Bupa ACIBADEM SİGORTA

GROUP HEALTH INSURANCE APPLICATION FORM

Please fill in all fields of the Application Form applicable to you in capital letters in readable form. This form does not partage of affer.

Group Name / Policy Holder		Inception Date Of The Day	___/___/___
Step Plan		Expiry Date Of The Day	___/___/___

POLICY HOLDER APPLICANT INFORMATIONS

	(1. Candidate) Himself / Herself	(2. Candidate) Spouse	(3. Candidate) Child	(4. Candidate) Child	(5. Candidate) Child
Name Last Name					
Date of Birth	__/__/___	__/__/___	__/__/___	__/__/___	__/__/___
Gender	☐F ☐M	☐F ☐M	☐F ☐M	☐F ☐M	☐F ☐M
Turkish ID NO/Passp./ Foreign ID NO					
Actual Working Place					
Department Code					
Register No					
Date of Recruitment					
Profession / Title					
Height / Weight	___cm___kg	___cm___kg	___cm___kg	___cm___kg	___cm___kg
Birth Week/Birth Weight*			___week___kg	___week___kg	___week___kg

*It must be filled for the child applications aged under 1 year old

POLICY HOLDER APPLICANT CONTACT INFORMATIONS (Contact informations must be on dear own for insurees.

	(1. Candidate) Himself / Herself	(2. Candidate) Spouse	(3. Candidate) Child	(4. Candidate) Child	(5. Candidate) Child
Phone No	(___) ________	(___) ________	(___) ________	(___) ________	(___) ________
GSM No					
E-mail					
Address					

BANK ACCOUNT DATA INFORMATION (Bank account informaton for out-of-network payment of medical expenses.) (Due to changed Insurance Law (Within the scope of the Circular No. 2021/1, the implementation of the Additional Article 6 of the Insurance Law No. 5684), In order to compensations/expenses payments, All insured persons aged 18 and over must have a bank account in their own name.)

	Account Holder	IBAN NO
(1. Candidate) Himself / Herself		
(2. Candidate) Spouse		
(3. Candidate) Child		
(4. Candidate) Child		
(5. Candidate) Child		

Name, Last Name, Stamp of the Policy Holder and the Date	Signature	Name, Last Name, Stamp of the Policy Insured and the Date	Signature
__/__/____		__/__/____	

Küçükbakkalköy Mah. Başar Sok. No:20 34750 Ataşehir - İstanbul Tel: +90 216 571 55 55 Faks: +90 216 571 55 56 MERSİS No: 0153003619800017
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Please answer the following questions for all of the persons to be included in this insurance.

During the establishment of the contract or in other cases due to the insurer's request, regarding the health status of individuals to be covered by insurance, the questions located in the Declaration Form must be answered fully and correctly. In case if the respective declaration contrary to the facts or under-declare and declaration obligations are not discharged due to the contract, in accordance with the Health Insurance General and Special Conditions of the policy, the Insurance Contract will be rearranged as of the stated date. Exception, deductible or additional premium may be applied to the policy as of the date of discovery or healthcare expenses paid for you may be recovered from you or your policy may be cancelled.

DECLARATION OF THE POLICY HOLDER

- The assumption of all individuals written on application form will be insurer, as a result of the evaluation of an application Form, Health Declaration Form, attached documents, reports, company records and other information prepared in parallel with the selected product, I know and accept the premium and the conditions of policy may change.
- E-mail addresses and other contact information written in the relevant sections of the Application Form belong to myself and Insured Candidates. By Bupa Acıbadem Sigorta Company, for all the information related to insurance contracts preliminary negotiations and agreements, declarations and the delivery of the policy, I agree to the use of the Information in this communication by SMS and / or by e-mail as the use of these contact details for notification and delivery of the policy etc.
- Regarding to the information, this Application Form is filled by myself.

Name, Last Name, Stamp of the Policy Holder and the Date	Signature	Name, Last Name, Stamp of the Policy Insured and the Date	Signature
__/__/____		__/__/____	

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GROUP HEALTH INSURANCE DECLARATION FORM

INFORMATION ABOUT THE OTHER INSURANCE, IF ANY

Do you have any Health and/or Life Policy purchased from another insurer which has expird or is still in effect?		☐ Yes ☐ No
Name of the Insurance Company :	Name of the Product :	Policy Number:

HEALTH INFORMATION

"For all YES answers you have given to the following questions regarding diseases or conditions, please state in the remarks section by stating insuree candidate and disease or the condition number; currently complaints diagnose of treatment or condition number; currently contlaints, diagnose treatment of ailment, name of attending physician, name of the hospital where the treatment is provided, your final status. In respect of the disease and/or condition which you have marked as YES, please attach the copies of all the physician, surgery and hospital discharge reports, test and pathology results, if any, to the application form.

Please State Below the Details of the Questions You Have Answered as Yes

No	Question	Answer
1	Cardiovascular diseases (Blood pressure, cholesterol, cardiac valve disease, cardiac failure, varicase, venous, statis etc.)	Y ☐ N ☐
2	Diabetes	Y ☐ N ☐
3	Cancer, Cyst, Tumour	Y ☐ N ☐
4	Nervous System Diseases (Multiple Sclerosis, stroke etc.)	Y ☐ N ☐
5	Blood Diseases	Y ☐ N ☐
6	Muculoskeletal System	Y ☐ N ☐
7	Back, Belly, Neck Disorders	Y ☐ N ☐
8	Knee Disorders	Y ☐ N ☐
9	Respirotary System Diseases (Pulmonary, Trechea, Larynx etc.)	Y ☐ N ☐
10	Otorhinolaryngology (Ear/Nose/Throat)	Y ☐ N ☐
11	Urinary System Diseases (Kidney, Bladdder)	Y ☐ N ☐
12	Endocrine (Hormonal) Diseases (Thyroid, Hyrophysis, cushing etc.)	Y ☐ N ☐
13	Gastrointestinal Diseases (Mouth, Esophagus, Stomach, Intestines, etc.)	Y ☐ N ☐
14	Liver Diseases	Y ☐ N ☐
15	Genital System Diseases (Ovary, Womb, Prostate, Testicles etc.)	Y ☐ N ☐
16	Breast Disease (Cyst, Adenoma, Tumour etc.)	Y ☐ N ☐
17	Psychological/Psychiatric Disorders	Y ☐ N ☐
18	Do You Have Any Diseases or Accidenta / occupations which is not stated above?	Y ☐ N ☐
19	Have You Ever Undergone Surgical Operetion / hospitalized?	Y ☐ N ☐
20	Are You Taking Any Medicine?	Y ☐ N ☐
21	Are You Pregnant? (If Yes Please Indicate The Week?)	Y ☐ N ☐
22	Do you have any known disorder, complaint, disease, even if you have not been examined by a physician?	Y ☐ N ☐

REMARKS

Candidate Intsured No	Question No	Complaint, Disease, Pain	Name of Physician, Hospital

Attached Documents:

Name, Last Name, Stamp of the Policy Holder and the Date	Signature	Name, Last Name, Stamp of the Policy Insured and the Date	Signature
__/__/____		__/__/____	

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DECLARATION OF THE POLICY HOLDER

• 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.

• All information of all insured applicants included in the application form and the health declaration form is provided with information and that the information in question completely reflects the truth of the insured person and his dependencies information such as guarantee, additional conditions (exemption, limit, additional premium, participation, waiting time, etc.) to be shared with the insurer, and to display all of this information on the electronic media.

• I have read and accepted the Special Conditions of the Policy and the General Conditions of Health Insurance relevant with the insurance contract for this application.

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

• I authorized and accepted given in this application form and the attached documents is full and true for the candidate individuals of insurance.

Name, Last Name, Stamp of the Policy Holder and the Date	Signature	Name, Last Name, Stamp of the Policy Insured and the Date	Signature
_ _ / _ _ / _ _ _ _		_ _ / _ _ / _ _ _ _	

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LETTER OF CONSENT

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.

Insured Turkish ID Number :
Insured Name Last Name :
Insured Sign/Date :

Child +18 Turkish ID Number :
Insured Name Last Name :
Insured Sign/Date :

Child +18 Turkish ID Number :
Insured Name Last Name :
Insured Sign/Date :

Spouse Turkish ID Number :
Insured Name Last Name :
Insured Sign/Date :

Child +18 Turkish ID Number :
Insured Name Last Name :
Insured Sign/Date :

Child +18 Turkish ID Number :
Insured Name Last Name :
Insured Sign/Date :

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