Dentalia Up

PRODUCT TRANSFER REQUEST

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

A. CONTACT DETAILS OF THE POLICYHOLDER (one application per owner)

☐ I have already taken out a dental product (Dentalia Plus) with SMA MLOZ Insurance. My contact details have remained the same. You can use them for this new membership. I enclose an identification sticker.

1. Name

First name

Phone number 0

E-mail address

National registry number

or
Affix an identification sticker of your health insurance fund.

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

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

3. **FINANCIAL ACCOUNT FOR REFUNDS**

IBAN

BIC

Payment of premiums by ☐ direct debit ☐ bank transfer

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

4. **PAYER** (to be completed if different from the policyholder)

Name, First name

Adress N° Box

Zip code City

B. POLICY HOLDER AND INSURED PERSON(S)

☐ I am aware that the transfer from Dentalia Plus to Dentalia Up is a family transfer. All persons previously insured by Dentalia Plus are therefore transferred at the same time.

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

For insurance with the mutual insurance company 'MLOZ Insurance'.

This analysis must always be carried out prior to affiliation.

You ask to be insured for a product:

5. **DENTAL CARE «DENTALIA UP»**

☐ You wish, in addition to the legally provided interventions :

- a dental care cover up to € 4.000 in case of accident and reimbursement up to € 4.000 for dental care in case of cancer ;
- increasingly high reimbursements according to the years of affiliation to the product ;
- for preventive dental care: reimbursement of up to 100 % of the amount that remains at your expense and no waiting period ;
- for curative dental care, prostheses, implants and periodontology: reimbursements of up to 80 % of the amount charged ;
- for your orthodontic costs: reimbursement of up to 60 % of the amount charged for which there has been an intervention of the compulsory insurance ;
- for preventive and curative dental care, reimbursement of supplements limited to 200 %.

6. Other specific requirements or 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

You had a contact with a advisor 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 COMPLETED BY THE CUSTOMER ADVISOR

Full 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):

☐ Dentalia Up

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

TO BE COMPLETED BY THE POLICYHOLDER. TICK YOUR CHOICE

7. ☐ 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). I have read the statutes, the general terms, the precontractual information sheet 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.

E. AFFILIATION WITHOUT CONTACT

Complete this box if you have had no contact with a customer advisor:
Tick your choice

8. ☐ 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 statutes, 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 «policyholder» and the insured person(s) wish to affiliate the following insurance product:

☐ Dentalia Up

☐ I agree that SMA MLOZ Insurance may contact my mutual insurance company or the Union Nationale des Mutualités Libres directly with a view to optimising my reimbursements on the basis of the data they have received in the context of compulsory and complementary insurance.

9. Done at ..... the .....

Policyholder(*)	**Signature**

Signature of customer advisor	

* must be completed

By signing this application, I declare that I have read the privacy information. Any intentional omission or inaccuracy will result in the nullity of the membership.

In accordance with the European Data Protection Regulation of 27 April 2016 (RGPD), your data will be processed by SMA MLOZ Insurance, acting as data controller and by your mutual insurance company, as agent and subcontractor of the latter, for the management of your insurance contracts. Our privacy policy ('Disclaimer') is available via the following link: https://www.mloz.be/fr/privacyMLOZInsurance <https://www.mloz.be/fr/privacyMLOZInsurance> or on request by mail (MLOZ - DPO - Route de Lennik 788A, 1070 Brussels).

Mutual insurance company «MLOZ Insurance» approved under the code number OCM 750/01 for branches 2 and 18, by the Office de Contrôle des mutualités et des unions nationales de mutualités. Registered office: route de Lennik 788A - 1070 Brussels - Belgium - (RPM Brussels) - Company number: 422.189.629.