(To be completed by the employee)

17 Acropoleos Ave., 2006 Strovolos, Nicosia
P.O.Box 20819, 1664 Nicosia
Tel.: 22 363496, Fax: 22 363400

Application Form for Members

Group Policy No. GP- **GROUP INSURANCE POLICY**

A. Employee Details

Surname:		**I.D. Number (or Passport No. only for foreigners):**	
Name:		**Middle Name:**	
Nationality:		**Date of Birth:**	...../...../..... **Age:**
Family Status:		**Gender:**	☐ Male ☐ Female
Name of Employer:		**Height - Weight:**	.....cm .....kg
Home Address:		**Telephone No:**	
Bank Name:		**Bank Account No:**	
IBAN No. :		**Email:**	

Note: The Bank Account will be used by CNP Cyprialife only for the purpose of paying claims by Direct Credit.

B. Details of Dependant Members

Note: To be completed only if dependants will participate in the Group Insurance Policy

Name/Surname	I.D. Number / Passport No.	Date of Birth	Relationship	Height - Weight
1.		..... / ..... /		-
2.		..... / ..... /		-
3.		..... / ..... /		-
4.		..... / ..... /		-

C. Health questionnaire of proposed insured persons

Please answer the following questions regarding:

- *Your health state.*
- *The health state of your dependant members, whom insurance cover is requested.*

- Name and address of your personal physician .....
- When did you last visit the doctor and for what reason? Give results .....

.....

Give his/her name and address if this differs from your personal doctor .....

- What is your daily consumption of: Alcohol ..... Cigarettes .....

Please answer the following questions by marking "X" in the relevant box	***YES***	***NO***
1. Have you at any time suffered or do you now suffer from:		
a) Diseases of the circulatory system (e.g. heart problem, chest pain, rheumatic fever, blood pressure, diseases of the arteries or veins)?		
b) Diseases of the respiratory system (e.g. tuberculosis, asthma, persistent cough, pneumonia)?		
c) Diseases of the genitor-urinary system (e.g. infections of the kidneys, urinary or genital organs, renal stones, venereal disease)?		
d) Diseases of the gastro-intestinal system (e.g. digestive disorders, gastric or duodenal ulcer, hepatitis B or other disorders of the liver or gall bladder)?		
e) Diseases of the nervous system or mental disorders (e.g. epilepsy, fits or fainting attacks, frequent headaches or nervous breakdown)?		
f) Diabetes or any disease of the blood, glands, spleen or skin?		
g) Unexplained night-sweats and/or loss of weight, persistent fever, chronic or recurrent diarrhoea, unexplained inflections of swollen glands?		
h) Do your suffer from eye or ear disease or from paralysis, varicose veins, hernia, intervertebral disc problem, multiple sclerosis, Parkinson's disease, cancer, leukaemia, poliomyelitis, muscle dystrophy, liver cirrhosis, coccyx cyst, pilonidal sinus, haemorrophilia or any other disease, disorder, defect or injury?		
2. Have you ever undergone any surgery?		

	YES	NO
3. Are you currently undergoing any medical observation, receiving any treatment or takin medicine?		
4. Have you ever tested positive for COVID-19?		
5. Have you ever had or been advised to have blood tests in connection with any viral disease (e.g. glandular fever, hepatitis, acquired immune disease system – AIDS or other relative diseases) or for any sexually transmitted disease? If yes, have you undergone any therapy?		
6. Have you received any blood transfusions within the past five years?		
7. Do you have any form of disability (e.g. blindness, deafness)?		
8. Have you ever had accidents?		
9. Have you ever received, or currently receive any disability benefit?		
10. Has any proposal for life, health or personal accident insurance ever been declined or accepted with special terms, or changed even if it did not proceed?		
11. Have you ever had any other health problems which are not mentioned above?		
12. Has any of your immediate family (father, mother, siblings) ever had or died from diabetes, heart or circulatory diseases, stroke, kidney disease, cancer, multiple sclerosis, mental disease or any heredity disease? Please list any such condition and the age at diagnosis below.		
13. FOR FEMALES ONLY ➢ If you are pregnant, please give us the month of your pregnancy: ……		
14. Do you have any other insurance with CNP Cyprialife? ➢ If yes, please give the Policy No. ……		

ATTENTION:

If you have given a positive answer on one or more of the questions above, regarding your health and/or your dependants which you have listed on this application, please give full details below: the name of the person for which a positive answer was given, as well as any other relevant information (e.g. disease, date, duration, medical results, names of physicians or hospitals e.t.c.) by marking the question number.

D. Table of additional declarations regarding the positive answers of the health questionnaire

Question Number	Name of proposed insured member	Additional information for positive answer

E. Information

In the context of your inclusion in the Group Policy mentioned above, CNP CYPRIALIFE LTD (the "Company") intends to collect and process the personal data that concern you, as well as the data of the persons mentioned in your application. The Company requests data which are necessary and relevant to purpose of examining your application. Certain data that concern you will be forwarded to the Company's associates for the purpose of evaluating your application (such as doctors for instance).When the Company collects and processes personal data, it ensured that this is carried out in a legitimate manner and that all necessary measures are taken in order to ensure their safety. For more information, please refer to the Company's Privacy Policy that is available in our website. Signatures of consent are required by the Insured member, his/her spouse and dependents (where applicable) of **sections A, B and C.**

E. Declaration of good health

I solemnly declare that all the answers given above are true, accurate and complete and that I have not omitted to mention any material information or facts that may affect the acceptance of this Application by the Company. I agree that the Application will form the basis for my insurance under the Group Policy.

I also declare that I have informed the individuals whose details are contained in this Application regarding the provision of their personal data by me to CNP CYPRIALIFE LTD.

Signature of Employee: ……..

Date: ..... / ..... / .....

Signature of Dependant……

Signature of Dependant .....……

Signature of Dependant .....….

Signature of Dependant.....….

INTERNAL USE ONLY

Comments:……

……

☐ Accepted

☐ Declined Signature of Underwriter…… Date: ……/……/……

A. CONSENT FORM FOR THE PROCESSING OF PERSONAL DATA

Purpose of collection and processing

CNP CYPRIALIFE LIMITED («CNP CYPRIALIFE»), its intermediaries and associates, within the context of the provision of insurance services (including, inter alia, the examination of the Proposal for the provision of insurance services, the pricing and collection of premiums, the assessment of a claim for the payment of compensation) intends to collect and process personal data that concern you or concern minors on whose behalf you provide their consent as their guardian. It is necessary that we collect and process such data so that we can provide you with insurance services.

CNP CYPRIALIFE'S Policy for the Processing of Personal Data

When CNP CYPRIALIFE collects and processes personal data, it ensures that this is carried out lawfully and that all necessary measures are taken so as to ensure their safety. CNP CYPRIALIFE's Policy for the Processing of Personal Data, which you may find on www.cnpcyprialife.com contains further information on the processing of personal data that is carried out; please read it carefully.

Categories of Personal Data

For the provision of insurance services we collect and process the following main categories of Personal Data:

- Personal data and identification data,
- Financial information and bank account information,
- Information concerning your health status, as well as information concerning your way of living,
- Family history, for instance, whether one of your parents or siblings has been affected by an illness,
- Information obtained through the use of our website and software applications (apps),
- Information you provide during a phone call with CNP CYPRIALIFE,
- Insurance history,
- Risk assessment information depending on the product you are interested in.

Withdrawal of consent

In case you wish to withdraw your consent to the processing of your personal data, please let us know in writing by sending a letter at the address 17, Acropoleos Avenue, Strovolos, P.O. Box 20819, 1664 Nicosia or dpo@cnpcyprus.com.

Please note that if you withdraw your consent, we may not be able to provide our insurance services to you.

Consent declaration

I have read the contents of this form which has been provided to me by CNP CYPRIALIFE and I consent to the collection and processing of the personal data described above for the purpose of providing insurance services.

Name and Surname	**Signature**
Insured Person:……	……
Dependant:……	……
Dependant:……	……
Dependant:……	……
Date:……	

Direct marketing

I wish to be informed of the services, products or plans offered by CNP CYPRIALIFE from time to time. For this purpose, I consent to the processing of my personal data by CNP CYPRIALIFE for the purpose of sending such information and communications.

Name and Surname	**Signature**
Insured Person:……	……
Dependant:……	……
Dependant:……	……
Dependant:……	……
Date:……	

B. AUTHORIZATION FOR THE COLLECTION AND PROVISION OF PERSONAL DATA

I hereby authorize CNP CYPRIALIFE LIMITED (hereinafter referred to as "the Company") to communicate with medical practitioners, health professionals, clinics and other healthcare organizations that have occasionally seen and treated me and/or the Dependent Persons who are included in the Insurance Application as well as other insurance companies to which I and/or the Dependent Persons have applied from time to time for insurance cover and to collect the necessary medical information regarding my physical or mental condition and/or the physical and mental condition of the Dependent Persons for the purposes of the Insurance Application as well as the management, servicing and execution of the Insurance Policy, through which insurance coverage is provided by the Company.

I hereby further authorize the above mentioned medical practitioners, healthcare professionals, clinics, other healthcare providers and insurance companies to provide the Company with the necessary medical information that will be requested from them by the Company for the above-mentioned purposes.

Name and Surname	**Signature**
Insured Person:……	**…….**
Dependant:……	**…….**
Dependant:……	**…….**
Dependant:……	**…….**

Date: ……..

C. AUTHORIZATION FOR THE COLLECTION AND PROVISION OF INSURED'S PERSONAL DATA

Name of Main Insured member:……

Name of Policy Owner: ……..……

Relationship with Policy Owner: ……..…….....
(Employee, member of Association / Union / Organization)

I hereby authorize the above mentioned Policyholder / Main member (*) to contact and provide CNP CYPRIALIFE LIMITED (hereinafter referred to as "the Company"), on my behalf and on my account, with my personal data, including data concerning my health, for the purposes of the Insurance Application as well as for the management, serving and execution of the Insurance Policy, through which insurance cover is provided to me by the Company. I hereby further authorize the Company to provide the Policyholder / Main member (*) with personal data relating to me, including health data, for the above-mentioned purposes.

Name and Surname	**Signature**
Insured Person:……	**…….**
Dependant:……	**…….**
Dependant:……	**…….**
Dependant:……	**…….**

Date: ……..

(*) If applicable