

# Modification form healthcare insurance

You can also register online at [www.zilverenkruis.nl](http://www.zilverenkruis.nl)

Please complete this form in block letters using a blue or black pen.

You can use this form to inform us of modifications. This is also possible via our website [www.zilverenkruis.nl](http://www.zilverenkruis.nl) or you can contact our customer service representatives at 071 751 00 51.

## When you do not have to do a thing

We receive our information from city hall. That means you do not need to inform us of certain data. That will save you some time. A move within the Netherlands or death is passed on to us by City hall within a few days.

I would like the modification(s) to take effect from  -  -

## 1 My details (policyholder)

Initials	<input type="text"/>	Suffix	<input type="text"/>	Surname	<input type="text"/>
Date of birth	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number <sup>1)</sup>	<input type="text"/>	<input type="text"/>
Address	<input type="text"/>	House number	<input type="text"/>	Addition	<input type="text"/>
Postal code	<input type="text"/>	Place of residence	<input type="text"/>	Country	<input type="text"/>
Home phone number	<input type="text"/>	Mobile number	<input type="text"/>		<input type="text"/>
E-mail address	<input type="text"/>	Insurance number	<input type="text"/>		<input type="text"/>

## 2 The modification applies for the following persons

The modification also applies to me. I do not have to fill in my details below.  The modification does not apply to me.

<b>Insured 1</b>	Initials <input type="text"/>	Suffix <input type="text"/>	Surname <input type="text"/>
Date of birth	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number <sup>1)</sup> <input type="text"/>
Insurance number	<input type="text"/>		
<b>Insured 2</b>	Initials <input type="text"/>	Suffix <input type="text"/>	Surname <input type="text"/>
Date of birth	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number <sup>1)</sup> <input type="text"/>
Insurance number	<input type="text"/>		
<b>Insured 3</b>	Initials <input type="text"/>	Suffix <input type="text"/>	Surname <input type="text"/>
Date of birth	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number <sup>1)</sup> <input type="text"/>
Insurance number	<input type="text"/>		
<b>Insured 4</b>	Initials <input type="text"/>	Suffix <input type="text"/>	Surname <input type="text"/>
Date of birth	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number <sup>1)</sup> <input type="text"/>
Insurance number	<input type="text"/>		

## 3 Modify Basic insurance

	Policyholder	Insured 1	Insured 2	Insured 3	Insured 4
<b>Basisverzekering</b>					
Budget	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Zeker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exclusief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Basis Plus Module</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 4 Modify or terminate group healthcare plan

I would like to participate in a group healthcare plan

Name group/company

Group collective number

Which family member is a member of, works for or receives social benefits from that organisation? (multiple family members possible)

Policyholder  Insured 1  Insured 2  Insured 3  Insured 4

I wish to terminate group healthcare plan.

## 5 Modify or terminate supplementary insurances (only possible from 1 January of the upcoming year)

- Please tick the relevant box in the table below to modify supplementary insurance.  
 Please tick the relevant box in the table below to terminate supplementary insurance.

	Policyholder	Insured 1	Insured 2	Insured 3	Insured 4
Aanvullend★	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aanvullend★★	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aanvullend★★★	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aanvullend★★★★	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitaal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 6 Modify or terminate dental insurance (only possible from 1 January of the upcoming year – only fill in for persons older than 18 years of age)

- Please tick the relevant box in the table below to modify dental insurance.  
 Please tick the relevant box in the table below to terminate dental insurance.

	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"/>
★★	<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"/>

### Additional question Aanvullend Tand ★★★ and ★★★★ (only fill in if you take out this insurance)\*

Has/have the policyholder/insured persons been to the dentist for a check-up during the past 13 months?

Policyholder  Insured 1  Insured 2  Insured 3  Insured 4

Does/do the policyholder/insured persons have the most extensive dental insurance with their current healthcare insurer?\*

Policyholder  Insured 1  Insured 2  Insured 3  Insured 4

\* We may need additional information. In that case, you will receive an additional application form.

## 7 Modify voluntary excess (only possible from 1 January of the upcoming year – only fill in for persons older than 18 years of age)

Policyholder	Insured 1	Insured 2	Insured 3	Insured 4
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None
<input type="checkbox"/> € 100,-	<input type="checkbox"/> € 100,-	<input type="checkbox"/> € 100,-	<input type="checkbox"/> € 100,-	<input type="checkbox"/> € 100,-
<input type="checkbox"/> € 200,-	<input type="checkbox"/> € 200,-	<input type="checkbox"/> € 200,-	<input type="checkbox"/> € 200,-	<input type="checkbox"/> € 200,-
<input type="checkbox"/> € 300,-	<input type="checkbox"/> € 300,-	<input type="checkbox"/> € 300,-	<input type="checkbox"/> € 300,-	<input type="checkbox"/> € 300,-
<input type="checkbox"/> € 400,-	<input type="checkbox"/> € 400,-	<input type="checkbox"/> € 400,-	<input type="checkbox"/> € 400,-	<input type="checkbox"/> € 400,-
<input type="checkbox"/> € 500,-	<input type="checkbox"/> € 500,-	<input type="checkbox"/> € 500,-	<input type="checkbox"/> € 500,-	<input type="checkbox"/> € 500,-

## 8 Premium payments and claim reimbursements

Your account number<sup>2)</sup>

I will pay the premium per  Month  Quarter  Six months<sup>3)</sup>  Year<sup>4)</sup>

How would you like to pay  Direct Debit  Through Authorized Payment (cost € 1,- per month)

- 1st of the month  
 24th prior to the month  
 27th prior to the month

NL10ZZZ302086370000 Zilveren Kruis Achmea Zorgverzekeringen N.V. / Achmea Zorgverzekeringen N.V. debits your insurance premium, deductible excess, statutory contribution and any other possible claims from your account. By signing this form you authorise us to do so.

## 9 Signature policyholder

I declare that I have answered the questions truthfully. I understand that any incorrect/incomplete information given on this form, or withholding of any facts which are important for the insurance policy, can make the insurance policy null and void.

Date   -   -

Signature policyholder

- 1) We need your social security number to verify your details against the municipal administration system.  
 You can find your social security number (burgerservicenummer) on your driving licence, passport or payslip.  
 2) Entering your account number is also necessary in order for us to pay your claims.  
 3) You get a 1.25% discount.  
 4) You get a 3% discount.

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