reinventando los seguros

Seguro de Estudios
Boletín de Adhesión

General details

Product 2329 – School Fees Insurance

Policyholder details

Name/Corporate name

Intermediary | Office | Tax ID No./Code | Policy No.

Details of the person to be insured: 1st insured

Name/Corporate name | First surname | Second surname (if applicable)

Tax ID No./Code | Address | No. | Floor (other)

City or town | Postcode | Province | Nationality

Date of birth | Sex | Occupation | Certificate no.

Landline | Mobile | Email | Country of tax residence

Details of the person to be insured: 2nd insured (to be completed in cases of joint life insurance)

Name/Corporate name | First surname | Second surname (if applicable)

Tax ID No./Code | Address | No. | Floor (other)

City or town | Postcode | Province | Nationality

Date of birth | Sex | Occupation | Certificate no.

Landline | Mobile | Email | Country of tax residence

Children's details

First child's school year | Second child's school year | Third child's school year

Fourth child's school year | Fifth child's school year | Sixth child's school year

Beneficiaries

In case of death: as shown in the policy.
In case of disability (if taken out in the policy): the insured.

Consent and authorisation clause

In compliance with Spain's Data Protection Act 15/99, of 13 December, the applicant is hereby informed of **and authorises the inclusion of their personal data in files belonging to AXA AURORA VIDA, S.A. DE SEGUROS Y REASEGUROS and the processing of such data** to handle their application. The provision of personal data in the application form is completely **voluntary** but **necessary** for handling the application. The applicant consents to the processing of their personal data, including health data, by the insurer and to the release by the insurer of their data to doctors, health centres, hospitals and other institutions or organisations which, in accordance with the purpose and object of the contract and for reasons of reinsurance and coinsurance, are involved in the management of the policy, including the insurance intermediary. The data shall be appropriate, relevant and not unreasonable for the stated purpose in relation to the contract of insurance.

The applicant may write to AXA SEGUROS E INVERSIONES, (Departamento de Marketing-CRM), Calle Emilio Vargas, 6, 28043 Madrid, or call either 901 900 009 or 93 366 93 51 to exercise their rights to access, rectify, erase and object to the use of their personal data under the terms laid down by prevailing legislation.

The undersigned applicant warrants that they have answered all the questions in the health questionnaire honestly and acknowledges that the answers they have given will be used as the basis for the risk assessment by AXA AURORA VIDA, S.A. DE SEGUROS Y REASEGUROS. They further accept the legal consequences of any omissions or untruthfulness.

In witness whereof:

In _____ on _____ _____ _____

1st insured's signature

2nd insured's signature

Representations by the person to be insured: 1st insured

Please answer the questions and mark the boxes with an "X" as appropriate

Height _____ cm Weight _____ kg Blood pressure _____ maximum _____ minimum

	Yes	No
1. Are you currently in good health with no symptoms of illness?	☐	☐
2. Are you on sick leave due to illness or accident?	☐	☐
3. Do you have any illnesses that require medical care?	☐	☐
4. Have you had any illnesses in the last five years?	☐	☐
5. Do you have any physical or mental disability?	☐	☐
6. Have you had any serious accidents, or have you undergone or are you going to undergo surgery?	☐	☐

If you answered "Yes" to any of questions 2, 3, 4, 5 or 6, please fill in the following information:

1. Nature of the illness or injury

2. Date, approximate duration and current state

3. Name and address of the doctors or institutions that have provided you with care

The insured states that they have answered the above questions completely and truthfully. They authorise doctors, medical institutions and other insurers to provide the insurer with the information required for this application or in order to settle a future claim.

In _____ on _____ _____ _____ 1st insured's signature

Representations by the person to be insured: 2nd insured (to be completed in cases of joint life insurance)

Please answer the questions and mark the boxes with an "X" as appropriate

Height _____ cm Weight _____ kg Blood pressure _____ maximum _____ minimum

	Yes	No
1. Are you currently in good health with no symptoms of illness?	☐	☐
2. Are you on sick leave due to illness or accident?	☐	☐
3. Do you have any illnesses that require medical care?	☐	☐
4. Have you had any illnesses in the last five years?	☐	☐
5. Do you have any physical or mental disability?	☐	☐
6. Have you had any serious accidents, or have you undergone or are you going to undergo surgery?	☐	☐

If you answered "Yes" to any of questions 2, 3, 4, 5 or 6, please fill in the following information:

1. Nature of the illness or injury

2. Date, approximate duration and current state

3. Name and address of the doctors or institutions that have provided you with care

The insured states that they have answered the above questions completely and truthfully. They authorise doctors, medical institutions and other insurers to provide the insurer with the information required for this application or in order to settle a future claim.

In _____ on _____ _____ _____ 2nd insured's signature