



INSURANCE APPLICATION

Name of the product to be contracted:

Application No.:

To be completed by Sanitas

Policy no: _____ Bar: _____ Effective from: _____

Department: _____ Agent Code: _____ 2nd Broker Code: _____

Office: _____ Manager Code: _____ Employee Code: _____

To be completed by the Broker:

Name: _____ DGS Registration no: _____

PART OF **Bupa****IMPORTANT:** It is necessary to submit, in addition to this application form, the questionnaire referring to **CONFIDENTIAL MEDICAL INFORMATION** in order to complete the process of registering new Insureds correctly.**DETAILS OF THE INSURANCE POLICYHOLDER**

Surname(s): _____ Given Name(s): _____

ID Document n°: _____ Tax ID card Passport NIE _____ Gender: Male FemaleDate of Birth: / / Nationality: _____

Company: _____

ADDRESS AND BANK DETAILS OF THE POLICYHOLDER

Street: _____ N°: _____ Block: _____ Staircase: _____ Floor: _____ Flat: _____

Town: _____ Postcode: _____ Province: _____

Telephone 1: _____ Telephone 2: _____ e-mail: _____

BANK DETAILS: IBAN: _____ CURRENT ACCOUNT: _____

BIC CODE: _____ PAYMENT FREQUENCY: Annual Six-monthly Quarterly Monthly**ADDRESS OF THE FIRST INSURED ON THE POLICY IF DIFFERENT FROM THE POLICYHOLDER'S ADDRESS**

Street: _____ N°: _____ Block: _____ Staircase: _____ Floor: _____ Flat: _____

Town: _____ Postcode: _____ Province: _____

SEND DOCUMENTATION TO: **The agent**

Street: _____ N°: _____ Block: _____ Staircase: _____ Floor: _____ Flat: _____

Town: _____ Postcode: _____ Province: _____

DETAILS OF THE INSURED(S)**INSURED 1**

IF THE POLICYHOLDER IS ALSO INSURED, HE OR SHE MUST APPEAR AS INSURED 1

Full name (surnames first): _____ Gender M/F: _____ Date of Birth: _____

Telephone 1: _____ Telephone 2: _____ Profession: _____

E-mail address: _____ NIF Passport NIE: _____

Document n°: _____

Are you now (or have you previously been) a member of Sanitas or BUPA? Yes No Previous Policy n°: _____Have you switched from a different Insurance Company Yes No Previous Insurer: _____**INSURED 2**

Relationship with Insured 1

Full name (surnames first): _____ Gender M/F: _____ Date of Birth: _____

Telephone 1: _____ Telephone 2: _____ Profession: _____

E-mail address: _____ NIF Passport NIE: _____

Document n°: _____

Are you now (or have you previously been) a member of Sanitas or BUPA? Yes No Previous Policy n°: _____Have you switched from a different Insurance Company Yes No Previous Insurer: _____**ADD-ONS CONTRACTED**

Do you wish to contract any of the add-ons? (Only valid if compatible with the product)

FOR ALL INSURED(S)

- Dental cover
- Medicines
- Cover in USA
- Optical cover
- Road/work accident coverage
- Family assistance
- Others _____

FOR POLICYHOLDER

- I.T. Guarantee
- Others _____

FOR SELECTED INSURED(S)

- | | | | |
|-----------------------------------|---|--------------|--------------------------|
| Reimbursement of expenses | <input type="checkbox"/> 11 <input type="checkbox"/> 12 | Others _____ | <input type="checkbox"/> |
| Indicate insured capital: _____ € | <input type="checkbox"/> | | |
| Reimbursement (Gyn/Ped) | <input type="checkbox"/> | | |
| Optical cover | <input type="checkbox"/> | | |
| Accidents | <input type="checkbox"/> | | |
| Indicate insured capital: _____ € | <input type="checkbox"/> | | |
| Income (hospital subsidy) | <input type="checkbox"/> | | |
| Alternative Medicine | <input type="checkbox"/> | | |

Signature of the Policyholder / Insured

Signature of the Broker

I declare that I have answered truthfully all of the questions contained in this application form and I acknowledge that I have received the **Insurance Information Prior to Contracting** contained in this application form and in the additional Prior Information Note. I hereby give my consent to the direct debit mandate for the insurance premium and the processing of the personal details also stipulated overleaf.

Date:

_____ on (month) (day) (year)

Information prior to contracting

By signing the front of the present insurance application form, the Policyholder acknowledges that he or she has been informed, on the date of the present, of the information indicated below pursuant to the provisions contained in article 96 of Law 20 dated July 14th, 2015, and in article 122 and 126 of the Regulations developing the same, that he or she has received, at his or her email address stipulated on the insurance application form, or in hard copy if no address is furnished, the additional Prior Information Note for the product referred to in the application form. SANITAS is under no obligation whatsoever as a result of this application, and reserves the right to accept or reject it for the purposes of taking out the policy.

APPLICABLE LEGISLATION.

The Insurance Contract Act (Law 50 dated October 8th, 1980), the Insurers and Reinsurers (Organization, Oversight and Solvency) Act (Law 20 dated July 14th, 2015), and the Regulations developing the same (Royal Decree 1,060 dated November 20th, 2015).

INSURER.

SANITAS, SOCIEDAD ANÓNIMA DE SEGUROS, has its registered office at Calle Ribera del Loira 52 (28042 Madrid, Spain) and tax ID no A-28037042. The supervision and monitoring of its activities corresponds to the Directorate General for Insurance and Pension Funds at the Ministry of the Economy and Competitiveness. Through its website, SANITAS will publish the statutory reports on its financial situation and solvency status within the terms foreseen in current legislation.

ACCEPTANCE OF TERMS AND CONDITIONS. NOTIFICATIONS.

If and when this insurance application is accepted, SANITAS will send an email to the Policyholder at the address provided by the latter on this application form. This email will feature a link allowing the Policyholder to register on the website and choose a Security Password.

Once he/she has obtained the password, the Policyholder must access www.sanitas.es, where the General and Particular Terms and Conditions of his/her policy are available; these must be accepted using the code sent to the mobile phone number provided in this form. The use of the Password code will be legally equivalent, for all purposes, to the Policyholder's handwritten signature. Sanitas may deny the insured cover if the policyholder does not accept the policy terms and conditions.

The Policyholder authorizes SANITAS to record any telephone communications and the computing and remote electronic records generated by accessing the SANITAS service. Such recordings and records may be used as evidence in any legal or arbitration proceedings which might arise between the two parties.

The Policyholder authorizes SANITAS to use his/her mobile telephone number and email address to send him/her any notifications, communications and information related to his/her policy by electronic means, provided current legislation so allows. The Policyholder accepts that any notification sent by SANITAS to the physical or email address or telephone number provided by the Policyholder when the application for insurance is made will be fully valid and effective until such time as a change in these details are notified to SANITAS.

The Policyholder will pass on the terms and conditions agreed and indicated in the previous paragraphs to any Insured parties in the policy who might wish to register and obtain their own security password, and hereby accepts the full legal validity of said terms and conditions, both on his/her own behalf and on behalf of the aforementioned Insured parties.

COMPLAINTS HANDLING BODIES.

In the event of any complaint regarding the insurance contract, the Policyholder, Insured, beneficiary, harmed third party or successor in rights of any of the above must address their complaint for resolution:

- To the Complaints Handling Department of SANITAS, by means of a signed letter (with the claimant's National Identification Document or a document accrediting their identity) addressed to the Insurer at Calle Ribera del Loira 52, 28042 Madrid or sent to fax number (+34) 915 852 468 or by email to the address reclamaciones@sanitas.es. We shall acknowledge receipt in writing and shall issue a formal reasoned resolution in writing within the maximum legal term of two months from the date of submission of the complaint.
- Once the Insurer's internal complaints process has been exhausted, or if the client does not accept the resolution reached, it will be possible to lodge a complaint in writing, facilitating the claimant's National Identification Document or a document accrediting their identity before the Directorate General for Insurance and Pension Funds. For this purpose, the claimant must show that the term stipulated for the resolution of the claim has elapsed or that consideration of the claim has been refused or the claim submitted has been rejected.
- Please be informed that SANITAS is not attached to any consumer rights board, without prejudice to the Insured's right to follow the administrative and legal proceedings specified in the complaints procedure set down in the General Terms and Conditions of their policy.

- In any case, it will be possible to resort to the competent Courts, which shall be those corresponding to the Insured's address.

RENEWAL, TERMINATION, UPDATING OF PREMIUMS AND OTHER INFORMATION.

- Renewal. Unless otherwise established in the policy, the insurance contract is of annual duration, calculated from the date it enters into force, and it will be tacitly extended for successive periods of one year unless either of the parties opposes said extension by communicating this fact to the other party, giving 2 months' notice if SANITAS effects this notification and 1 month if it is the Policyholder. Under no circumstances will Sanitas oppose the extension if the insured is over 65 years old, provided that they have been insured with Sanitas for 5 years or more and without any missed payments, or if they are undergoing treatment for one of the serious diseases listed below, which was first diagnosed during the period the insured was included on the policy, (Active oncological processes; Tributary heart diseases of surgical or interventional treatment; Organ transplants; Complex orthopaedic surgery in evolution phase; Degenerative or demyelinating diseases of the nervous system; Acute kidney failure; Torpid chronic respiratory failure; Chronic hepatopathy (excluding those of alcohol origin); Acute Myocardial Infarction with heart failure; Macular degeneration.
- Termination of the contract (generally speaking, without prejudice to the provisions of statute and in the General and Particular Terms and Conditions of the policy).
 - SANITAS may terminate the policy:
 - In the event of any inaccuracy or withholding of information by the Policyholder when completing the health questionnaire for the Insured/s. Such termination shall take effect by means of a declaration addressed to the Policyholder within 1 month from when SANITAS becomes aware of the inaccuracy or withholding of information.
 - If, due to the fault of the Policyholder, the initial premium is not paid on maturity, unless SANITAS opts to require payment through enforcement. In the event of non-payment of subsequent premiums, instalment payments or co-payments, then art. 15 of Law 50/1980 and the Terms and Conditions of the policy shall apply.
 - The Policyholder may terminate the policy in the following cases by notifying SANITAS of this fact in writing:
 - On receipt, in due course, of a notification from SANITAS regarding a variation in the amount of the premiums payable for the next annual period. In such cases, the termination shall take effect from the conclusion of the annual period in course, provided that the Policyholder notifies SANITAS at least one month prior to the aforesaid date.
 - Whenever there is a change in the national medical staff of SANITAS, provided that this change affects at least 50% of those professionals making up its staff prior to the change.
- Objective risk factors to be considered in the rate of the premium to be applied in successive renewals of the policy: age of each Insured; geographical area for the provision of the services; variation in the costs of health-care services; frequency of the use of benefits; inclusion of technological medical innovations or new insured cover.
- The Policyholder is not entitled to have the policy reinstated. Optional ancillary guarantees offered in the policy, over and above the cover. Applicable premium tariffs.
- For healthcare policies the insured can access the professionals on the medical chart corresponding to the product purchased under the terms and conditions and with the limits set out in the general terms and conditions. For reimbursement products there will be no access limits, provided that the medical service is included in the cover.
- You can read the report about Sanitas' financial situation and solvency at: <http://corporativo.sanitas.es/>
- You can check the premiums applicable for every age range and the supplementary optional cover available at www.sanitas.es
- If the policy is taken out through a sales representative employed by Sanitas, the nature of their remuneration will comprise the salary agreed between Sanitas and the employee.

Direct debit mandate

Through the signature placed on the front of this form, the Policyholder and Debtor for the insurance premium authorizes Sanitas S.A. de Seguros to present a direct debit for the amount corresponding to the insurance premium for the policy referred to on this application form and any other amount payable by the Policyholder in connection

with said policy. Furthermore, the bank indicated is authorized to effect the said debits against the Policyholder's account following the instructions received from Sanitas S.A. de Seguros.

Basic Data Protection Information

- Coordinator:** SANITAS, SOCIEDAD ANÓNIMA DE SEGUROS (Sanitas), with registered offices at C/ Ribera del Loira, 52, 28042 Madrid, Spain.
- Purpose:** Your personal data provided by the Applicant about the Policyholder and Insureds, including their health data, will be processed for the following purposes: Formalise, develop and implement the insurance contract (Performance of a contract); Provide and cover the healthcare service included in the insurance contract, for which purpose it may request and obtain health information from healthcare professionals; Research to design care models included in the insurance contract; Offer and manage care and prevention programmes (health promotion service) included in the insurance contract; Manage the actuarial risk in order to determine the appropriate rate in each case, and others; Comply with the obligations corresponding to Sanitas by law, including those related to insurance regulations, tax laws, data protection regulations, and others; Analyse your interests and needs based on the data provided by you, including but not limited to your health data, personal data generated as a result of the service provided by Sanitas and data obtained through other means; Send marketing communications by any channel, including electronic means; Carry out procedures for anonymization and pseudoanonymization of your personal data; Transfer your personal data to companies within the group for marketing purposes and scientific and / or statistical research purposes and to third-party collaborating companies for marketing purposes.
- Legitimation:** Performance of a contract, comply with legal obligations, legitimate interests, scientific and / or statistical research purposes, and consent, as detailed in Additional Information.
- Recipients:** Group of companies and third-party collaborating companies. In addition, International transfers carried out by processors and subprocessors are based on the Spanish Data Protection Authorization and/or Standard Contractual Clauses.
- Rights:** Access, rectification, erasure and other rights, as explained in Additional

Information.

- Additional information:** more information regarding the processing your personal data is available at <https://www.sanitas.es/RGPD.html>

Lack of acceptance of the data processing included below does not condition the application form or the insurance contract with Sanitas. Unless specified otherwise — by checking one of the following options— by signing this clause the Applicant agrees that SANITAS processes the data provided for the following purposes:

- | | | | |
|--------------------------|--------------------------|---|--|
| Yes | No | <input type="checkbox"/> <input type="checkbox"/> | I agree to process my personal data to promote Sanitas or third-party company products and services, including marketing communications via electronic means or equivalent sent by Sanitas, even if I do not take out the insurance. |
| <input type="checkbox"/> | <input type="checkbox"/> | | |
| Yes | No | <input type="checkbox"/> <input type="checkbox"/> | I agree to transfer and process my personal data by Sanitas group companies for scientific and / or statistical research purposes and marketing purposes, in addition to third-party collaborating companies identified in Additional Information, in order to send me marketing information related to financial products and services, insurance, social and healthcare and/ or health or wellness products and services, including marketing communications via electronic means. |
| <input type="checkbox"/> | <input type="checkbox"/> | | |
| Yes | No | <input type="checkbox"/> <input type="checkbox"/> | I agree to process my personal data for the purpose of Sanitas analysing my interests and needs based on the data I provide, including, but not limited to, my health data, personal data generated as a consequence of a service provided by Sanitas or that Sanitas has obtained via other means; this processing may include automated decision making. |
| <input type="checkbox"/> | <input type="checkbox"/> | | |

I have read and understand the information provided in relation to the processing of my personal data.

Policyholder / Insured's Signature

Date:
day month year



BEFORE COMPLETING THIS APPLICATION FORM, PLEASE READ THESE INDICATIONS CAREFULLY

- 1) Fill in each and every one of the boxes with the appropriate answer. Do not leave any boxes blank. Dashes are not an acceptable way of responding.
- 2) In the case of paired organs or limbs, indicate left or right.
- 3) **The following pathologies, procedures or treatments do NOT need to be declared when filling in this health questionnaire:** appendicitis, tonsillitis, childbirth or Caesarean section, ligature of Fallopian tubes, vasectomy, phimosis, contraceptive treatments and allergy-related treatments.

PART OF **Bupa**

ANSWER FOR INSURED 1

Full name (surnames first): _____

ARE YOU OR HAVE YOU BEEN ADMITTED TO ANY HOSPITAL OR CLINIC AND/OR HAVE YOU BEEN SUBJECTED TO ANY SURGERY?

YES NO **If affirmative, please give details, indicating dates:** _____

IS ANY SURGICAL PROCEDURE PLANNED?

YES NO **If affirmative, please give details:** _____

ARE YOU CURRENTLY RECEIVING MEDICAL TREATMENT OR UNDER MEDICAL SUPERVISION?

YES NO **If affirmative, please give details:** _____

DECLARATION OF OTHER ILLNESSES:

Are you suffering from (or have you suffered from) any of the following processes, pathologies or illnesses? (Answer yes/no in each case). YES NO

Y N	Y N	Y N	Y N
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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If you have contracted a POLICY OR COMPLEMENT FOR INCOME OR ACCIDENT PROTECTION, please answer the following questions:

- YES NO Have you ever suffered any accident? Are you suffering from (or have you suffered from) any chronic, congenital or systemic disease or physical limitation?
- YES NO Have you ever contracted or are you in the process of contracting any other accident insurance, life assurance, sickness protection policy, and/or hospitalization cover?
- YES NO Are you left-handed?

Indicate capital insured: € _____ Name of the beneficiary in the event of compensation on the death of the Insured _____ ID Card number of the beneficiary: _____

ANSWER FOR INSURED 2

Full name (surnames first): _____

ARE YOU OR HAVE YOU BEEN ADMITTED TO ANY HOSPITAL OR CLINIC AND/OR HAVE YOU BEEN SUBJECTED TO ANY SURGERY?

YES NO **If affirmative, please give details, indicating dates:** _____

IS ANY SURGICAL PROCEDURE PLANNED?

YES NO **If affirmative, please give details:** _____

ARE YOU CURRENTLY RECEIVING MEDICAL TREATMENT OR UNDER MEDICAL SUPERVISION?

YES NO **If affirmative, please give details:** _____

DECLARATION OF OTHER ILLNESSES:

Are you suffering from (or have you suffered from) any of the following processes, pathologies or illnesses? (Answer yes/no in each case). YES NO

Y N	Y N	Y N	Y N
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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If you have contracted a POLICY OR COMPLEMENT FOR INCOME OR ACCIDENT PROTECTION, please answer the following questions:

- YES NO Have you ever suffered any accident? Are you suffering from (or have you suffered from) any chronic, congenital or systemic disease or physical limitation?
- YES NO Have you ever contracted or are you in the process of contracting any other accident insurance, life assurance, sickness protection policy, and/or hospitalization cover?
- YES NO Are you left-handed?

Indicate capital insured: € _____ Name of the beneficiary in the event of compensation on the death of the Insured _____ ID Card number of the beneficiary: _____

INCLUSION OF NEWBORN CHILDREN

Provide a discharge report in the event of a birth occurring in a centre not included in the medical roster of Sanitas

Given name and surname(s) of the father: _____ Father's card number: _____

Given name and surname(s) of the mother: _____ Mother's card number: _____

Insured Newborn 1

YES NO Is the baby premature? YES NO Did (or does) the child require any special health-care?

YES NO Is the baby premature? YES NO Does the child present any congenital disease?

Insured Newborn 2

YES NO Did (or does) the child require any special health-care?

YES NO Is the baby premature? YES NO Does the child present any congenital disease?

Signature of the Policyholder / Insured

Signature of the Broker

Date:

_____ on (month) (day) (year)