

DENTALIS

REGISTRATION REQUEST

« DENTALIS : A dental insurance at unbeatable prices »

I, the undersigned : Name : First name :
 Street : Nr. : Box :
 Postal code : City :
 Telephone : E-mail :
 Financial account (IBAN) : _____

National registration nr. :

Request the registration to DENTALIS dental insurance

From __ / __ / ____

For the persons listed below :

Please affix a sticker from your mutual health insurance company

NAME	FIRST NAME	NATIONAL NUMBER (or date of birth)	SEX (M/F)

CERTIFICATE OF COVERAGE				
<i>(Table to be completed by your previous insurance company)</i>				
We hereby declare that the persons listed below had a dental insurance at our company.				
Insured person(s)	Date of birth	Starting date of the contract	End date of the contract	Start payments of premium
Type of coverage :				
Insurance company's name :				
Name :		Signature and stamp :		

Neutra Mutual Insurance Company treats the data mentioned on this form in accordance with the Act of 8 December 1992 on the protection of privacy in relation to the processing of personal data. The data you transmit to Neutra Mutual Insurance Company are processed as part of the intervention by your Neutra insurance and will only be transferred to the members of the staff who treat your file. Every person whose data are processed, has the possibility to consult or correct these data, or, if there is a good reason, have them erased by means of a written request mentioning the date and their signature. This request has to be sent to Neutra Mutual Insurance Company, with a copy of the ID-card.
 By signing this request, I allow Neutr M.I.C. to process my personal and medical data.

Drawn up on __ / __ / ____ in Signature :

**TO FILL IN IF A COUNSELOR OF YOUR MUTUAL
HEALTH INSURANCE COMPANY GAVE YOU ADVICE
DUTY OF INFORMATION
FORM FOR A DENTAL INSURANCE - DENTALIS (No-Life)**

Member data : I the undersigned : Name : First name :

Already subscribed to a hospitalization insurance : Yes No

Written proof of the advice :

After having received all the requested information, I decide, with full background knowledge, to subscribe to the DENTALIS dental insurance.

The member expressly acknowledges that he has accurately represented all circumstances known to him that might influence the advice given by NEUTRA Mutual Insurance Company. The member also acknowledges that the content of the insurance contract that he chose corresponds to the analysis of his needs and requirements and that he was informed on the range and limits of this contract.

I acknowledge that I have been informed on the capacity of the counselor.

Done in two copies, one of which is passed on to the member.

Drawn up on __ / __ / ____ in

Signature of the policyholder :

« Read and approved »

Name and first name of the counselor :

Acting as :

person in contact with the public at Symbio

responsible for distribution at Symbio

.....

Signature of the counselor :

In accordance with the Act of 8 December 1992 on the protection of privacy in relation to the processing of personal data, you have a right to access and rectify data concerning you. More information on this matter can be obtained by contacting the Commission for the Protection of Privacy, Rue de la Presse 35 - 1000 Brussels (02/274.48.00 - www.privacycommission.be). Do you want to express a complaint? All complaints should be directed in writing to the M.I.C. NEUTRA (address: Rue de Joie 5, 4000 Liège - fax : 04/254.54.37 - e-mail : gestion-des-plaintes@neutrahospi.be). If you are not satisfied with the written response you have received and the disagreement persists, you can contact the Insurance Ombudsman (Square de Meeûs 35 - 1000 Brussels - phone : 02/547.58.71 - Fax : 02/547.59.75).