GROUP HEALTH INSURANCE PROPOSAL FORM

Group and Company Name :
Position :

Fill the form using readable capital letters. Your identity information has to be filled by being referred to your certificate of birth. If the number of family members to be insured is more than five, please fill a second form.

Family members to be insured	Herself / Himself	Spouse	1st Child	2nd Child	3rd Child
Name					
Surname					
MERNIS Identity Number (for Turkish citizens)	I I I I I I I I I I I	I I I I I I I I I I I	I I I I I I I I I I I	I I I I I I I I I I I	I I I I I I I I I I I
Tax Department					
Tax Number	I I I I I I I I I I	I I I I I I I I I I	I I I I I I I I I I	I I I I I I I I I I	I I I I I I I I I I
Birth Date	……/……/……..	……/……/……..	……/……/……..	……/……/……..	……/……/……..
Sex	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Father's Name					
Marital Status	Single ☐ Married ☐	Single ☐ Maried ☐	Single ☐ Maried ☐	Single ☐ Maried ☐	Single ☐ Maried ☐
Height / Weight (For children under 1 year-old, height / weight at the birth should be written down)	Cm Kg /	Cm Kg /	Cm Kg /	Cm Kg /	Cm Kg /
Do you smoke? Daily Usage Number / Usage Duration	Yes ☐ No ☐ /	Yes ☐ No ☐ /	Yes ☐ No ☐ /	Yes ☐ No ☐ /	Yes ☐ No ☐ /
Do you take alcohol? Usage Frequency / Amount Usage Duration	Yes ☐ No ☐ I I	Yes ☐ No ☐ I I	Yes ☐ No ☐ I I	Yes ☐ No ☐ I I	Yes ☐ No ☐ I I
For male: Have you completed the military service? If answer is no, please write the reason on the space.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
For female: Are you pregnant?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Contact Information : (Please fill the boxes related to residence adress information completely.)

City		County		Quarter	
District		Avenue		Street	
Name of Housing Estate		Name of Apartment		Block/Apt. No	
Door No		Floor No		Postal Code	
Home Tel.	(0..)- …	Work Tel.	(0..)- …	GSM Tel.	(0..)- … .. ..
E-Mail Adress					

Information of Bank Account Personnel Wage Paid Into:

Bank Name		Branch		Account Number	
IBAN NO					

	Yes	No	Social Security Association/ Number
Are you insured by SSK, Emekli Sandığı or Bağkur at this moment?	☐	☐	If Yes;
If you have had private health and / or life insurance in our company or any other insurance company until now, please write the name of the company by stating the period.			
Did you ever have an unaccepted application for private health and/or life insurance made to our company or any other insurance company? If your answer is yes, please state the reason of deniance.			

Attention Please :

"Health Status Information" part on the back of the page is valid for you and family members to be insured. Please mark one of the options which are "yes" and "no". If none of the options is marked, then your answer is accepted as "no".
In "Health Status Information" part, state diagnoses, applied treatments, operations, and diseases, illnesses or complaints whose symptoms are obvious even if no treatment has been applied and/or no physician/health organization has been applied during this application and/or before this application. In "Explanations" part, please write detailed information on the mentioned points in this paragraph, and send the related reports, and all the abnormal test results determined until the date you fill this form, and even if normal, reports of computerized tomography, magnetic resonance (MR), mammography, ultrasonography (USG, Doppler USG), scintigraphy,

endoscopy (gastroscopy, colonoscopy, etc.), biopsy, angiography, echocardiography, afforded EKG (stress test, treadmill) by attaching to the form.

Health Status Information

If "yes" is marked for any of the questions below, remember to write details in "Explanations" part.		Her/himself		Spouse		1st Child		2nd Child		3rd Child	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1.	Asthma, tuberculosis, pneumonia, persistent cough, blood spitting or other breathing system diseases.										
2.	Hipertension, rheumatic fever, coronary vessel disease, hearth attack, rhtym disorders, diseases about hearth or hearth vessels.										
3.	Anemics, blood diseases, diseases about blood circulation or vessels.										
4.	Norologic and psychological diseases such as epilepsy, migrant, paralysis, multiple syclerosis, menenjit, depression, neurological diseases, psychosis										
5.	Diabetics, goitre, gout or other methabolics and endocrine diseases.										
6.	Lumbago, crick, neck hernia, osteoporosis, rheumatism, arthritis, poliomyelite (child paralysis), spina bifida, fractures or other diseases of backbone, bone, joint, tendon, fiber and muscles.										
7.	Cataract, glaucoma, absence/loss of seeing or hearing, otit, hardness in breathing, apnea and other eye, ear, nose, throat diseases.										
8.	Stomach/duodenal ulcer, gastritis, chronic or repetitive dierra, ulserative colit, crohn disease, hemorrhoid, anal fissure, gripes or other digestive system (food pipe,stomach, entrails, gallblader, anus) diseases										
9.	Hepatitis, hepatitis carrier or other diseases of liver, spleen, gallbladder and pancreas.										
10.	Kidney stone or gravel, urinar system infection, prostate enlargement, varicosel or other diseases of urogenital system, and syphlsis, diseases transmitted by sexual relation such as HIV infection or AIDS.										
11.	Malignant or no-malignant tumors, cyst, cancer, masses like fat meringue (If your answer is "yes", cite location, if removed whether the mass was malignant or no-malignant, and add the pathology report).										
12	Endometriosis, ovarian cyst, myom, irregular menstrual period, infertility treatment, or other ginecologic diseases or disfunctions.										
13	Psoriasis, egsama or other skin, hair, haired skin diseases.										
14	Even if no physician has been applied to, or no treatment has been offered; genetic, congenital or chronic diseases, disabilities and body deformations not mentioned above.										
15	With any reason except for mentioned above, applications to physician, or medical institute, in-patient treatments, post operations, cosmetics, esthatic operations.										
16	Have you ever been proposed to make a diagnosis test, in-patient treatment, or to be taken under an operation? Do you have any uncompleted treatment, or any test results of which you wait for.										

Explanations (Please attach reports and/or test results related to disorders you stated to the proposal form)

Name / Surname	Detailed Information Diagnosis and Treatment		Starting / Ending Date		Status at the moment

DECLARATION / ENGAGEMENT

I, as the insured candidate whose sign is below, I accept, declare, and engage the following points.

1. I accept, declare, and engage that information I have provided above about myself and family members (“relatives”) mentioned in this form whom I want to be insured is complete and true, and that I have not hidden any point that Koç Allianz Sigorta A.Ş. (Koç Allianz) has to know.
2. I accept and declare that Koç Allianz is going to realize processes on the base of my declaration on this proposal form (“form”), and reception of the form does not mean any obligating acceptation and engagement for Koç Allianz. I accept and declare that the rights of Koç Allianz to reevaluate, and make changes on the policy or deny it completely because of the risks and/or disorders occurring between the date when the form has been filled (“declaration date”) and the date when the insurance statement or policy has been arranged.
3. Koç Allianz has the right to realize processes on the base of my declaration on this proposal form (“form”) without waiting any information and documents from the insurance companies I was previously insured. The receipt of the Form by Koç Allianz does not mean that Koç Allianz accepts or subscribes to make the insurance contract. I accept and declare that Koç Allianz has the right to unilaterally make changes on the policy or deny it completely because of the risks and/or disorders occurring between

the date when the form has been filled (“declaration date”) and the date when the insurance statement or policy has been arranged, or because of the risks and/or disorders determined according to the information and documents obtained after the policy arrangement from my previous insurance companies.

4. Starting from the declaration date, and in case of acceptance during the policy period, related to my declarations and/or additional demands Koç Allianz has the right to ask for the medical information and documents belonging to me and/or my relatives mentioned in this form by applying to any health organization not bounded with physicians, hospitals, laboratories and to and other insurance companies in order to determine the details and the truthfulness of my declaration and application. Within bounds of this point, I declare, accept, and engage irrevocably that I will not attempt by applying to any health organization, or association, or physician, or insurance companies in order to prevent the usage of authorization I have provided to Koç Allianz, that I will not make any attempt on the legal and criminal base in boundaries of legal arrangements including but not bounded with health regulation against to both of Koç Allianz and physician, health organization and association, or insurance companies that provide the information and/or document to Koç Allianz in the cases that information and/or documents are used by Koç Allianz, provided that this usage be only limited by the relation based on the policy, and that this usage be presented directly to myself, and/or when required, in front of judicial authority.

Name / Surname of Owner of Declaration (Personnel)	Declaration Date	Sign of Owner of Declaration

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