



**Please complete in full using a blue or black pen**

**1 My details** (= policyholder)

Initial(s)  Additional name details  Surname

Date of birth  -  -   Male  Female

Citizen's Service Number (BSN)/Tax and Social Insurance (SoFi) number\*

Nationality\*\*  NL  Other

Street name  House no.  Additional address information

Postcode  Place of residence  Country

Telephone number (home)  Telephone number (work)

Mobile telephone number  E-mail address

\* Please do not forget to fill in your BSN/SoFi number. Without your Tax and Social Insurance/Citizen's Service number, we will not be able to process your application.

\*\* If you or one of the people to be insured does not have Dutch nationality, please enclose a copy of your alien's identity card. If someone has the nationality of a country within the EEA, a copy of their passport will suffice.

**2 I wish to register the following people for the Beter Af Policy**

I wish to register myself as well. I do not need to fill in my details below.  I do not wish to register myself.

**Insured party 1** Initial(s)  Additional name details

Surname  Date of birth  -  -

Male  Female Nationality  NL  Other

Relationship with the policyholder  Partner  Child  Other  BSN/SoFi-number

**Insured party 2** Initial(s)  Additional name details

Surname  Date of birth  -  -

Male  Female Nationality  NL  Other

Relationship with the policyholder  Partner  Child  Other  BSN/SoFi-number

**Insured party 3** Initial(s)  Additional name details

Surname  Date of birth  -  -

Male  Female Nationality  NL  Other

Relationship with the policyholder  Partner  Child  Other  BSN/SoFi-number

**Insured party 4** Initial(s)  Additional name details

Surname  Date of birth  -  -

Male  Female Nationality  NL  Other

Relationship with the policyholder  Partner  Child  Other  BSN/SoFi-number

**3 Different home address** (please complete if this is different to the address under 1)

Street name  House no.  Additional address information

Postcode  Place of residence  Country

Which insured person(s) live(s) at this address? Insured party 1  Insured party 2  Insured party 3  Insured party 4

**4 Participation in group insurance**

Name of group policy  Group number

Registration number

Which family member generates the right to register for this group insurance? (several family members possible). For example due to employment at the company in question, or membership of or a payment from the body in question.

Myself  Insured party 1  Insured party 2  Insured party 3  Insured party 4

**5 Payment of premium and receipt of reimbursements**

My bank account number is  I wish to pay via  Direct debit\*  Giro slip

I wish to pay the premium every  Month  Quarter  Six months  Year

\* I hereby authorise Zilveren Kruis Achmea Zorgverzekeringen N.V. to deduct the amounts owed from my account until further notice.

**6 I am applying for this insurance policy in connection with** (Please do not forget to fill in the date)

The creation of a right to basic insurance  A transfer from another insurer

A return from abroad  What is the reason for the transfer

Highly skilled migrants. Arrival in the Netherlands

Uninsured  As of date  -  -

## 7 Current service

If you are transferring from another care insurer, please fill in the details of your current insurer below.

N.B.: Please also provide these details if your current basic insurance has already ended.

	Policyholder	Insured party 1	Insured party 2	Insured party 3	Insured party 4
Current insurer					
Current policy number					
End date (if applicable)					

If you transfer as of 1 January, Zilveren Kruis Achmea will ensure that your basic insurance and any accompanying supplementary insurance policies are cancelled with your current insurer. By signing this form you give us permission to do this. You yourself do not need to take any additional action. In the case of a transfer as of a different date, you will have to inform your insurer of the cancellation yourself.

## 8 Supplementary insurance policies

	Policyholder	Insured party 1	Insured party 2	Insured party 3	Insured party 4
Beter Af Plus Policy 1 star	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beter Af Plus Policy 2 stars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beter Af Plus Policy 3 stars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beter Af Plus Policy 4 stars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beter Af Dental Policy 1 star	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beter Af Dental Policy 2 stars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beter Af Dental Policy 3 stars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beter Af Dental Policy 4 stars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beter Af Hospital Extra Package*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* Class cover and reimbursement

## 9 Additional questions relating to the Beter Af Plus Policy 4 stars (only fill in if you are applying for this insurance policy)

Have you or one of the people to be insured had more than 20 appointments for physiotherapy, manual therapy or remedial therapy (Cesar/Mensendieck) during the past 12 months or do you expect to have more than 20 appointments during the coming 12 months?

Policyholder	Insured party 1	Insured party 2	Insured party 3	Insured party 4
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## 10 Additional questions relating to the Beter Af Dental Policy 2, 3 and 4 stars (only fill in if you are applying for this insurance policies)

Have the persons to be insured been to the dentist for a check-up in the past 13 months?

Policyholder	Insured party 1	Insured party 2	Insured party 3	Insured party 4
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do the persons to be insured have the most extensive dental insurance from their current insurer?\*

Policyholder	Insured party 1	Insured party 2	Insured party 3	Insured party 4
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

\* We may need additional information. In that case you will be sent an extra application form.

## 11 Additional questions relating to the Beter Af Hospital Extra Package (only fill in if you are applying for this insurance policy)

Have any of the persons to be insured been admitted to hospital or are they going to be admitted in the near future?

Policyholder	Insured party 1	Insured party 2	Insured party 3	Insured party 4
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## 12 Voluntary deductible excess (only fill in for people aged 18 and over. This risk is additional to the obligatory deductible excess of € 150,-).

	Policyholder	Insured party 1	Insured party 2	Insured party 3	Insured party 4
€ 0,-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
€ 100,-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
€ 200,-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
€ 300,-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
€ 400,-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
€ 500,-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 13 Assessment of insurance obligation (only fill in for people aged 18 and over)

Do you receive personal income	Policyholder <input type="checkbox"/> Yes <input type="checkbox"/> No	Insured party 1 <input type="checkbox"/> Yes <input type="checkbox"/> No	Insured party 2 <input type="checkbox"/> Yes <input type="checkbox"/> No	Insured party 3 <input type="checkbox"/> Yes <input type="checkbox"/> No	Insured party 4 <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you receive your personal income from	<input type="checkbox"/> The Netherlands <input type="checkbox"/> Abroad <input type="checkbox"/> Both	<input type="checkbox"/> The Netherlands <input type="checkbox"/> Abroad <input type="checkbox"/> Both	<input type="checkbox"/> The Netherlands <input type="checkbox"/> Abroad <input type="checkbox"/> Both	<input type="checkbox"/> The Netherlands <input type="checkbox"/> Abroad <input type="checkbox"/> Both	<input type="checkbox"/> The Netherlands <input type="checkbox"/> Abroad <input type="checkbox"/> Both

## 14 Policyholder's signature

I declare that I have filled in the answers truthfully. I understand that if this form is filled in incorrectly/incompletely, or if I fail to disclose any facts which are important for the insurance policy/policies, the insurance may be rendered null and void. We need personal data to process applications for an insurance policy. We use these details at Achmea in order to enter into and implement agreements, in order to fulfil statutory obligations and to inform you about products and services which are relevant to you. Achmea can consult your details at the Stichting CIS in Zeist. The aim is to manage the risks and combat fraud. The privacy regulations of the Stichting CIS apply.

Date  -  -  Policyholder's signature

Please send the completely filled in and signed form to Zilveren Kruis Achmea, afdeling Polisservice, Antwoordnummer 5158, 3000 VB Rotterdam. No stamp is required.