Membership Application (with Health Questionnaire)

Adeslas

Group name ______________________________

Application number ☐☐☐☐☐☐☐☐☐

☐ Incorporation ☐ Cancellation ☐ Modification

Policy number ☐☐☐☐☐☐☐☐☐☐ ☐☐

Certificate number ☐☐☐☐☐☐☐☐☐

Delegation ☐☐☐ Effective date ☐☐ ☐☐ ☐☐☐☐ Remittance of documentation ☐ Customer ☐ KAM ☐ Company

Mediator Code 1 ______________________ Mediator Code 2 ______________________

Holder Data

Surname and First Name ______________________ NIF/NIE ______________

Address: Type of Roadway ________ Street name ______________________ Street number _____ Floor _____

Post Code ____________ Town or City ______________________

Date of birth ______________ Marital Status __________ Gender ☐ Male ☐ Female Employee Number ______________

Telephone no. ______________ Mobile phone ______________ E-mail address ______________

Would the holder wish to be insured by the policy? ☐ Yes ☐ No Are you requesting exemption from the claims waiting period? ☐ Yes ☐ No

Do you have any other policy with SegurCaixa Adeslas? No. of Policy ______________

Form of payment ☐ Monthly ☐ Quarterly ☐ Annually ☐ Bi-monthly ☐ Six- monthly

IBAN ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐ ☐☐☐☐☐☐☐☐☐☐

Product ______________________ Additional complements ______________________

Insured Data

Number of Insured ☐☐

1) Surname and First Name ______________________ NIF/NIE ______________

Address ______________________ Post Code ____________ Town or City ______________

Date of birth ______________ Gender ☐ Male ☐ Female Relationship ______________

Telephone no ______________ Mobile phone ______________ E-mail address ______________

Do you have any other policy with SegurCaixa Adeslas? No. of Policy ______________ Are you requesting exemption from the claims waiting period? ☐ Yes ☐ No

Product ______________________ Additional complements ______________________

2) Surname and First Name ______________________ NIF/NIE ______________

Address ______________________ Post Code ____________ Town or City ______________

Date of birth ______________ Gender ☐ Male ☐ Female Relationship ______________

Telephone no ______________ Mobile phone ______________ E-mail address ______________

Do you have any other policy with SegurCaixa Adeslas? No. of Policy ______________ Are you requesting exemption from the claims waiting period? ☐ Yes ☐ No

Product ______________________ Additional complements ______________________

3) Surname and First Name ______________________ NIF/NIE ______________

Address ______________________ Post Code ____________ Town or City ______________

Date of birth ______________ Gender ☐ Male ☐ Female Relationship ______________

Telephone no ______________ Mobile phone ______________ E-mail address ______________

Do you have any other policy with SegurCaixa Adeslas? No. of Policy ______________ Are you requesting exemption from the claims waiting period? ☐ Yes ☐ No

Product ______________________ Additional complements ______________________

OBSERVATIONS

Application Decision: ☐ ACCEPTED ☐ REJECTED ☐ EXCLUSIONS

INFORMATION OF INTEREST TO THE CUSTOMER

In accordance with what is set out in the currently valid Law on the Regulation, Supervision and Solvency of Insurance and Reinsurance Companies, the applicant is informed that the insurance undertaking is SegurCaixa Adeslas, S.A. de Seguros y Reaseguros whose fiscal identification number is: A-28011864, and that its registered office is at: Paseo de la Castellana, 259 C (Torre de Cristal), 28046 Madrid (Spain). Registered in the Commercial Registry of Madrid, book 36733, sheet 213, page M-658265, and that the insurance contract which is being requested is subject to Spanish legislation.

1. Furthermore, the applicant is informed that, without prejudice to the possibility of resorting to legal proceedings, the policy holder, the insured party, the beneficiary, injured parties or any of their rightsholders, will be able to file complaints and/or claims against actions on the part of the insurer which he/she considers injurious or which infringe on his/her legally recognised rights or interests as set out in the insurance contract. In accordance with the legislation in force in said regard, the Insurer makes available for said purpose a Customer Service Department (CSD) which said parties may contact in order to file any complaints or claims they may wish to make, when the office or service concerned does not resolve said matter to the satisfaction of these parties. Complaints and claims may be presented at the Customer Service Department of any office of the Insurer open to the public, or sent to the address or email address established for said purpose. The contact details of this service are:Torre de Cristal, Paseo de la Castellana 259C, 28046 Madrid.

The CSD will acknowledge in writing the receipt of any complaints or claims, and will proceed to resolve these on a grounded basis within the legally stipulated maximum term of two months as from the date of presentation thereof.

2. The interested parties may likewise file a complaint or claim with the Claims Service of the Directorate General of Insurance and Pension Funds. In order to do so, they must accredit that two months have expired from the date of presentation of the complaint or claim to the CSD in which time said Customer Service Department failed to resolve the petition or refused to consider or disallowed said petition in whole or in part.

3. Notwithstanding the above actions and any other actions to which the interested parties are entitled pursuant to insurance regulations, said interested parties may take any legal action they deem suitable before the courts of ordinary jurisdiction.

BASIC INFORMATION CONCERNING PERSONAL DATA PROTECTION

DATA CONTROLLER
SegurCaixa Adeslas, S.A. de Seguros y Reaseguros.

PURPOSE
Maintenance of the contractual relationship.

So that we can contact you to inform you about products and services offered by SegurCaixa Adeslas that might be of interest to you. For this purpose, your data shall be processed to apply profiling/segmentation techniques that will make it possible for the products and services that we might offer you suit your interests and needs as closely as possible. If you do not want us to contact you for this purpose, you can indicate this by ticking the box below.

M I do not want to be contacted to be informed about products or services offered by SegurCaixa Adeslas, S.A. de Seguros y Reaseguros.

LEGITIMATION
For the management of the insurance contract: the execution of a contract.

To provide information about products or services of SegurCaixa Adeslas: the legitimate interest of the data controller.

RECIPIENTS
The data shall not be transferred to third parties, unless legally obliged.

However, if you provide your **consent** by ticking the box below, your data may be communicated to CaixaBank, S.A. and to companies of the "la Caixa" Group so that they can contact you to inform you about their products or services.

RIGHTS
To access, rectify and have data deleted, and other rights as explained in the additional information.

ADDITIONAL INFORMATION
You can find more information about the data protection policy of SegurCaixa Adeslas, including how to withdraw consent, in the General Conditions of your insurance policies and/or on the following web page:
www.segurcaixaadeslas.es/es/proteccion-de-datos

You agree that your personal data shall be communicated to CaixaBank, S.A. and to companies of the "la Caixa" Group so that they can contact you to inform you about their products or services. ☐ YES ☐ NO

Date ______________ Signature ______________

The Insurer SegurCaixa Adeslas, S.A. de Seguros y Reaseguros - Paseo de la Castellana, 259 C (Torre de Cristal), 28046 Madrid (Spain). Registered in the Commercial Registry of Madrid, book 36733, sheet 213, page M-658265. VAT No.: A28011864.

S.OS.F.60I/09 CS

Health Questionnaire

DO NOT WRITE IN THE SHADED BOXES

Adeslas

Group name ______

Application number ______ Certificate number ______ Policy number ______

	HOLDER	INSURED 1 (*)	INSURED 2 (*)	INSURED 3 (*)
HEALTH-RELATED INFORMATION	Surname and First Name Weight ______ Height ______ Gender ____ Age ______	Surname and First Name Weight ______ Height ______ Gender ____ Age ______ Relationship with the applicant ______	Surname and First Name Weight ______ Height ______ Gender ____ Age ______ Relationship with the applicant ______	Surname and First Name Weight ______ Height ______ Gender ____ Age ______ Relationship with the applicant ______

Nº	QUESTION		OBSERVATIONS		OBSERVATIONS		OBSERVATIONS		OBSERVATIONS
1	Do you suffer or have you suffered any illness in the last five years?	Yes ☐ No ☐	Please specify which, date, treatment and evolution	Yes ☐ No ☐	Please specify which, date, treatment and evolution	Yes ☐ No ☐	Please specify which, date, treatment and evolution	Yes ☐ No ☐	Please specify which, date, treatment and evolution
	Have the illnesses you have suffered until now left any lesions or sequelae?	Yes ☐ No ☐	Please specify	Yes ☐ No ☐	Please specify	Yes ☐ No ☐	Please specify	Yes ☐ No ☐	Please specify
2	Have you been operated on or admitted into hospital at any time?	Yes ☐ No ☐	Please specify date and reason	Yes ☐ No ☐	Please specify date and reason	Yes ☐ No ☐	Please specify date and reason	Yes ☐ No ☐	Please specify date and reason
3	At what date and for what reason did you visit the doctor the last time?	DATE ....../....../......	Reason Please specify speciality and next date for visit	DATE ....../....../......	Reason Please specify speciality and next date for visit	DATE ....../....../......	Reason Please specify speciality and next date for visit	DATE ....../....../......	Reason Please specify speciality and next date for visit
4	Have you suffered or do you suffer any physical defect, deformity, disability or congenital lesion?	Yes ☐ No ☐	Please specify which, date, treatment and evolution	Yes ☐ No ☐	Please specify which, date, treatment and evolution	Yes ☐ No ☐	Please specify which, date, treatment and evolution	Yes ☐ No ☐	Please specify which, date, treatment and evolution
5	Have you suffered any o traumatism or accident?	Yes ☐ No ☐	Please specify date, treatment and sequelae	Yes ☐ No ☐	Please specify date, treatment and sequelae	Yes ☐ No ☐	Please specify date, treatment and sequelae	Yes ☐ No ☐	Please specify date, treatment and sequelae
6	Are you currently under medical control or following any kind of treatment?	Yes ☐ No ☐	Please specify which	Yes ☐ No ☐	Please specify which	Yes ☐ No ☐	Please specify which	Yes ☐ No ☐	Please specify which
	From what you know about your current state of health: a) Do you know whether you will need any study or treatment within the next year?	Yes ☐ No ☐	Please specify which	Yes ☐ No ☐	Please specify which	Yes ☐ No ☐	Please specify which	Yes ☐ No ☐	Please specify which
	b) Will you need to be admitted into hospital within that time period?	Yes ☐ No ☐	Please state the reason	Yes ☐ No ☐	Please state the reason	Yes ☐ No ☐	Please state the reason	Yes ☐ No ☐	Please state the reason
7	Are you or have you been a smoker?	Yes ☐ No ☐	Please specify amount per day	Yes ☐ No ☐	Please specify amount per day	Yes ☐ No ☐	Please specify amount per day	Yes ☐ No ☐	Please specify amount per day
	Do you consume or have you consumed alcoholic drinks regularly?	Yes ☐ No ☐	Please specify amount per day and type of drinks	Yes ☐ No ☐	Please specify amount per day and type of drinks	Yes ☐ No ☐	Please specify amount per day and type of drinks	Yes ☐ No ☐	Please specify amount per day and type of drinks
	Do you consume or have you consumed narcotics?	Yes ☐ No ☐	Please specify the type of products	Yes ☐ No ☐	Please specify the type of products	Yes ☐ No ☐	Please specify the type of products	Yes ☐ No ☐	Please specify the type of products

(*) In the case of a minor or disabled person, this questionnaire will be filled in by the legal representative

Date and Signature				
OBSERVATIONS	☐ Accepted ☐ Rejected	☐ Accepted ☐ Rejected	☐ Accepted ☐ Rejected	☐ Accepted ☐ Rejected

CONFIDENCIAL • KEEP IN CLOSED ENVELOPE • CONFIDENTIAL

ALL INFORMATION MUST BE LEGIBLY FILLED-IN AND WITHOUT CORRECTIONS

The undersigned states, under their responsibility, that their answers to the questions made are truthful and complete, authorising SegurCaixa Adeslas to undertake any verification deemed convenient on the origin and evolution of the illnesses or ailments that may, given the case, require assistance under this Policy. The undersigned authorises the Company, if any illness has been suffered, to contact the intervening doctors.

SegurCaixa Adeslas may reach a decision on the Policy within a month from the time it knows of the deponent's reservations or inaccuracies in filling in the questionnaire, although this right can not be based on the Insurer's lack of knowledge on the Policy Holder's state of health information that is not included in the above questions.

If fraud or serious fault exits in filling in this questionnaire, SegurCaixa Adeslas shall in any case and from now on be freed of the obligations established for it by the insurance policy (Art. 10 Law on Insurance Contracts)

SegurCaixa Adeslas, S.A. de Seguros y Reaseguros, as the data processing controller, shall process the provided personal data to carry out a risk assessment in compliance with the provisions of the Insurance Contract Act. The data provided shall not be assigned to third parties. You can find more information about the data protection policy of SegurCaixa Adeslas, and especially how to exercise your rights of access, rectification, deletion and others, on the following web page: www.segurcaixaadeslas.es/es/proteccion-de-datos.

The Insurer SegurCaixa Adeslas, S.A. de Seguros y Reaseguros - Paseo de la Castellana, 259 C (Torre de Cristal), 28046 Madrid (Spain). Registered in the Commercial Registry of Madrid, book 36733, sheet 213, page M-658265. VAT No.: A28011864.