



Ambler Correduría de Seguros, SL
 Contact Telephone: 93 238 71 10

POLICY/FAMILY N°:-----
EFFECTIVE DATE:-----

BULLETIN FOR ADHESION TO GROUP POLICY

TAKER OF THE INSURANCE		T.I.N:	
Insured	Name:		Surnames:
	Sex:	Date of birth	
	Passport Number .:		
	Profession:		
Home address	Address :	City:	Zip Code:
Individual	Province:	Country:	Private telephone:
	Mobil Telephone:		
Service payment	Bank.:	A/C.	
	Account holder's name		

START DATE: **END DATE**

STATEMENT OF HEALTH

Weight _____ / Height _____

- ANSWER "YES" or "NO"
- Do you have any chronic diseases or have you suffered from any conditions that have incapacitated you for more than 15 days?
 - Have you had or are you going to have a surgical operation / treatment at a health centre?
 - WOMEN ONLY- Have you suffered from any gynaecological conditions? _____ Are you pregnant? _____ If so, do you wish to pay the pregnancy excess? _____ (the cost of the pregnancy excess is 2025 Euros)
 - Do you have or have you had any similar policies for the cover applied for? (If so, indicate the Company, cover insured and whether it is still valid): _____

This application does not oblige the Entity to enter into the Insurance contract, nor does it give any rights to use the benefits therein until such time as MAPFRE CAJA SALUD S.A., accepts the application by issuing the corresponding policy and provided that, unless otherwise agreed, the first insurance premium is paid. If any of the policy holders do not have Foreigner Identity Card Numbers, they undertake to provide MAPFRE CAJA SALUD, S.A. with these as soon as they are available.

The undersigned expressly authorises the medical department of MAPFRE CAJA SALUD to, as appropriate, request the appropriate doctors or institutions to obtain the information required to assess the risk, for managing incidents and authorising future services.

The policy holder recognises their responsibility for statements made above regarding their state of health and that of their family, even though they may not be in their handwriting, and is aware that any omissions or inaccuracies may lead to the reduction or even the total loss of the cover guaranteed.

In on of of
Signature of the policy holder

COVER (mark the correct box with an X)

Broad Cover Buccodental Cover ASSISTANCE Buccodental Cover YES NO

Notes			Contracte control
SURCHARGE	Profession	Disease	

Bulletin for promotional period valid until ----- 2007

The policies are taken out with the MAPFRE. S.A. insurance company