

International Healthcare Plans

Application Form

Please note that you can **apply online** for one of our **International Healthcare Plans for Individuals** at www.allianzworldwidecare.com. Otherwise, please complete this form in **BLOCK CAPITALS**.

Allianz 
Allianz Worldwide Care

If you are adding a new dependant, please state your existing policy number:

1 Applicant details

Please enter the details of all persons to be covered under this contract, including the principal member and any dependants. Dependants can include your spouse/partner and any children financially dependant on the principal member up to the day before their 18th birthday, or up to the day before their 24th birthday if in full-time education. Where the child is 18 years of age or older, please attach a letter from college/university confirming student status or a copy of the student's ID. We will consider applicants for cover up to the day before their 70th birthday.

Principal member

You must notify us of any change of contact details so we can ensure that correspondence reaches you.

Mr. Mrs. Ms. Miss Other First name

Other initials Surname

Date of birth Gender Male Female

Correspondence address
(where you are/will be based for the majority of the insurance period)

Home telephone COUNTRY CODE AREA CODE

Office telephone COUNTRY CODE AREA CODE

Mobile telephone COUNTRY CODE NETWORK CODE

Fax COUNTRY CODE AREA CODE

Email address (mandatory)

Occupation

Home country

(A country for which you hold a current passport and/or to which you would want to be repatriated)

Country of residence

(The country in which you occupy/will occupy the majority of your time for the period of your insurance cover)

Nationality

Please indicate the language in which you wish to receive your policy documentation English German French Spanish Italian

Next of kin

Name

Address

Home telephone COUNTRY CODE AREA CODE

Mobile telephone COUNTRY CODE NETWORK CODE

Email address

Please tick this box if the above named person is also your nominated **Death Benefit beneficiary** (applicable to the Premier/Premier Individual Core Plan only)

If not, please nominate the Death Benefit beneficiary/beneficiaries by stating their full name and relationship to you e.g. spouse, child, parent etc

Details of any current domestic or international health insurance

Name of insurer

Policy number Start date

The following details are only to be completed if you are applying to join an existing group scheme

Group name

Group number

Dependant 1

Mr. Mrs. Ms. Miss Other _____ First name _____
 Surname _____
 Date of birth Gender Male Female Relationship to principal member Spouse Child
 Occupation _____
 Home country _____
(A country for which you hold a current passport and/or to which you would want to be repatriated)
 Country of residence _____
(The country in which you occupy/will occupy the majority of your time for the period of your insurance cover)
 Nationality _____

Details of any current domestic or international health insurance

Name of insurer _____
 Policy number _____ Start date

Dependant 2

Mr. Mrs. Ms. Miss Other _____ First name _____
 Surname _____
 Date of birth Gender Male Female Relationship to principal member Spouse Child
 Occupation _____
 Home country _____
(A country for which you hold a current passport and/or to which you would want to be repatriated)
 Country of residence _____
(The country in which you occupy/will occupy the majority of your time for the period of your insurance cover)
 Nationality _____

Details of any current domestic or international health insurance

Name of insurer _____
 Policy number _____ Start date

Dependant 3

Mr. Mrs. Ms. Miss Other _____ First name _____
 Surname _____
 Date of birth Gender Male Female Relationship to principal member Spouse Child
 Occupation _____
 Home country _____
(A country for which you hold a current passport and/or to which you would want to be repatriated)
 Country of residence _____
(The country in which you occupy/will occupy the majority of your time for the period of your insurance cover)
 Nationality _____

Details of any current domestic or international health insurance

Name of insurer _____
 Policy number _____ Start date

Dependant 4

Mr. Mrs. Ms. Miss Other _____ First name _____
 Surname _____
 Date of birth Gender Male Female Relationship to principal member Spouse Child
 Occupation _____
 Home country _____
(A country for which you hold a current passport and/or to which you would want to be repatriated)
 Country of residence _____
(The country in which you occupy/will occupy the majority of your time for the period of your insurance cover)
 Nationality _____

Details of any current domestic or international health insurance

Name of insurer _____
 Policy number _____ Start date

If there is not sufficient space for all dependants, please use another Application Form.

2 Policy commencement date

Please indicate the date you require cover from:

Cover is conditional upon acceptance of your application, which is only confirmed when an Insurance Certificate is issued to you.

3 Plan details

(This section does not need to be completed if you are applying as part of a group scheme.)

International Healthcare Plans

Please tick to indicate the type of plan(s) and deductible you require:

Core Plan	Out-patient Plan	Out-patient deductible	Maternity Plan	Dental Plan	Repatriation Plan
Premier Individual <input type="checkbox"/>	Gold Individual <input type="checkbox"/>	0 <input type="checkbox"/>	Premier Maternity <input type="checkbox"/>	Dental 1 <input type="checkbox"/>	Repatriation Plan <input type="checkbox"/>
Club Individual <input type="checkbox"/>	Silver Individual <input type="checkbox"/>	€100/£75/CHF150/\$140 <input type="checkbox"/>	Club Maternity <input type="checkbox"/>	Dental 2 <input type="checkbox"/>	
Classic Individual <input type="checkbox"/>	Bronze Individual <input type="checkbox"/>	€200/£150/CHF300/\$280 <input type="checkbox"/>			
Essential Individual <input type="checkbox"/>	Crystal Individual <input type="checkbox"/>				

Out-patient, Dental and Repatriation Plans can only be purchased in conjunction with a Core Plan. Please note that Dental Plan 1 can only be purchased in conjunction with the Premier Individual Core Plan and Gold Individual Out-patient Plan.

Premier Maternity can only be purchased with the Premier Individual Core Plan. Club Maternity can only be purchased with the Club Individual Core Plan. Please note that an Out-patient Plan must be selected in conjunction with a Maternity Plan. Maternity Plans are available to couples and families i.e. a spouse/partner must also be insured on the policy.

Please note that each plan chosen will apply to all policy members.

Your plan selection can only be amended at policy renewal. If you want to increase your level of cover, full medical underwriting and waiting periods may apply and an additional premium amount will be payable.

If your plan is not listed in the sections above, please state your chosen Core Plan and any supplementary plans:

Please tick to indicate the area of cover you require: Worldwide Worldwide excluding USA Africa

4 Payment details

(This section does not need to be completed if you are applying as part of a group scheme and your employer is paying the premium.)

No payment should be made until you have been notified of your policy number.

4.1 Payment currency

Please tick to indicate your preferred payment currency:

Euro UK Sterling CHF Swiss Franc US Dollars

4.2 Payment frequency and method

Please tick to indicate your preferred payment frequency and method:

	Annual	Half yearly	Quarterly	Monthly
Credit card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cheque	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Not available
Bank transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Not available

4.3 Credit card payment details

If you choose to pay by credit card, please provide the following information:

Type of credit card MasterCard VISA
Card number
Expiry date

Credit card authorisation

I authorise Allianz Worldwide Care to charge my credit card account with my healthcare premium (of which I will be notified at acceptance of cover/renewal or upon a request made by me which impacts my premium, such as adding a dependant). This will continue until the instruction is cancelled, by me giving written notice to Allianz Worldwide Care. I understand I will be given one month's notice of any annual premium rate increase.

Cardholder's name
Cardholder's signature Date

Payment charges and details

Payments are subject to the following administration surcharges:
3% for half yearly payments,
4% for quarterly payments and
5% for monthly payments.
There is no administration charge for annual payment.

- Our premiums are expressed in whole numbers (i.e. without any cents or pence etc), so please note that payment frequency surcharge percentages may be slightly higher or lower than those stated.
- Cheques must be made payable to Allianz Worldwide Care, with the policyholder's name and policy number stated on the back of the cheque.
- Bank transfers must include policyholder's name and policy number.
- For payment by cheque/bank transfer, please ensure that payments are received in time, to avoid possible delays to claims processing.
- We will only accept payment by credit card via MasterCard or VISA.
- Allianz Worldwide Care does not accept liability for any payment which does not clearly identify the policyholder.
- If Insurance Premium Tax and other government levies apply, these will be stated on your invoice/payment details letter.

5 Pre-existing conditions

Pre-existing conditions are medical conditions or any related conditions, for which one or more symptoms have been shown at some point during the five years prior to commencement of cover, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition about which you or your dependants could reasonably have been assumed to have known will be deemed to be pre-existing. Pre-existing conditions are covered under the policy, unless otherwise advised by us in writing. Conditions arising between signing the Application Form and confirmation of acceptance by our Underwriting Team will equally be deemed to be pre-existing. Therefore, it is necessary that you advise us of any material changes to the information provided, between submission of this application and acceptance by us. You are hereby obliged on request to provide any further information that we might require.

6 Health declaration

Please answer the following questions on the basis of your complete medical past, unless otherwise requested. All material facts (facts likely to influence the insurer's assessment and acceptance of this application) including those relating to these questions, must be disclosed. Failure to do so may invalidate the policy. If you are in any doubt as to whether a fact is material, then it should be disclosed.

	Principal member	Dependant 1	Dependant 2	Dependant 3	Dependant 4
1. What is your height/weight?	cm <input type="text"/> kg <input type="text"/>	cm <input type="text"/> kg <input type="text"/>	cm <input type="text"/> kg <input type="text"/>	cm <input type="text"/> kg <input type="text"/>	cm <input type="text"/> kg <input type="text"/>
2. Have you consumed any form of tobacco in the past year? Type Daily consumption/amount	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> <input type="text"/>
3. How many units of alcohol do you drink per week? (1 short = 1 unit, 250ml beer = 1 unit, 1 glass wine = 1 unit)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4. Are you currently suffering from any complaints, illnesses, after-effects of an accident, mental or physical disabilities, psychiatric disorders or chronic/long term medical or dental conditions?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Have you ever suffered from, been in hospital with, or received treatment, tests or investigations for:					
a) Rheumatism, gout, arthritis or disease of the muscles or joints including the back?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Epilepsy or other neurological disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c) Any digestive disorder including stomach and/or bowel problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
d) Anxiety, depression, psychiatric or mental illness?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
e) Gynaecological disorders or fertility?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
f) Any disorder of the kidneys, bladder or liver/pancreas including diabetes?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
g) Any lump, cyst, mole or cancer?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
h) Any eye, ear, nose or skin disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
i) Any heart condition, stroke or raised blood pressure/cholesterol?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
j) Asthma, chronic bronchitis or any other respiratory condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
k) Any other illness or injury requiring medical attention (excluding colds and influenza)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Have you ever been advised to consult a doctor for a recurrent complaint, or been advised to have any diagnostic test or treatment which has not been completed or that you still await the results of?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Have you ever tested positive for HIV, Hepatitis B or C? Are you awaiting the results of such a test?	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>

If the result is negative, having an HIV test will not, in itself, have any effect on your acceptance terms for insurance.

8. Have you ever suffered from or been in hospital for any other disorder or as a result of an accident which required that you:

- a) Received more than 14 days treatment? Yes No Yes No Yes No Yes No Yes No
- b) Were off work for more than one week? Yes No Yes No Yes No Yes No Yes No
- c) Had specialised treatment? Yes No Yes No Yes No Yes No Yes No

9. Are you pregnant? Yes No Yes No Yes No Yes No Yes No
 If yes, please state expected date of childbirth dd/mm/yy dd/mm/yy dd/mm/yy dd/mm/yy dd/mm/yy

10. Have either of your parents or any of your brothers or sisters, living or deceased, suffered (before the age of 65) from diabetes, heart disease, high blood pressure, cancer, kidney disease, raised cholesterol, nervous or brain disorders such as Alzheimer's, Parkinson's, or M.S., eye, hearing or speech disorders or any family disorder? Yes No Yes No Yes No Yes No Yes No

11. Have you had cancer screenings or general check-ups within the last five years? Yes No Yes No Yes No Yes No Yes No

Additional information

If you answered "Yes" to any of the questions from 4 to 11, please provide details in the box below. Failure to provide complete information may delay the processing of your application. **If in doubt as to whether a fact or information is material, then it must be disclosed.**

Name	Question number	Where applicable, please provide the date of first diagnosis/consultation, name and address of treating physician, frequency and severity of symptoms, date of last episode as well as details of any past, current or known future treatment

Name	Question number	Where applicable, please provide the date of first diagnosis/consultation, name and address of treating physician, frequency and severity of symptoms, date of last episode as well as details of any past, current or known future treatment

If there is not sufficient space for your additional information, please use another Application Form.

Additional information (continued)

Please state the name, address and telephone number of your family doctor:

Mr. Mrs. Ms. Miss Other First name
Surname
Address

Telephone number COUNTRY CODE – AREA CODE –
Date of last visit d | d m | m y | y
Please state the date that you first became a patient of this doctor d | d m | m y | y

7 Dental declaration

(Should only be completed if you are purchasing dental cover.)

	Principal member	Dependant 1	Dependant 2	Dependant 3	Dependant 4
a) Are you currently undergoing or been advised to undergo any treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Do you have missing teeth which have not been replaced (excluding wisdom teeth)? If yes, how many?	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>
c) Have you denture sets (crowns, inlays, implants, bridges, fillings, etc.)? If yes, how many?	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/>
d) Do you suffer from parodontosis?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
e) Have you had a dental check up within the last five years? If yes, please state the: Date Outcome	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> dd /mm/ yy <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> dd /mm/ yy <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> dd /mm/ yy <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> dd /mm/ yy <input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="text"/> dd /mm/ yy <input type="text"/>

If you answered "Yes" to question a), please complete a Dental Questionnaire, which can be downloaded from our website: www.allianzworldwidecare.com.

Please state the name, address and telephone number of your family dentist:

Mr. Mrs. Ms. Miss Other First name
Surname
Address

Telephone number COUNTRY CODE – AREA CODE –

8 Data Protection Acts – collection and use of personal information

In these statements, references to information include personal data and information given by you to us, whether in your application, any Claim Form and/or supporting documents or any information we may collect in connection with any product or service we provide. Allianz Worldwide Care, a member of the Allianz Group, is an Irish authorised non-life insurance company and shall be the data controller in respect of all such information.

Uses: Information you supply may be used for the purposes of insurance administration (including underwriting, processing, claims handling, reinsurance and fraud prevention) by us.

Sensitive data: We need to collect sensitive data relating to you (such as medical and health details) in order to assess the terms of insurance we issue/arrange or to administer claims which arise.

Retention: We will not retain your data for longer than is necessary for the purposes for which it is obtained.

Consent: By providing us with your information, you consent to all of your information being used, processed, disclosed and retained as set out above.

Representation: By your signature you warrant and represent to us that you have authority to act on behalf of your dependants in respect of all personal information you provide to us, you have the authority of your dependants to disclose this personal information for the uses listed above and you are consenting to the processing, disclosure, use and retention of your dependants information on their behalf. In these statements, all references to "you" or "your" shall be deemed to include both you and your dependants.

Access: You have the right to request and receive a copy of your personal data held by us. Should you wish to exercise this right, you should write to us under Section 4 of the Data Protection Acts 1988 and 2003, for the attention of the Data Protection Officer, at Allianz Worldwide Care, 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland, or by email to: client.services@allianzworldwidecare.com. A fee of €6.35 is chargeable under the terms of the Data Protection Acts and cheques should be made payable to Allianz Worldwide Care.

9 Declaration

Please read the following declarations carefully and only sign below if you understand and accept them.

- (a) I declare that all information supplied above is true and complete, including those answers that are not in my own handwriting. I also declare that I have not suppressed, misrepresented or misstated any material fact. I understand that this application shall be the basis of the contract between Allianz Worldwide Care and myself, and that any false, incorrect or misleading statement may render this insurance null and void.
- (b) I undertake to inform Allianz Worldwide Care immediately in writing of any changes in my or my dependants' state of health occurring after the Application Form has been signed and before the start date of my policy.
- (c) I understand that I can withdraw my application in writing by letter, email or fax, within 30 days from the date I receive the full terms and conditions of my policy, and provided that I have not submitted a claim, I am entitled to a full refund of the premium.
- (d) I accept that it is my responsibility to check the accuracy of the information contained within the Insurance Certificate, once issued. If the content is not in accordance with the Application Form, the situation will be considered accepted if I enter no protest within 30 days following the issue date of the Insurance Certificate.
- (e) I consent to the fact that Allianz Worldwide Care, if it considers it appropriate, will check statements concerning my health condition and will check with other healthcare insurers, all statements concerning previous, or existing contracts applied for. I authorise all such practitioners, physicians, dentists, members of medical professions, employees of hospitals and health authorities as well as medical facilities to release my medical records to Allianz Worldwide Care. I also make this statement for my co-insured dependants, including those who cannot assess the meaning of this statement.
- (f) I accept that this policy will be subject to the standard policy terms and conditions effective at the time of policy commencement contained within the Benefit Guide. I confirm that I have read and understand the full definitions, benefits, exclusions and conditions of this policy including the details relating to pre-existing conditions.

As the principal member, I sign this declaration and Application Form on behalf of all persons included in this Application Form.

Principal member's signature

Date

[d | d] [m | m] [y | y]

For office use only - agent details and stamp

Direct Health

office@direct-health.biz

Agency ID: 196983

Please return your fully completed form by:

Scan and email to: underwriting@allianzworldwidecare.com

Fax to: + 353 1 629 7117

Alternatively you can post it to:

Allianz Worldwide Care
18B Beckett Way
Park West Business Campus
Nangor Road
Dublin 12
Ireland

Helpline: + 353 1 630 1301

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