Hospitalia

Dentalia Plus

NEW AFFILIATION REQUEST OR REQUEST TO CHANGE A PRODUCT

To put a term to your insurance contract(s), please use a resignation form.

A. CONTACT DETAILS OF THE POLICYHOLDER (one affiliation request per policy holder)

1. Name

First name

Phone no. 0

E-mail address:

National registry number

or
Affix an identification sticker of your health insurance fund

2. I would like to receive the communication regarding my insurances (invoices, contractual information, general information, etc.)

☐ electronically (by e-mail, MyMut, consultation on the website...) as long as the documents are available digitally

☐ on paper

3. **FINANCIAL ACCOUNT FOR REFUNDS**

IBAN

BIC

Payment of the premiums by ☐ direct debit ☐ bank transfer

Payment frequency ☐ year ☐ semester ☐ quarter ☐ month (if direct debit)

4. **PREMIUM CONTRIBUTOR** (to fill in if not the policyholder)

Identity

Address No. Box

Zip code City

B. POLICY HOLDER AND INSURED PERSON(S)
(to be completed by all persons to be insured including the policyholder)

5.

	Name and first name of all insured person(s)	Birth date
Policy holder A		
Insured person B		
Insured person C		
Insured person D		
Insured person E		
Insured person F		

C. NEEDS ANALYSIS FOR POLICY HOLDER AND INSURED PERSON(S) MENTIONED IN BOX B

For an insurance of the "MLOZ insurance" health insurance company.

This analysis must always be done prior to the affiliation to Hospitalia, Hospitalia Medium, Hospitalia Plus, the Warranty serious illnesses and Hospitalia Continuity (8A) - Dentalia Plus (8B) - Hospitalia Ambulant (8C).

In order to be able to propose an adequate insurance, we will analyse your wishes and needs on basis of the questions hereunder. We draw your attention to the risk of underinsurance, over-insurance, multiple insurances and bad insurance cover. Our health insurance fund has the status of insurance agent related to the HIC "MLOZ Insurance" by which we can only propose to take out an insurance contract of the HIC.

6. You are already covered by an insurance:

	Name of the insurer*	Name of the product*
☐ Hospitalisation		
☐ Ambulatory care		
☐ Dental care		

* optional

7. If the policy holder or one of the insured person(s) has a different cover, please specify hereunder:

☐ Hospitalisation
☐ Ambulatory care
☐ Dental care

Points of concern:

If you have a hospitalisation insurance from another insurer but suffer now from a new pre-existing disease; on basis of the medical questionnaire, the fee and room supplements during a hospitalisation in a private room can be excluded from the reimbursement.

You know that a delivery will only be reimbursed after 9 months of affiliation to our hospital products. There is a reimbursement after 6 months, except for the room and fee supplements in a private room.

You ask an insurance for one or more product(s):

8 A. THE HOSPITALISATION

☐ You are already covered by a group hospitalisation insurance (employer), you would like to choose a continuous coverage and thus procure yourself a certain warranty if your current insurance would stop (e.g. in the event of resignation, change of employment or retirement). Upon termination of your group insurance, you can affiliate to Hospitalia, Hospitalia Medium or Hospitalia Plus without any new waiting period, medical questionnaire or extra premium. Furthermore, you would like to benefit from an intervention of maximum € 50 per day as a complement of your group insurance. **(if checked, go to box 8B)**

Correspond to Hospitalia Continuity

In case of hospitalisation, you prefer to stay in this room type:

☐ private room — **Correspond to Hospitalia Plus / Hospitalia Medium**

☐ twin or ward room — **Correspond to Hospitalia**

For the reimbursement of fee supplements during a hospitalisation, you give preference to the following reimbursement percentag. **(Please answer this question only if you have chosen the room type 'private room')**:

☐ 200% of the conventional rate — **Correspond to Hospitalia Medium**

☐ 300% of the conventional rate — **Correspond to Hospitalia Plus**

For the care provided before or after your hospitalisation, you want a guarantee reimbursing. **Please answer this question only if you have chosen the room type 'twin or ward room'**:

☐ 30 days before and 90 days after — **Correspond to Hospitalia**

☐ 60 days before and 180 days after — **Correspond to Hospitalia Medium**

For the costs due to a serious illness, you prefer: **(please answer this question regardless of the type of room you choose)** :

☐ not being insured to the warranty serious illness

☐ being insured to the warranty serious illness

8 B. THE DENTAL CARE

☐ In addition to the interventions of the compulsory insurance, you would like to get:
a reimbursement of up to 100 % of the amount that remains at your expense for preventive dental care; a reimbursement of up to 80 % of the amount at your expense for curative dental care, prostheses, implants and periodontology; and a reimbursement of up to 60 % of the amount at your expense for orthodontic treatment.

Correspond to Dentalia Plus

8 C. AMBULATORY CARE (medical care without hospitalisation or one day hospitalisation)

☐ You wish, in addition to the statutory allowance:
The refund of 50% of your patient's share for medical consultations, visits and technical dispensations of doctors, the refund of 50% of your medication and intervention in the purchase of your material (dentures, eye care, hearing aids).

Correspond to Hospitalia Ambulatory

9. Other requirements or specific needs:

You certify the accuracy of the information provided through this form and declare that you have accurately specified your needs and requirements.

D. CONTACT WITH ADVICE FOLLOWED OR NOT FOLLOWED

You had a contact with a counsellor of the health insurance fund during which you have read through this questionnaire. This box will be completed according to whether you choose to follow the proposed product(s) or not.
If you have not had any contact with a counsellor of the health insurance fund, go directly to box E.

TO BE FILLED IN BY THE CUSTOMER ADVISOR

Name and first name of the advisor:

On the basis of the needs and requirements analysis above, we recommend you the following insurance product(s) of the health insurance company 'MLOZ Insurance' for the policy holder and the insured person(s):

☐ Hospitalia Plus ☐ Hospitalia Medium ☐ Hospitalia
☐ Warranty serious illnesses*

* affiliation only possible if you are affiliated to Hospitalia, Hospitalia Medium or Hospitalia Plus

☐ Hospitalia Continuity ☐ Hospitalia Ambulatory ☐ Dentalia Plus

This table must be filled in if there are different proposals for one or more insured person(s):

	Name and first name of all insured person(s) (*)	Chosen product(s)
Policy holder A		
Insured person B		
Insured person C		
Insured person D		
Insured person E		
Insured person F		

Motivation of the adviser of the health insurance fund related to the advised product(s) (this field must be filled in):

TO BE FILLED IN BY THE POLICY HOLDERS: TICK YOUR CHOICE

10. ☐ I, the policy holder, **take the above advice** and wish to get an insurance for the advised insurance product(s). I acknowledge that the content of the insurance policy I chose matches my requirements and needs and that I have been expressly informed about the scope and the limits of this (these) insurance product(s). The customer advisor has read through with me the general terms and conditions and the information sheet(s) of the chosen insurance product(s) on paper or on the Internet. I have received a copy with all the necessary additional information. I have been informed of the website address.

11. ☐ I, the policy holder, d**o not take the above advice**. I the policy holder and insured person(s), wish to affiliate to the following insurance product(s):

☐ Hospitalia Plus ☐ Hospitalia Medium ☐ Hospitalia
☐ Warranty serious illnesses*

* affiliation only possible if you are affiliated to Hospitalia, Hospitalia Medium or Hospitalia Plus

☐ Hospitalia Continuity ☐ Hospitalia Ambulatory ☐ Dentalia Plus

I acknowledge that the content of the insurance policy I chose matches my requirements and needs and that I have been expressly informed about the scope and the limits of this (these) insurance product(s). The customer advisor has read through with me the general terms and conditions and the information sheet(s) of the chosen insurance product(s) on paper or on the Internet. I have received a copy with all the needed additional information and I have been informed of the website address where I can find this information.

If you have not followed the advice you have been given, please indicate the reason.

E. AFFILIATION WITHOUT CONTACT

Fill in this box if you had no contact with a customer advisor: Tick your choice

12. ☐ I, the policy holder **completed the needs analysis by myself. I did not have any contact with a customer advisor** and have therefore not received any advice.
I expressly acknowledge that I have read the general terms and conditions and the information sheet(s) of the chosen insurance product(s) on paper or on the Internet, the scope and limitations of the chosen insurance product(s) which correspond(s) to my needs and requirements.

I the policy holder and insured person(s), wish to affiliate to the following insurance product(s):

☐ Hospitalia Plus ☐ Hospitalia Medium ☐ Hospitalia
☐ Hospitalia Warranty serious illnesses*

* affiliation only possible if you are affiliated to Hospitalia, Hospitalia Medium or Hospitalia Plus

☐ Hospitalia Continuity ☐ Hospitalia Ambulatory ☐ Dentalia Plus

13. **This table must be filled in if there are different proposals for one or more insured person(s):**

	Name and first name of all insured person(s) (*)	Chosen product(s)
Policy holder A		
Insured person B		
Insured person C		
Insured person D		
Insured person E		
Insured person F		

14. Done in ..... On .....

Policy holder(*)	**Signature**

Signature of the customer advisor	

* Must be completed

By signing this request, I declare that I have read the information concerning the protection of privacy on page 5 of the document. I promise to respect the statutes of the HIC. ***Any intentional omission or intentional inaccuracy will lead to the nullity of the affiliation.*** *For each person willing to affiliate to the Hospitalia products: I attach to this document, in individual sealed envelopes, a medical questionnaire for the medical counsellor. I agree that the SMA MLOZ Insurance may contact my health insurance company or the National Association of Independent Health Insurance Funds directly in order to optimise my reimbursements on the basis of the data they have received in the context of the compulsory and complementary insurance.*

"MLOZ Insurance" health insurance company approved under code OCM/750/01 for branches 2 and 18, by the Control Office of health insurance funds and national associations. Head office: route de Lennik 788A, 1070 Brussels - Belgium (RPM Brussels) - Enterprise number: 422.189.629.

HOW TO TICK THE BOXES ON THE FRONT OF THIS AFFILIATION REQUEST OR REQUEST TO CHANGE A PRODUCT?

To join and remain a member of the HIC (health insurance company) "MLOZ Insurance", the policy holder has to be affiliated to the complementary services under one of the four following sections: Partenamut (509) – Freie Krankenkasse (515) – Helan Onafhankelijk ziekenfonds (526), all members of the National Association of independent health insurance funds.

You choose:

- the hospitalisation cover, either Hospitalia, or Hospitalia Medium or Hospitalia Plus, the warranty serious illnesses or Hospitalia Continuity.
- the ambulatory cover, Hospitalia Ambulatory.
- the dental care cover, Dentalia Plus.

For any new affiliation or change of product, a customer advisor is at your disposal and will help you choose the right solution for your situation. Fill in and enclose a medical questionnaire for an affiliation to and the Warranty Serious Illnesses.

BEWARE: No medical questionnaire needs to be completed for an affiliation to Dentalia Plus as well as for a transfer from Hospitalia Medium to Hospitalia, and from Hospitalia Plus to Hospitalia Medium, Hospitalia or Hospitalia Continuity.

The languages of communication with our HIC are French, Dutch, English and German.

ENTITLEMENT TO REIMBURSEMENTS

To benefit from our reimbursements, a 6-month waiting period starting at the affiliation date has to be accomplished. There is a waiting period of 12 months for Dentalia Plus for the reimbursement of prostheses, implants and orthodontic dispensations. There is no waiting period in case of accident, with the agreement of the medical counsellor of the HIC.

There is no waiting period for the newborn if the waiting period of the parents ends before the birth (+ exceptions). For an affiliation to a product of the HIC, after a similar insurance, the waiting period can be cancelled according to the conditions mentioned in the statutes. No reimbursement is granted for a hospitalisation beginning during the waiting period.

In case of pre-existing disease, disorder or state (such as pregnancy) existing at the affiliation date and leading to a hospitalisation, the compensation is limited (on condition that the general waiting period is achieved): exclusion of the room and fee supplements if the insured person chooses to stay in a private room for Hospitalia, Hospitalia Medium and Hospitalia Plus, and for Hospitalia Ambulatory, there will be no reimbursement of the ambulatory costs of the dispensations, medicine and prostheses which are directly related to this pre-existing disorder, disease or state.

In case of delivery during the first 9 months of affiliation to the product, the delivery can be considered as the result of a pre-existing state. In this case, the hospitalisation costs are covered, with the exclusion of room and fee supplements charged if the insured person chooses to stay in a private room, on condition that the general waiting period is achieved. However, that limitation does not apply if the delivery takes place after 9 months of cumulated membership to a similar HIC-insurance and to the insurance Hospitalia.

PAYMENT TERMS FOR THE PREMIUMS

The premium can be paid by quarter, semester or year. The possibility of a monthly payment is subject to a direct debit. It must be paid in advance, which means it must be received before the first day of the first month of the quarter, semester or year, or, in case of direct debit, within the first 10 days of the month, quarter, semester or year.

The policy holder who did not pay his premium before the first day of the quarter, receives a formal notification by registered letter demanding payment of the premium within 15 days as from the day after the delivery of the registered letter at the post office. This formal notification informs him of the suspension of the guarantee in case of non-payment within the stated term. It starts a 45-day term at the end of which the membership will be cancelled automatically.

This affiliation request is a policy proposal which does not bind the candidate policy holder or the HIC to conclude the insurance policy. The signature of this document does not mean that the cover takes effect.

Within thirty days from the reception of the proposal you have filled in, the HIC will have informed you by letter:

- *either of the acceptance via the acceptance letter (therefore the insurance policy starts the first day of the month following the month during which the HIC received the "affiliation request" and the "medical questionnaire") with or without limitations for pre-existing disease, disorder or state;*
- *or of the wish, on the HIC medical counsellor's initiative, to get additional information on the basis of the medical questionnaire.*

When further information is requested, you have forty-five days to provide an answer. If this term is respected, with or without limitations for pre-existing disease, disorder or state, the insurance policy starts the first day of the month following the month during which the HIC received the "affiliation request" and the "medical questionnaire".

If this term is not respected, the insurance policy still starts the first day of the month following the month during which the HIC received the "affiliation request" and the "medical questionnaire" with a limitation of intervention for the pre-existing disease, disorder or state mentioned on the medical questionnaire.

In accordance with the European Regulation of 27 April 2016 on Data Protection (GDPR), your data will be processed by the HIC MLOZ Insurance, acting as data controller for the management of your health insurance contracts. Our privacy policy is available on request by mail (MLOZ - DPO, route de Lennik 788A at 1070 Brussels) or through the following link: https://www.mloz.be/fr/privacyMLOZInsurance.