COSMOS insurance Always by your side.

Cyprus Choice

GROUP MEDICAL INSURANCE APPLICATION FORM

Warning:
Please answer all of the questions on this form honestly and in full. If you miss any information out, or give us misleading information, this could mean that we do not pay or proportionately reduce any subsequent claim in respect of you or your dependants and/or cancel your cover. If you are uncertain about whether any particular fact should be disclosed to us, you should include it. Once completed the form should be returned to us at 46 Griva Digeni Avenue, 1080, Nicosia Cyprus.

Main Insured's Details

Title (Mr./Mrs./Ms.)	First Name(s)	Surname
Date of Birth (dd/mm/yyyy)	Nationality	ID/Passport Number
Sex (M/F)	Height (cm)	Weight (Kg)
Address		
District		Postcode
Email address		Telephone(s)

Eligible Dependent Details

Surname & Name	ID/ Passport No.	Sex (M/F)	Nationality	Date of Birth (dd/mm/yyyy)	Relation (Spouse / Child)	Height (cm)	Weight (kg)

Questions 1-7 must be completed for each person applying for cover
For any positive answer please provide additional information in section 6 below.

	YES	NO
1. Including work permit exams and annual physicals, **within the past 5 years, has any applicant:** a. Consulted or received any treatment by a doctor, therapist, counsellor, dentist or other health care professional?		
b. Been admitted to any hospital, clinic, day care or other treatment facility?		
2. Is any applicant taking any medications, prescribed or otherwise, or receiving treatment or therapy of any kind?		
3. Is any applicant currently pregnant? (If yes, in which month?)		
4. Is there any known or likely need for any applicant to seek advice, treatment or investigations from a health care professional? (this includes symptoms you are aware of, even if undiagnosed or untreated)		

5. Has any applicant ever experienced symptoms of, or received treatment or investigations for any of the following?

	YES	NO		YES	NO
a. AIDS, AIDS-related complex (ARC), HIV diagnosis			k. High blood pressure, raised cholesterol, other blood disorder		
b. Alcohol dependency and/or drug abuse			l. Ears, eyes, nose or throat problem		
c. Arthritis, back, bone, joint, muscle or nerve problem			m. Irregular periods, fibroids, other pelvic disorder		
d. Asthma, bronchitis, other respiratory problem			n. Injury, syndrome or physical defect/deformity		
e. Cancer, tumour, growth or cyst			o. Skin problems		
f. Dental problem or gum disease			p. Stomach, bowel, liver, kidney or gall-bladder problem		
g. Depression, stress, anxiety, other psychological disorder			q. Varicose veins, circulation problem		
h. Diabetes, thyroid, other hormonal disorder			r. Prostate or reproductive organ disorders or abnormal smears		
i. Epilepsy, seizures, dizziness or fainting spells			s. Any other disorder or condition (acute or chronic) not listed above		
j. Heart disease, stroke, other heart problem					

6. If the answer to any of the above is 'YES' please provide the following details for each symptom/condition
(please use additional paper if necessary)

Item No.	Name of person(s) this relates to	Symptom / Nature of disorder / Infected Areas / Diagnosis	Date(s) of treatment / tests / onset	Treatment received and/or Medication taken	Status: stable / ongoing / full recovery

7. Previous Insurance

	YES	NO
Has any applicant ever been denied any other insurance cover, or offered coverage with any exclusions? If YES, please provide applicant name and details:		
Have you, or has any applicant ever applied for medical coverage with Cosmos? If YES, please provide previous policy number:		

How we handle your personal data

In order for us to provide quotes, insurance policies or deal with any claims in connection with the insurance arrangements that you have with us, we need to collect and process personal data about you, including:

- individual details, such as name, address and date of birth;
- risk details, which is information we need to collect in order to assess the risk to be insured and provide a quote.

This may include data relating to your health;

- current and past claims details, which may also include data relating to your health.

We might collect your personal data from various sources, including your insurance intermediary (if any) and medical experts appointed to treat you in the event of a claim. We will keep your personal data only for so long as is necessary and for the purpose for which it was originally collected.

The provision of insurance involves the sharing of personal data between different insurance market participants, including brokers, insurers and reinsurers, and third parties who provide services in connection with the insurance, such as medical experts, each of whom may be located outside of your country of residence.

If you have any questions in relation to the use of your or your dependant's personal data visit **www.cosmosinsurance.com.cy/terms**

When we need your consent

In order to provide insurance cover and deal with insurance claims, we may need to process categories of personal data which have additional protection under data protection law, such as your health data.
Your consent to this processing may be necessary for us to achieve this.
Your consent may be withdrawn at any time. However, if consent is withdrawn this will impact our ability to provide insurance or pay claims.

Authorisation

I, the undersigned declare that I have carefully read all the questions. I fully understood them and that all my answers are complete and truthful and I accept this proposal of mine to form the basis of the contract which shall be issued and shall come into force from the date of its issuance and received by me, provided that the first premium shall have been fully paid and the state of health as well as the rest of the conditions affecting the insurability of the insured person and of the insured dependants shall remain as they have been declared in the proposal.

I have been informed in accordance with the provisions of the Law 125(I) 2018, which I have fully understood and following that by providing my consent to the processing of my sensitive personal data and I will enable COSMOS INSURANCE COMPANY PUBLIC LTD and/or its agents to provide me with a custom made insurance proposal suitable for the needs of myself and my dependants, therefore:

	YES	NO
I consent for COSMOS INSURANCE COMPANY PUBLIC LTD and or its agents to process my sensitive personal data provided through the present application for the purpose of providing me with a custom made medical insurance	☐	☐
I consent for COSMOS INSURANCE COMPANY PUBLIC LTD and or its agents to process the sensitive personal data of my dependants provided through the present application for the purpose of providing them with a custom made medical insurance	☐	☐
I consent for COSMOS INSURANCE COMPANY PUBLIC LTD and its agents to process my personal data for the purpose of promoting otherinsurance products	☐	☐
Furthermore and for the aim of the proper evaluation of my application I hereby authorize any medical practitioner, hospital, clinic, insurance company or other organization, institution having data or knowledge about myself or about my health, as well as about any proposed dependant with me person, to give COSMOS INSURANCE COMPANY PUBLIC LTD every information that may be required for the purpose of providing me with a custom made medical insurance.	☐	☐

Main Insured's Signature

Date D D M M Y Y

Spouse's Signature
(Spouse must sign when spouse coverage is requested)

Date D D M M Y Y

Adult Dependant Signature

Date D D M M Y Y

Adult Dependant Signature

Date D D M M Y Y

Declaration of Continued Good Health
(to be completed if cover is not approved within 90 days from the date original application is signed)
Since the date the original Health Insurance Application was signed, has the main insured or any eligible dependant:

	YES	NO
1. Experienced any symptoms of any new health problem or condition?	☐	☐
2. Received any advice, treatment or investigations from any health professional or hospital facility?	☐	☐
3. Any intention/need to seek advice, treatment or investigations from a health professional or hospital in future?	☐	☐

If the answer is YES to any of the above, please provide applicant name and full details on Page 1
It is understood and agreed that the above statements and answers are true and complete to the best of my knowledge.
It is understood that additional information or examination by a physician may be required.

Signature	**Date** D D M M Y Y

To be completed by the Policyholder

Policyholder's/Employer's Full Name	
Main Insured's/Employee's Full Name	
Date of Recruitment (dd/mm/yyyy)	Date of Entry/Inclusion to the plan (dd/mm/yyyy)
Insured's Occupation/Position/Duties	

Policyholder's Signature	**Date** D D M M Y Y

COSMOS insurance