YapıKredi Sigorta

YapıKredi Emeklilik

INSTITUTIONAL INSURANCE APPLICATION FORM

- ✔ In case any incomplete or incorrect information declared within this form, Yapı Kredi Sigorta A.Ş./Yapı Kredi Emeklilik A.Ş. preserve the right not to reimburse the indemnity and /or cancel the insurance policy in conformity with the provisions of Turkish Trade Law and General Conditions of Health Insurance.
- ✔ **Yapı Kredi Sigorta A.Ş./Yapı Kredi Emeklilik A.Ş. shall have the right to access the data and documentation from the doctors, health institutions and other relevant authorities with respect to the declarations specified within this form by the insured person and respect to the treatments.**
- ✔ In case any incomplete information or additional examination, all requests will be notified to the applicant or institutional authorities in written format. The applicants may be included in the cover of the policy after the requested forms / documents are reached to and evaluated by the Yapı Kredi Sigorta AŞ./Yapı Kredi Emeklilik A.Ş.
- ✔ **It is sufficient to fill in a single form for the employee together with the members of his/her family to be included into the scope of the insurance. All forms shall be signed by the employee.**

WILL BE FILLED OUT BY THE INSTITUTE AUTHORITY

The requested date when the employee will be included in the cover of the policy :

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

Company Name		**Home Phone**	
Job / Title		**Office Phone**	
Beginning Date of Employment		**GSM**	
Martial Status		**e-mail**	

Bank account information that the medical costs will be wired

Bank Name		Name/Code of the branch		IBAN	T R

	Employe	Spouse	1st Child	2nd Child	3rd Child	4th Child
Name						
Surname						
Father's Name						
Nationality						
Identity Card Nr.						
Tax Registration Nr.						
Local Tax Office						
Gender						
Height/Weight						
Date of Birth						
Occupation						

* *This field must be filled by Turkish Citizens.*
** *This field must be filled by persons of foreign nationality.*

1- Do the individuals to be insured have an active, expired, rejected or cancelled life or health insurance policy?
(If yes, please indicate the name of the insurance, insurance company, application/policy number, the reason(s) if rejected or cancelled and any illness excluded (deducted) from the insurance policy.) Yes ☐ No ☐

Insurance Name :..... Title of Company :..... Application/Policy Nr:.....

Commencement Date of Insurance : ☐☐/☐☐/☐☐☐☐ Expiry Date of Insurance : ☐☐/☐☐/☐☐☐☐

Names of the Family Members Covered :.....

Reason of Cancellation/Rejection : .....

Illness(es) Excluded by Insurance : .....

2 - Does or did the applicant or his/her spouse to be insured smoke or use alcohol?
(In case other tobacco products like cigar, pipe, water-pipe, etc. are used, it shall be written on the explanation part.) Yes ☐ No ☐

Applicant: : Smoking .....piece/day for.....years quit for..... years Alcohol .....glass/week for .....years quit for..... years

Spouse : Smoking .....piece/day for.....years quit for..... years Alcohol .....glass/week for .....years quit for..... years

Explanation : .....

3 - Is the applicant or applicant's spouse to be insured pregnant? Yes ☐ No ☐

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Please also fill in the back page completely ☞

4 - Is there any abnormal variation in laboratory parameters (blood, urine etc.) of the individuals to be insured determined? Is there any treatment under continuous control (Hypertension, cholesterol, hormonal disorder of prolactin, high blood sugar or etc.)?
(If yes, please indicate the name of the individual, high examination results and enclose copies of examination results, if any.) Yes ❑ No ❑

5 - Did the individuals to be insured suffer from any disorder or have any surgical operation?
Do they have any current illness that requires a surgery or any disorder (even it is under control)?
(If yes, please indicate the individual's name, illness, date, medical institution, types of medical intervention, drug names and dosage.) Yes ❑ No ❑

6 - If the individuals suffer or suffered from any one of the illnesses listed below or related illnesses still continue, please mark the side box and define individual's name, duration of treatment by indicating diagnosis or kind of treatment, name of doctor and health institution, and final health status.
Please also enclose copies of surgery report, pathology report and final inspection reports to this form.

- ❑ High Blood Pressure-Hypertension
- ❑ Cardiovascular Diseases (Coronary Disease, etc.)
- ❑ Allergy, Asthma and Tuberculosis
- ❑ Other Lungs Diseases
- ❑ Diabetes
- ❑ Thyroid (Goiter)
- ❑ Hormonal Diseases
- ❑ Liver Diseases
- ❑ Pancreatic or Splenetic Diseases
- ❑ Abdominal, Navel, Inguinal, Stomach Hernia
- ❑ Stomach Ulcer, Reflux and Other Stomach Diseases
- ❑ Colitis (Crohn, Ulcerative), Diverticula or Other Intestinal Diseases
- ❑ Kidney and Urinary Tract Diseases (Stone, Nephritis, Nephrectomy etc.)
- ❑ Prostate, Male Genital Organ Disorders
- ❑ Gynaecological Diseases (Uterus, Ovary and Other Gynaecological Diseases)
- ❑ Breast Diseases
- ❑ Aesthetic-Reconstructive Surgery
- ❑ Ear, Nose and Throat Diseases
- ❑ Eye Diseases and Eye Refraction Disorders 6 or Over Degrees
- ❑ Rheumatic Diseases
- ❑ Muscle, Connective Tissue or Bone Diseases
- ❑ Hernia of the Loins, Cervical Discal, Dorsal and Other Spinal Diseases
- ❑ Cerebral and Cerebrovascular Diseases
- ❑ Other Nervous System Diseases (Paralysis, Epilepsy, MS, etc.)
- ❑ Tumour (Nonmalignant, Benign), Nodule, Cyst
- ❑ All Kind of Cancer
- ❑ Blood Diseases
- ❑ AIDS and HIV Type Viruses and Related Diseases
- ❑ Nervous Diseases / Mental Disorders (Depression, Panic Attack, etc.)
- ❑ Other Diseases (Varicosis, Dermoid Cyst, Hemorrhoid, Anal Fissure, etc.)

Name Surname	Name of Illness	Treatment	Date	Doctor/Hospital	Current Status

7 - For the cases other than aforementioned, is there any other medical problem of the individual to be insured, whether or not it requires a doctor's inspection?
(If yes, please indicate the name of the individual and illness.) Yes ❑ No ❑

With respect to the conditions of the insurance, I herewith acknowledge and agree that Yapı Kredi Sigorta A.Ş./Yapı Kredi Emeklilik A.Ş. will not be considered to assume any obligation in connection with Medical History Declaration Form that I have filled in a complete manner and disclosed all the relevant information that must be submitted to Yapı Kredi Sigorta A.Ş./Yapı Kredi Emeklilik A.Ş., and that I have not declared any incorrect and/or insufficient information, and that I accept the exclusion of any illness or disorders that I have suffered before or during the course of the signature of this form, otherwise any dispute thereof will not induce any responsibility whatsoever to Yapı Kredi Sigorta A.Ş./Yapı Kredi Emeklilik A.Ş., and I authorize Yapı Kredi Sigorta A.Ş./Yapı Kredi Emeklilik A.Ş. to access the data and documentation from the doctors, health institutions and other relevant authorities with respect to the declarations I specified within this form.

EMPLOYEE		Date
Name, Surname	Signature	

PLEASE, BE SURE TO FILL IN BOTH PAGES COMPLETELY AND TOGETHER WITH THE DATE AND SIGNATURE.