

Aanvullend Tand Application Form



You can use this form to apply for health insurance. Please use a black or blue pen to complete this form. It is quicker to apply for health insurance on our website, zilverenkruis.nl. If you apply for insurance online, you do not need to fill in this form.

1 My details (policyholder)

Initials Infix Last name

Date of birth - - Male Female Social Security Number

Nationality Dutch Other

Street name House number Addition

Postal code City Country

Home phone number Mobile telephone number

E-mail address Insurance number

2 Other insured persons

Who else do you want the policy to cover? (this only applies to persons of 18 or older)

The change also applies to me. I do not need to provide my details again below. The change does not apply to me.

Insured 1 Initials Infix Last name

Date of birth - - Male Female Social Security Number

Insurance number

Insured 2 Initials Infix Last name

Date of birth - - Male Female Social Security Number

Insurance number

Insured 3 Initials Infix Last name

Date of birth - - Male Female Social Security Number

Insurance number

Insured 4 Initials Infix Last name

Date of birth - - Male Female Social Security Number

Insurance number

3 Aanvullend Tand

	Policyholder	Insured 1	Insured 2	Insured 3	Insured 4
Aanvullend Tand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Basis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
★	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
★★	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
★★★	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
★★★★	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

★ or ★★ If you apply for ★ or ★★-star Aanvullend Tand dental insurance, you do not need to answer any questions about your teeth. All you need to do is sign the form.

★★★ or ★★★★ If you apply for ★★★ or ★★★★-star Aanvullend Tand dental insurance, please answer the questions in section 3.1.

3.1 Additional questions if you apply for ★★★ or ★★★★-star Aanvullend Tand dental insurance

A Have you had a dental check-up in the last 13 months?

Yes No If you answered no, please specify who Policyholder Insured 1 Insured 2 Insured 3 Insured 4

B Are you missing more than 4 teeth and/or molars? You do not need to count wisdom teeth.

Yes No If you answered no, please specify who Policyholder Insured 1 Insured 2 Insured 3 Insured 4

Have the missing teeth and/or molars been replaced?

Yes No If you answered no, please specify who Policyholder Insured 1 Insured 2 Insured 3 Insured 4

Are the teeth and/or molars missing because of overcrowding or orthodontic treatment?

Yes No If you answered no, please specify who Policyholder Insured 1 Insured 2 Insured 3 Insured 4

C Does one of the persons to be insured have dental restoration prostheses such as crowns/post cores, (bonded) bridges, implants or a (partial) denture (frame or plate)?

Yes No If you answered yes, please specify who Policyholder Insured 1 Insured 2 Insured 3 Insured 4

Which prostheses and how many?

Are these dental restoration prostheses more than 10 years old?

Yes No If you answered yes, please specify who Policyholder Insured 1 Insured 2 Insured 3 Insured 4

Which prostheses and how many?

D Has one of the persons to be insured had root canal treatment on more than 2 and/or molars without having a crown fitted?

Yes No If you answered yes, please specify who Policyholder Insured 1 Insured 2 Insured 3 Insured 4

E Has one of the persons to be insured undergone, or are they planning to undergo, (extensive) periodontal treatment performed by a periodontist or oral hygienist?

Yes No If you answered yes, please specify who Policyholder Insured 1 Insured 2 Insured 3 Insured 4

From whom did you get treatment? Periodontist Oral hygienist

Did you or are you planning to undergo the treatment to prevent gum disease?

Yes No

F Is one of the persons to be insured anticipating dental treatment over the next 2 years?

Yes No If you answered yes, please specify who Policyholder Insured 1 Insured 2 Insured 3 Insured 4

What type of treatment?

Extensive periodontal treatment

Crown(s), bridge(s), inlay(s)

Root canal treatment

four or more fillings

Implants

Partial or full denture

G Does one of the persons to be insured have comprehensive dental insurance provided by another insurer?

Yes No If you answered yes, please specify who Policyholder Insured 1 Insured 2 Insured 3 Insured 4

4 Policyholder signature

In signing this form, you declare that: ■ you are familiar with the content of the Insurance Product Information documents. You can read and download the documents on zk.nl/informatiedocument ■ all of the information you have provided is correct ■ you have not concealed any important information ■ you are aware that we may terminate your insurance or reject your application if you have provided false or inaccurate information ■ you are aware that you are obliged to pay the premium once the policy commences.

We will use the information you have provided: ■ to register you for insurance ■ to improve our service ■ to ensure that your details are not misused by third parties ■ to send you information about other products offered by Achmea or Zilveren Kruis ■ we ensure that your details are protected in accordance with the data protection regulations issued by the Dutch Data Protection Authority (College Bescherming Persoonsgegevens (CBP) ■ In our privacy statement we inform you how we deal with your personal details.

Date

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Policyholder signature

**Send the completed and signed form to Zilveren Kruis, t.a.v. Serviceteam Polis, Antwoordnummer 10290, 2300 AK Leiden.
A stamp is not necessary.**