been informed, and accept that my health records is one of the special categories of personal data and my personal data including health records can be processed without explicit consent for insurance companies operating in the financing and management of health services, if requested by your company, I will provide my personal “e-nabız” records to the insurance company for the evaluation of the proposal, compensation / provision request.

My personal data, for the purposes set out above, with supervisory and regulatory authorities and relevant public authorities; I understand and accept that can be transferred and shared with the distribution channel, the shareholders, direct / indirect domestic / foreign subsidiaries, reinsurers, serviced, cooperated persons and organizations, support service providers, brokers,other insurance companies and the insurer / insurer who has the insurance contract.

Under the Law on the Protection of Personal Data, I have to learn whether my personal data has been processed, request information if it has been processed, find out whether it is used appropriately for the purposes of the transaction, know the third parties transferred abroad or abroad, Without prejudice to the exceptions stipulated in the Act on the Protection of Personal Data Requesting that they be deleted / destroyed under the conditions laid down in Article 7 of the Protection of Personal Data Act, objecting to the occurrence of an unfavorable outcome because it is analyzed by automatic systems exclusively, the right to demand that the damage be solved in case you are wounded because it is processed in violation of the law, I hereby declare that I have been informed about the possession of the Insurer, without prejudice to the rights arising from this form and this form. I know and accept that the right to refuse is reserved if the Insurer is repeating the level to which it is unreasonable, requiring disproportionate technical effort, those who threaten the confidentiality of others or are otherwise extremely difficult.

3. I declare that I have read and understood the General Terms and Conditions of the Health Insurance Policy and its Special Terms.

4. I declare that the information I gave in this Declaration Form and its accompanying documents is complete and accurate.

5. I agree that your company may send messages of information and marketing, sent by SMS, telephone, e-mail and other communication channels.

6. I declare that all medical health information provided in this Declaration Form and its accompanying documents is complete and correct.

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_ _/ _ _/ _ _ _ _	_ _/ _ _/ _ _ _ _

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According to the "Regulation on Private Health Insurance" and "Protection of Personal Data" Legislation;

• Risk measurement within the scope of policies and compensation payments organized for your company, evaluation of compensation claims, the use of rights arising from the insurance contract and fulfillment of obligations, planning and statistical studies within the scope of insurance transactions and insurance transactions, and for the development of special opportunities; I acknowledge and accept that my personal data, including my health data, must be processed.
I give consent to the provision of information and documents about me with my given health information as well as the relevant legal regulations from Türkiye Sigorta Birliği (Turkish Insurance Association) Sosyal Güvenlik Kurumu(Social Security Institution), Sağlık Bakanlığı (Ministry of Health), all health institutions and organizations, other insurance companies and public institutions and organizations, private sector organizations such as the T.C. Hazine ve Maliye Bakanlığı (Ministry of Treasury and Finance of Turkey), Sigorta Bilgi ve Gözetim Merkezi (SBGM) (Insurance Information and Surveillance Center) and public health institutions, pharmacies, laboratories, physicians and other relevant third party. All such data shall be retained by the Insurer on matters which may be obtained, stored, retained, disclosed, provided that the legislation permits it, transferred to third parties or otherwise processed, I declare that I am informed and gave it approval.
My personal data, for the relevant insurance proposals / policies during the effective date and the retention periods stipulated in the legislation; I understand and agree that it may be retained in writing or electronic media.
I acknowledge that I have been informed, and accept that my health records is one of the special categories of personal data and my personal data including health records can be processed without explicit consent for insurance companies operating in the financing and management of health services, if requested by your company, I will provide my personal “e-nabız” records to the insurance company for the evaluation of the proposal, compensation / provision request.
My personal data, for the purposes set out above, with supervisory and regulatory authorities and relevant public authorities; I understand and accept that can be transferred and shared with the distribution channel, the shareholders, direct / indirect domestic / foreign subsidiaries, reinsurers, serviced, cooperated persons and organizations, support service providers, brokers,other insurance companies and the insurer / insurer who has the insurance contract.
Under the Law on the Protection of Personal Data, I have to learn whether my personal data has been processed, request information if it has been processed, find out whether it is used appropriately for the purposes of the transaction, know the third parties transferred abroad or abroad, Without prejudice to the exceptions stipulated in the Act on the Protection of Personal Data Requesting that they be deleted / destroyed under the conditions laid down in Article 7 of the Protection of Personal Data Act, objecting to the occurrence of an unfavorable outcome because it is analyzed by automatic systems exclusively, the right to demand that the damage be solved in case you are wounded because it is processed in violation of the law, I hereby declare that I have been informed about the possession of the Insurer, without prejudice to the rights arising from this form and this form. I know and accept that the right to refuse is reserved if the Insurer is repeating the level to which it is unreasonable, requiring disproportionate technical effort, those who threaten the confidentiality of others or are otherwise extremely difficult.
• The Proposal / Application Form and the Health Declaration Form together with all the information that is provided within the information and the fact that knowledge completely reflects the truth (such as exemption, limit, additional premium, participation, waiting period and so on) and justification for the insurance period of the person and his dependents; I agree and declare that this information is shared with the Insurer and that all such information can be displayed on the electronic media. I request and sue for my e-mail address, My GSM number and / or my address in the Mernis registry which I have indicated on the insurance application form, can be used to inform about my insurance transactions and for policy / certificate submission.

TR ID No of the Insured	:	Partner TR ID No	:
Name and Surname of the Insured	:	Name and Surname of the Insured	:
Signature of the Insured	:	Signature of the Insured	:
Date	:	Date	:
Child 18+ TR ID No	:	Child 18+ TR ID No	:
Name and Surname of the Insured	:	Name and Surname of the Insured	:
Signature of the Insured	:	Signature of the Insured	:
Date	:	Date	:
Child 18+ TR ID No	:	Child 18+ TR ID No	:
Name and Surname of the Insured	:	Name and Surname of the Insured	:
Signature of the Insured	:	Signature of the Insured	:
Date	:	Date	:

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