HOSPITALIZATION

REGISTRATION REQUEST FOR NEUTRA

I, the undersigned : Name : ..... First name :.....

Street : ..... Nr. : ..... Box : ...

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

Telephone : ..... E-mail : .....

National registration number : .....

Financial account (IBAN) : __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

Request the registration from : _ _ / _ _ / _ _ _ _

☐ to Neutra Base ☐ to Neutra Optimum ☐ to Neutra + ☐ to Neutra Comfort ☐ to Neutra Top

For the persons listed below :

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

Were the above mentioned people already covered by a different hospitalization insurance ? ☐ Yes ☐ No

If so, at which company ? .....

From _ _ / _ _ / _ _ _ _ to _ _ / _ _ / _ _ _ _ *(please join a certificate from this company)*

Additional fee **percentage** to be charged in case of hospitalization:

..... % INAMI price or ..... % real costs.

Medical history of the people requesting their registration :

.....

.....

By signing this application form, I agree to comply with the statutes and internal regulations of the NEUTRA Mutual Insurance Company. I also agree to sign up and pay for the advantages and services organized by Symbio, Mutualité Neutre.

Drawn up on _ _ / _ _ / _ _ _ _ in ..... Signature : .....

Please affix a sticker from your mutual health insurance company

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).

- Please turn over -

TO FILL IN IF A COUNSELOR OF YOUR MUTUAL HEALTH INSURANCE COMPANY GAVE YOU ADVICE

DUTY OF INFORMATION

FORM FOR A HOSPITALIZATION INSURANCE (No-Life)

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

What are your needs and expectations ?

Coverage for hospitalization fees :	☐ Reimbursement of the real cost	☐ Flat-rate reimbursement
Coverage in case of serious illness :	☐ Yes	☐ No
Coverage in private room :	☐ Yes	☐ No
Coverage for dental care :	☐ Yes	☐ No
Coverage abroad :	☐ Yes	☐ No

What's your current situation ?

Already subscribed to a hospitalization insurance :	☐ Yes	☐ No	
Family situation :	☐ Single	☐ Couple	☐ Children (number : .....)
Available income :	☐ High	☐ Medium	☐ Low

Written proof of the advice :
Based on the above mentioned information and in an effort to avoid each form of over-insurance, under-insurance or inadequate coverage, **we recommended our member to subscribe to the following product**:

.....

The member chose : ☐ Neutra Base ☐ Neutra Optimum

☐ Neutra + ☐ Neutra Comfort ☐ Neutra Top

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 :.....