Henner™

JOH Insurances

IEI LIFE INSURANCE

Application Form

INDIVIDUALS

Tips on how to fill out this application form

Completing insurance applications is no fun job so in order to speed up the process and prevent mistakes we have gathered all potential issues in the application form and wrote them down below to help you to complete this form correctly at once.

PART 1 Application form

YOUR DETAILS

1. Residential address: if you have no fixed address (yet) please leave blank and only fill in the country you will be living in / moving to.
2. Mailing address: Henner will not send info by ordinary post.

PAYMENT

1. Fill out how you would like to pay (SEPA withdraw, or bank transfer) If you choose SEPA withdraw, don't forget to fill out the SEPA mandate form which is added to this applicationform!

EFFECTIVE DATE OF COVERAGE

1. Please choose a date in the future. The actual startdate of the insurance is the date you will be accepted by Henner for the insurance, or your requested date of coverage, whichever is later.

CHOOSE YOUR AMOUNT INSURED FOR LIFE COVER

1. Life: Minimum amount: €100.000. Maximum amount: €500.000.

YOUR DECLARATION

1. Please read the text
2. Place the date of signing this declaration
3. Place your signature
4. Add the place you are when signing this declaration (city + country)
5. **ADD THE WORDS 'READ AND AGREED' IN HANDWRITING. (IMPORTANT!)**

HOW TO APPLY?

1. Please send us the application form by email (contact@johoinsurances.org) and do not send it by ordinary mail. Email is allowed, is much quicker and we can follow up more easy with you and the insurer.
2. Always add a copy of your passport.

Your details

Last name _____

First name _____

Date of birth ___ / ___ / ____ (dd/mm/yyyy) Nationality _____ Gender (M/F) ____

Residential address[1] _____

City _____ Country _____ Postcode _____

Mailing address [2] _____

City _____ Country _____ Postcode _____

Phone number _____ Mobile _____ Email[3] _____

Occupation _____

Payment

How would you like to pay your premium?

☐ Annually ☐ Semi-annually ☐ Quarterly

Select your method of payment:

☐ SEPA automatic withdrawal *(For EURO policies only)*

☐ Bank Transfer *(account details for transfer will be provided with your invoice)*

Effective date of coverage

When would you like your cover to start?

_____ / _____ / _____
dd mm yyyy

Your membership and that of your dependants are effective on the date indicated on your Certificate of Enrolment, and at the earliest on the day after we receive the Application Form and Health Declaration Form duly filled and signed, along with all requested additional information, subject to approval by HENNER - SAS Medical Advisory Board and payment of first premium.

▶Your Area of Coverage

☒ Worldwide excluding USA

You will be covered worldwide excluding USA. In the USA you are covered only for a duration of up to 90 days per insurance year during trips and holidays.

▶Choose your Currency

☐ Euro ☐ US Dollar

▶Choose your Amount insured for the Life cover

☐ Life Cover

☐ Policy holder

Insured amount(1)

(1) The minimum sum insured shall be 100,000 EUR/130,000 USD and can be increased up to a maximum sum insured of 500,000 EUR/625,000 USD. Premiums and benefits (insured amount) are calculated on the basis of the sum insured.

Your declaration

I, the undersigned, certify that the information filled in the present Application Form, as well as in the Health Declaration Form, is correct and sincere, and certify not having declared or withheld any information which might falsify the risk assessment. I understand and have taken note that any false declaration or non-disclosure will void coverage under this policy and in this case the insurer would retain paid premiums as civil damages and I and my dependants will be obliged to reimburse perceived benefits.

I acknowledge that I have read and understood the guarantees described in the General Conditions of the International Expat Insurance Package policy provided with this Application Form.

I have duly noted that my enrolment under the International Expat Insurance Package policy shall be effective subject to:

- Approval by the HENNER - SAS Medical Advisory Board of the enclosed health declaration duly filled out by myself and all my dependants who have reached majority
- Payment of premium

In the event of my death, I appoint as beneficiary my surviving spouse unless legally separated; otherwise in equal shares my children born or to be born, the share of a deceased child going to his/her own children or to his/her brothers and sisters if he/she has no children; otherwise in equal shares my surviving parents; or in their absence, my heirs.

I further note that should I wish to change beneficiaries at any time, I shall write formally to HENNER - SAS with details of the requested changes and clearly identify any new beneficiaries.

Signature: ..... Signed on date (dd/mm/yyyy).....

Signed in which city ..... Signed in which country .....

Write 'read and agreed' on the dotted lines .....

How to apply?

To apply for cover, please complete this Application Form as well as the Health Declaration Form. These forms should then be sent directly to your insurance broker (by email or by post) at the following address:

JOHO Insurances
Paviljoensgracht 18
2512 BP The Hague (Den Haag)
THE NETHERLANDS
Email: **info@johoinsurances.org**

When submitting, remember also to include:

- A copy of your ID or passport

If your Application is accepted you will be sent a Premium Invoice and your Policy will not be in force until that premium is paid. Please make sure to answer all questions and to sign the forms.

We look forward to being of service.

Insurance contract n°:
LIFE & DISABILITY - 080719/001 (1st USD) 080719/002 (1st EURO)

SEPA Direct Debit Mandate

By signing this mandate, you authorize Henner to send instructions to your bank to debit your account in accordance with the instructions from Henner.
As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks, starting from the date on which your account was debited.

CREDITOR:

Henner GMC
14 boulevard du Général Leclerc,
CS 20058, 92527 Neuilly-sur-Seine Cedex
France

Creditor identifier
FR56ZZZ414162

DEBTOR: (Please complete the following fields in capital letters)

Last & First Name:……

Address:……
……

ZIP Code: …… City: …… Country: ……

Account number to debit (Please enclose bank details):

IBAN : |_|_|_|_| |_|_|_|_| |_|_|_|_| |_|_|_|_| |_|_|

THIRD PARTY- DEBTOR (If different from DEBTOR):

If you are paying someone else's bill, please indicate your first and last name.
If you are paying for yourself, do not complete.

Last & First Name: ……

Type of payment: Recurrent

Place : ……Date : …./…../…….

Payer's Signature:

To return to:

Henner
14 boulevard du Général Leclerc,
CS 20058, 92527 Neuilly-sur-Seine Cedex
France

H7854 – 03/2017

Your rights concerning the present debit mandate are explained in a document which you can obtain from your bank.

Tips on how to fill out this application form

PART 2 YOUR HEALTH DECLARATION FORM

The health declaration needs to be filled out by yourself completely.

"Signing of the health declaration (last page of the document)"

1. **Please elaborate on all questions you have answered 'yes' to.**
2. **Place the date of signing this declaration on the bottom of the page**
3. **Place your signature**
4. **Add the place you are when signing this declaration (city + country)**
5. **ADD THE WORDS 'READ AND APPROVED' IN HANDWRITING. (IMPORTANT!)**

Important explanation from JoHo Insurances for the health declaration

Where do you send the health declaration?

There is specific legislation for processing medical information via health declarations. This legislation is also applicable to the health declaration in this document. We (JoHo Insurances) would like to point out some specific points relating to providing the health declaration to the insurance company.

OPTION 1 – Sending the health declaration directly to the insurance company.

Because of privacy legislation there is no need for us (JoHo Insurances) to have insight in the health declaration completed by you. You can send the health declaration directly to Henner (insurance company), via regular mail or email (medical@henner.com). If you prefer to send the health declaration directly to the insurance company, you can also work with a 'separated' health declaration. You can request this version from us via email (info@johoinsurances.org). You can also 'snip' this health declaration from this document. There are several programs online which allow you to split pdf documents. Could you please inform us by email of the date you have sent the health declaration to the health insurance company? This enables us to monitor the application process.

OPTION 2 – Sending the health declaration to JoHo Insurances

Because of speed, review and proper monitoring you can also send the entire application (application + health declaration + copy ID/passport) by email to us (info@johoinsurances.org). We will review the documents for completeness and make sure that these documents will be provided to the correct department of the insurance company. This is the only action we perform with your health declaration. Of course we do not use the declaration for other purposes.

In order to review your health declaration for completeness and to send it to the insurance company, the privacy legislation requires us to ask for your approval for these actions. By signing this document you provide us with this approval.

Thank you in advance!

By signing this document, I authorize JoHo Insurances to receive, review and forward the health declaration completed by me, to the insurance company for the (medical) acceptance of my insurance application.

Date:

Place:

Signature:

IEI LIFE INSURANCE
YOUR HEALTH DECLARATION FORM

Please complete this health declaration for yourself

KINDLY COMPLETE, DATE AND SIGN YOUR HEALTH DECLARATION

		Main Insured
1	**Family name**	
2	**First name**	
3	**Date of birth** (DD/MMM/YYYY)	
4	**Height** ☐ Cm ☐ Inches	
5	**Weight** ☐ Kg ☐ lbs	
6	**Gender**	☐ M ☐ F
7	Have you smoked over the past seven years ? *If yes, kindly indicate the average number of cigarettes smoked per day and when you ceased smoking if relevant*	☐ Yes ☐ No
8	**Over the past 10 years, have you undergone :**	
a.	A surgery ?	☐ Yes ☐ No
b.	A laser treatment, chemotherapy, radiation therapy?	☐ Yes ☐ No
9	**Over the past 5 years, have you been afflicted by an illness or been the victim of a self motivated accident :**	
a.	Have taken sick leave for over 3 consecutive weeks ?	☐ Yes ☐ No
b.	Undergone medical treatment for over a month	☐ Yes ☐ No
10	**Have you suffered from or ever been diagnosed with :**	
a.	Nervous disorders (for example: chronic fatigue, anxiety, depression, migraine, epilepsy)	☐ Yes ☐ No
b.	Spinal chord disorders (for example: lower back pain, sciatica, herniated disc, stiff neck…)	☐ Yes ☐ No
c.	Arthritis and / or rheumatism (for example: hip, knee, shoulder, hands…)	☐ Yes ☐ No
d.	Heart disease and / or vascular disorders (for example: hypertension, angina / chest pain, heart attack, heart rhythm abnormalities, aneurysm…)	☐ Yes ☐ No
e.	Diseases of the esophagus, stomach, intestines, liver, pancreas (for example: stomach ulcers, Crohn's disease, ulcerative colitis…)	☐ Yes ☐ No
f.	Urinary problems (for example: renal colic, testicular or prostate disorders , bladder or kidney problems, polyp..)	☐ Yes ☐ No
g.	A trauma, disease or illness requiring regular medical care and / or regular medical treatment in the future.	☐ Yes ☐ No
h.	Any other trauma, accident, complaint, disease or illness (not mentioned in the above categories)	☐ Yes ☐ No
11	**Have you ever performed a serological screening test as follows:** ***If yes, kindly specify the result in the table on page 3***	
a.	Hepatitis B virus(HBV) ?	☐ Yes ☐ No
b.	Hepatitis C (HCV) ?	☐ Yes ☐ No
c.	HIV (AIDS) ?	☐ Yes ☐ No
12	**Have you ever had addiction problems related to alcohol and / or drugs?**	☐ Yes ☐ No

13	**Within the next 12 months following the effective date of your contract, do you think you may :**	
a.	Go to see a doctor or require any medical test (for example. laboratory, imaging, endoscopy…) and / or see a specialist and / or seek medical or surgical treatment?	☐ Yes ☐ No
b.	Receive hospital treatment? (for example: removal of tonsils, removal of a cyst, removal of a mole…)	☐ Yes ☐ No
14	Do you suffer from a handicap, disability or chronic illness?	☐ Yes ☐ No
15	In the 12 months preceding the effective date of your contract, have you taken more than 3 days sick leave?	☐ Yes ☐ No
16	Do you or anyone in your family have a history of the following diseases? Heart disease, vascular, neurological, psychiatric, cancer, diabetes?	☐ Yes ☐ No
17	Are you currently on sick leave ?	☐ Yes ☐ No
18	Are you entitled to a disability pension ?	☐ Yes ☐ No
	Are you going to be declared disabled ?	☐ Yes ☐ No
19	Are you currently the beneficiary of anyone's insurance?	☐ Yes ☐ No
	Have you ever been refused, restricted or received a premium loading for a previous health insurance policy?	☐ Yes ☐ No
20	Do you pilot or fly as a passenger in a private or aviation club aircraft (excluding regular commercial aircrafts)?	☐ Yes ☐ No
21	Have you suffered any condition other than those mentioned above?	☐ Yes ☐ No
22	Please add any other information regarding your health status that we should know.	

IEI LIFE INSURANCE
HEALTH DECLARATION

If you answered "yes" to any of the above questions, kindly clarify the details in the table below:

	Question number	Date of declaration of the first symptoms	Date of the last symptoms	Treatments, tests and results	Complementary precisions
Main insured					

To ensure medical confidentiality, you must submit this questionnaire and any medical documents sealed and marked confidential. These documents should be provided to Joho Insurances who will address them to the medical board of HENNER. **Please provide your answer on a separate piece of paper and attach it to this Declaration when sending if you need more space to provide your response.**

I certify that the statements above are complete, accurate and truthful and agree to provide the medical board of HENNER all the medical information that they need. Any misrepresentation or omission shall render the policy null and void and the premiums paid will be retained by the insurer as damages. The Insured and his dependants will have to refund the benefits they have received.

Please complete and sign the next page.

IEI LIFE INSURANCE
HEALTH DECLARATION

To be completed by the main insured:

Emailaddress: .....
(this is necessary for our medical board to contact you in regards to this health declaration)

Signature: ..... Signed on date (dd/mm/yyyy).....

Signed in which city ..... Signed in which country .....

Write 'read and approved' on the dotted lines .....

Step by step guide on how to fill out the beneficiary form correctly

General remark

The form can be filled out online using a pdf program, however signing the doc digitally at the bottom (so without printing / scanning) can be challenging. If you do not manage to sign digitally then we ask you to fill out the docs digitally, print, sign the doc manually and scan / photograph the doc and email it back to us. We do not offer further assistance by phone or email on 'how to sign digitally'.

Member company

This part is already filled out for you, except for "Policy No".

At "Policy No" you need to fill out the following:

If you pay your insurancepremium in Euro fill out: **080719/002** or

If you pay your insurancepremium in Dollar fill out: **080719/001**

Insured person

At "Social Security No" – you can leave that blank.

At "Marital status":

1. The definition of 'marital life assured' is that you live together, you have signed a document which stipulates that, but you are not officially married.

2. "PACS" is a typical French form of living together. If this applies to you then you know what it means.

Choose the formula

Choose which formula applies on your beneficiaries (1 or 2) and fill out the info requested if you choose formula 2 using the recommendations on page 3 of this document.

Signature of the insured

As mentioned above, please sign the doc manually (print / sign / scan) if you do not manage to get the doc signed digitally.

Allianz Care

Designation of Beneficiary(ies) in Case of Death

Member company

Member company: HENNER SAS

Company address: 14 BD DU GENERAL LECLERC

92200 NEUILLY-SUR-SEINE FRANCE

SIRET No. 32337773900301 Policy No.

Insured person

I, undersigned

Name

First name

Maiden name

Gender: Male ☐ Female ☐

Social Security No.

Marital status : Single ☐ Married ☐ Widow(er) ☐ Divorced ☐ Marital life assured ☐ PACS ☐

Address of insured

Res., Bldg., Entry. Postal Code

City

declare cancelling all previous beneficiary designations and tick the desired formula:

☐ **1st formula :** I opt for the following designation type:

In case of death, the lump sum will be allocated in the order of preference

- to the Insured's spouse, not legally separated or divorced from the Insured, Civil Union Partner (PACs or foreign equivalent), Common Law/Life partner in cohabitation as declared to the Policyholder,
- otherwise, to the born and unborn children of the insured, equally among them, the share of the pre-deceased reverting to his/her own children or to his siblings if he/she has no children
- otherwise, to the father and mother equally between them, the share of the pre-deceased reverting to the survivor
- otherwise, to the heirs.

or

☐ **the 2nd formula :** I do not opt for the 1st formula and name as beneficiary(ies) :

By opting for the 2nd formula, the Insured may provide several successive beneficiaries based on the standard clause and if he/she wishes for an exact breakdown between each beneficiary, he/she should indicate the share of each and terminate the nomination by stating: "otherwise, to my heirs." (See Reverse) **If neither option is chosen, the 1st formula will be applied.**

The Insured may modify the designation at anytime and assign the benefit of the insurance to one or more natural or legal person(s) of his/her choice after his/her admission to the insurance.

Signature of the insured

☐ Read and approved.

Place

Date D D / M M / Y Y Y Y

Recommendations for filling in the Designation of Beneficiaries Form

Important

End the beneficiary nomination in case of death by "otherwise, to my heirs." Whomever the chosen beneficiary, avoid designating him/her only using last name, title and relation (e.g. Mr. X, my spouse); Please indicate his/her full name.

Nomination of a spouse

It is best not to simply indicate "my spouse." Write in the following form: "my non-separated spouse" and please indicate his/her full name. Thus, in case of remarriage, the lump sum will be paid to the current spouse and in case of divorce or legal separation; the lump sum will revert to the beneficiary of the second rank.

Nomination of Civil Partner/Cohabitation/PAC or local equivalent

Please indicate "my partner" or "partner under a PACS/(specify local equivalent)". The person who can prove his/her status of partner at the time of death of the insured shall claim the benefit of capital. The partner must prove his/her status by producing a cohabitation certificate, proof of common address, or issued by an official regulatory body. The partner must submit the PACS or local equivalent legal agreement that has been recogised accepted by a Court of law.

Nomination of children

If you designate your children by using his/her name, this will exclude the unborn. As appropriate, prefer the following formula: "my children born or unborn, living or represented, equally among them," the share of the pre-deceased reverting to his own children or siblings if there are no children. Please indicate his/her full name(s).

Nomination of parents

As appropriate, you can use the following formula: "My father and mother equally between them, the share of the pre-deceased reverting to the survivor," or if you want to nominate one of your parents, "my father, otherwise my mother" (or vice versa). Please indicate his/her full name(s).

Other nominations

If you nominate multiple beneficiaries, it is important to specify the degree of each of them and his/her full name(s).
Case 1: You wish the capital to be paid in full to the first nominated person and if the latter has died, to the survivor.
Write as follows: "Mr X ..., otherwise Mrs Y ...".
Case 2 : You wish that the lump sum should be distributed equally between the different beneficiaries.
Write as follows: "Mr X ... Mrs Y ... and Mr Z ... equally among them." In case of death of one of them, his share will revert to his survivor.
Case 3 : You wish that that the lump sum should unevenly distributed between different beneficiaries, within the limit of 100% of the capital. Write as follows:
"30% to Mr X ... 50% ... to Mrs Y and 20% to Mr Z ..."
It is also useful to provide - if the beneficiary you have named is pre-deceased - the fate of his share.

Conditions of Designation

You may modify the designation order of the standard clause (1st formula) at any time and designate any natural or legal person(s) of your choice by private or notarial deed. You must inform us in writing of the designation of the beneficiary (ies). Any modifications to the designation of beneficiaries must be equally notified to the Insurer, in the same manner, the beneficiary clause may also be modified when it is no longer appropriate. Once the beneficiary (ies) has been designated by name, you must provide their full contact details: name, maiden name, first name, date and place of birth, address. In the event of death, this he information used is necessary to be used by AWP Health & Life S.A. to facilitate the search for the beneficiary.

Conditions of Acceptance

The designation of a beneficiary becomes irrevocable with the beneficiary's acceptance subject to the conditions as stipulated in Article L.132-9 of the French Insurance Code. The acceptance shall be by private or official notarial declaration signed by the Insured and the beneficiary. The Insurer must be notified of the acceptance in order to take effect. If the self-designation becomes void, the aforementioned order of designation is applicable.

Notwithstanding the above and regardless of any other designation, when the lump sum amount is calculated taking into account dependents, the corresponding increases in lump sum should only benefit the persons taken into account when calculating these increases. If the beneficiary designated by the Insured Person or pursuant to the aforementioned standard clause is effectively responsible for the persons taken into consideration when calculating the increases, the Insurer shall allocate them to the designated person. If the designated beneficiary is not legally responsible for those persons, the Insurer shall allocate the increases among the dependents in equal shares. The share of the lump sum corresponding to those increases is equal to the difference between the lump sum due according to the situation and the legal dependents of the Insured and the lump sum the Insurer would have had to pay if the Insured had been single without dependents. The Insurer shall then pay the remainder to the beneficiary designated by the Insured. In the case of death of the Insured and of one or several designated beneficiaries during a single event without the possibility to determine the order of deaths, the Insured is presumed to have survived for the purposes of determining the beneficiaries of the lump sum.