Policy Alteration Form

This document must be printed out, filled out and uploaded onto myeurolife portal.

I the undersigned _____

with Identity Card number _____ , do state that I wish to make the following alteration to my Insurance

Policy number: _____

Check ✔ the correct box:

☐ **1. Change premium allocation**

The premium allocation of Funds to be altered as follows:

Balanced: _____ % Income: _____ % Growth: _____ % Conservative: _____ %

Note

I acknowledge that this alteration will apply as of the date of the next premium due.

☐ **2. Transfer Units/Value from Fund to Fund**

☐ Transfer percentage _____ % of Units or Value of units in € _____ from the Balanced Fund to the _____ Fund.

☐ Transfer percentage _____ % of Units or Value of units in € _____ from the Income Fund to the _____ Fund.

☐ Transfer percentage _____ % of Units or Value of units in € _____ from the Growth Fund to the _____ Fund.

☐ Transfer percentage _____ % of Units or Value of units in € _____ from the Conservative Fund to the _____ Fund.

Note

I acknowledge that this alteration will apply as of the date of filing of my application, according to the Redemption Price on the Evaluation Date that follows the effective date of the Alteration.

☐ 3. Change frequency of premium payments

Depending on the Basic Plan, premiums can be paid monthly, quarterly, semi-annually or annually.

From monthly to _____ From quarterly to _____

From semi-annual to _____ From annual to _____

Note

I acknowledge that my request will take effect according to the commencement date of my policy. Regarding Additional Benefits and Basic Plans not linked to investment units, where the premium is paid other than annually, an additional charge applies on the premium - 5% for the monthly schedule, 4% for the quarterly schedule and 2% for the semi-annual schedule.

☐ 4. Add/Increase the Annual Claims Excess Amounts for the medica health program

Depending on your selection, the Annual Claims Excess Amounts may be €500, €1,000, €2,000, €5,000, €8,000, €10,000 or €20,000.
The Annual Claims Excess Amount may be increased from _____ , to _____ .

Note

Due date is subsequent to the filing of the application.

- For the Medica health program, in the event of treatment abroad the Annual Claims Excess Amount of up to €2,000 does not apply. An Annual Claims Excess Amount greater than €2,000 will be reduced by 50%.
- The platform cannot be used to apply for a reduction in the excess amount. Please contact your insurance advisor.

☐ 5. Add/Deduct/Amend outpatient cover - Medica Plus or Medica Comfort

A. Medica Plus

The plan offers all the benefits of the Medica health program, while also offering outpatient benefits, meaning cover for medical incidents not requiring hospital treatment.

Options

Option 1 - Full Package
Option 2 - Covers €20 for doctor's fee per visit
Option 3 - no cover for doctor's fee

☐ To add the option for outpatient cover for Medica Plus, select:

Option 1 ☐ Option 2 ☐ Option 3 ☐

☐ Change from Option _____ to Option _____ .

☐ To remove the option for outpatient cover for Medica Plus, select:

Option 1 ☐ Option 2 ☐ Option 3 ☐

B. Medica Comfort

This program offers outpatient benefits, meaning cover for medical incidents not requiring hospital treatment. It also combines with the inpatient benefits of the Medica health program, offering the option to select the Annual Claims Excess Amount for Inpatient Care.

Options

Option 1 - Covers 5 visits with €40 for doctor's fee
Option 2 - Does not cover doctor's fee

☐ To add the option for outpatient cover for Medica Comfort, select:

Option 1 ☐ Option 2 ☐

☐ Change from Option _____ to Option _____ .

☐ To remove the option for outpatient cover for Medica Comfort, select:

Option 1 ☐ Option 2 ☐

Note

I acknowledge that this alteration will apply as of the next policy anniversary.

For other changes/alterations, deduction/reduction of cover, premium reduction, redemption of investment units, etc., please contact your Insurance Advisor.

I hereby do affirm that I have discussed with my insurance advisor the above alteration which I am applying for:

Full Name of Insurance Advisor: _____

Insurance Advisor's Code: _____

Signature: _____ Date: / /