Application for an individual hospitalisation insurance

At the end of affiliation to a corporate-sponsored health insurance

Kindly complete, sign and return the form by e-mail to: hospi.retail@aginsurance.be.
If you scan the form, please check that the content is clearly legible.

To be filled in by the employer

Information provided by the employer to the employee

Important notice: the information contained in this document shall be provided to the insured staff member at the latest 30 days after forfeiture of the benefit under the corporate-sponsored health cover together with the request form 'Request for individual continuation of the corporate-sponsored health cover'.

Information on the employer

Name of the employer: .....

Date on which the employee has been informed of the entitlement to individual continuation of a corporate-sponsored policy:

...../...../.....

Information on the employee

Name & first name: .....

Street: ..... N°: .....

Postal code: ..... City: .....

Data concerning the plans (*)

Group n°: ..... S/Groupe n°: ..... Contract n°: .....

Information for the employee

You are entitled, under the conditions of article 208 of the law of 4 april 2014 on Insurance, to continue the corporate-sponsored health cover agreement(**)

☐ health care ☐ guaranteed income

on an individual basis. In order to be eligible, you must have been insured with a private insurer for an uninterrupted period during the last 2 years.

The entitlement to continuation also applies for family members, if they were affiliates at the time of forfeiture of the corporate-sponsored policy.

Affiliation to the corporate-sponsored health cover agreement (health care/guaranteed income) terminated on ...../...../.....

In order to continue this (these) corporate-sponsored insurance(s) on an individual basis, the attached document must be forwarded, **fully completed**, to AG at the address under reference within **30 days after receipt of this letter**. You are entitled to further extend this term for a supplementary period of 30 days provided you inform AG thereof by letter or by email.

This information is provided to the employer as stipulated in article 208 of the law of 4 april 2014 on insurance of the above-mentioned law.

Made out in ....., on ...../...../.....

Signature of the employee: Signature of the employer:

(*) If the employee is affiliated to various health covers, would you please mention any of the reference numbers, preferably the hospitalization insurance.

(**) Please cross your choice.

Group Insurance (Health Care)

Individual continuation of the corporate-sponsored health cover

This document makes it possibly to apply for an individual insurance.
This application does not bind you to closing an agreement.

Kindly complete, sign and return the form by e-mail to: hospi.retail@aginsurance.be.
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To be filled in by the employee

Data of the employer who offered the corporate-sponsored health cover

Name of the employer: .....

Date on which your employer informed you of the loss of the corporate-sponsored health cover: ..... / ..... / .....

Identity of member of personnel

Name: ..... First name: .....

Gender*: ☐ M ☐ F Date of birth: ..... / ..... / .....

Street: ..... N°: ..... B: .....

Postal Code: ..... City: .....

Phone number: ..... Fax: .....

Email (private): .....

Hospitalization cover

Group n°: ..... S/Groupe n°: ..... Contract n°: .....

Date on which the hospitalization cover was started? ..... / ..... / .....

Date on which the hospitalization cover was ended? (This date has been communicated by your employer) ..... / ..... / .....

Please give an overview of all your hospitalization covers during the last 2 years? Private cover as well as cover offered by the employer:

	Beginning	Ending	Insurance Company	Employer (if any)
1	..... / ..... /	..... / ..... /	.....	.....
2	..... / ..... /	..... / ..... /	.....	.....
3	..... / ..... /	..... / ..... /	.....	.....
4	..... / ..... /	..... / ..... /	.....	.....
5	..... / ..... /	..... / ..... /	.....	.....

The data of the members of family who were covered by the collective Insurance and wish to continue their cover on an individual basis:

Family	Name & First name	Date of birth	Gender*	Postal code
Spouse/Partner	.....	...../...../.....	☐ M ☐ F	.....
1st child	.....	...../...../.....	☐ M ☐ F	.....
2nd child	.....	...../...../.....	☐ M ☐ F	.....
3rd child	.....	...../...../.....	☐ M ☐ F	.....
4th child	.....	...../...../.....	☐ M ☐ F	.....
5th child	.....	...../...../.....	☐ M ☐ F	.....

Are you affiliated to AG Care Vision or AG Care Vision Full?* ☐ Yes: contract n°: 04/8 .....

☐ No

Other Health Care Cover(s)

If you wish to continue an other Health Care Cover, please mention the cover:

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As a data controller, AG processes your personal data for the purposes mentioned in the general terms and conditions, and in particular with a view to manage your hospitalization insurance. More information about the processing of your personal data can be found in the general terms and conditions and in our Privacy Notice on www.aginsurance.be.

Made out in ....., on ...../...../.....

Signature of the affiliate:

Please send your application to:
hospi.retail@aginsurance.be
OR
AG
Employee Benefits – Health Care 1JQ5B
Boulevard Emile Jacqmain 53
1000 Brussels

* Please cross your choice.

AG Insurance (abbreviated AG) SA/NV - 53 blvd E. Jacqmain, 1000 Brussels - www.aginsurance.be - info@aginsurance.be - IBAN: BE13 2100 0007 6339 - BIC: GEBABEBB - RPM/RPR Brussels - VAT BE 0404.494.849 - Belgian insurance company licensed under code 0079, under the supervision of the National Bank of Belgium, 14 blvd de Berlaimont, 1000 Brussels