Group insurance

Application form

AG INSURANCE

Please, fill out this form completely, have it signed, and send it back to us, while keeping a copy for yourself. Any missing information (e.g. National Registration No.) will delay data processing.

■ Information concerning the plans (*) : ☐ Retirement ☐ Death ☐ Disability ☐ Health

Group n° ____ Subgroup n° ____

For AG Insurance use only - Membership N° ____

■ Information concerning the employer :

Name and company number of the employer : ____

■ Information concerning the member of personnel (**) :

Name and first name of member of personnel : ____ Registration N° : ____

N° National Register : ____ Date of birth : ___ / ___ / ___ Sex : ☐ FEM. ☐ MALE

Street ____ N° : ____ B. : ____ Language : ☐ NL ☐ FR ☐ EN ☐ DE

Postal Code : ____ City : ____

Professional e-mail address : ____

Family situation : ☐ married / legally cohabiting[1] ☐ single[2] ☐ widow(er) ☐ cohabiting Date of marriage : ___ / ___ / ___

Name and first name of the spouse/partner : ____ Date of birth : ___ / ___ / ___

Name and first name of the children :

	Name	Date of birth	Family Allowance
1st child	____	___ / ___ / ___	Yes ☐ No ☐
2nd child	____	___ / ___ / ___	Yes ☐ No ☐
3rd child	____	___ / ___ / ___	Yes ☐ No ☐
4th child	____	___ / ___ / ___	Yes ☐ No ☐

Are the family members to be insured in the health plan ? Yes ☐ No ☐

Beneficiaries in case of death : the beneficiaries in case of death are designated in the regulations of your group insurance. In case you wish to designate other beneficiaries than those indicated in the regulations, it is recommended to use the appropriate document "Designation/Modification of the beneficiary(ies)".

To be completed by the employer (**): Date of participation for the retriment and/or life plans : ___/___/___ Date of employment : ___/___/___

Contract type : ☐ fixed-term contract Effectiveness date : ___/___/___ ☐ open ended contract Effectiveness date : ___/___/___

Employment status : ☐ Wage-earning ☐ Self-employed

Personnel category : ☐ Management ☐ Executive ☐ Employee ☐ Worker ☐ self-employed ☐ Other : ____

Insurance Combination (if endowment insurance) : ☐ Following plan rules ☐ Other : 10/ ___

Fulltime gross salary : ☐ Monthly ☐ Annually Amount : ____ EUR (see plan rules or special conditions).

Part-time : ☐ Yes ☐ No If yes, % part-time : ___ %.

Reason for inactivity: ☐ Career break ☐ Disability ☐ Unemployment with company supplement

In case of death the undersigned authorizes his attending physician(s) to issue a declaration on the cause of his/her death to the medical advisor of AG Insurance.

He declares to keep a copy of this document, to be aware of the terms and conditions of the group insurance and to agree to the latter

Collection and use of data are in accordance with the provisions of the Belgian law on the protection of privacy.

AG Insurance, in charge of processing, may process such personal data gathered for the purpose of the management of its insurance services and products which it distributes, including the promotion of these, the management of the accounts, the drawing-up of statistics, and reserves the right to communicate the data to third parties if any statutory or contractual obligation or legitimate interest exists.
You are entitled to consult your data and, if necessary, to have them amended.
If you do not wish your data to be processed for purposes of direct marketing, you may object to it expressly, free of charge, by ticking this box : ☐

The document "Information concerning the application form for Health Insurance" has been completed and sended directly to the medical adviser of AG Insurance.

Very important : the employer certifies the data relating to the family situation and the full address of the member of personnel to be accurate.

Made out in ____ , on ____

Signature of the employer, Signature of the member of personnel,

0079-2279033E-30072016

(*) Please indicate the plans for which participation is required. (**) Please tick the appropriate box.
1 included "separed" en "legally separated". 2 included "divorced"

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