



APPLICATION FORM

A SUBSCRIBER *Name and reference code of Golden Care counsellor.....*

As a subscriber to the Plan, you are the legal representative towards Golden Care of all persons to insure included on this Application Form. A subscriber may choose not to be insured if cover is required for dependant(s) only.

■ **1 • You, Subscriber**

a- Mr. Mrs Miss Other b- Single Married Divorced Widow(er)

c- Surname:

d- First name(s) :

e- Gender : ... Male Female

f- Birth date: Day ___ Month ___ Year _____ g- Country of birth:

h- Nationality :..... i- Profession :.....

j- Address of usual residence:.....

Zip/City :..... Country :.....

(If usual residence is different from above for a person to insure on this form, please specify address on a separate sheet).

■ **2 • Your postal address:**.....

Zip/City:..... Country :.....

■ **3 • Your contact numbers** (please specify the country and area codes)

Pers.: Prof.: Fax:

Email:

■ **4 • Preferred language of correspondence:** English French German

B COVERAGE

■ **1 • Choose your plan and deductible:**

EveriCover, with a deductible of CHF: 75 400 800 1 500 4 000 8 000 15 000

Hospicover, with a deductible of CHF: 75 400 800 1 500

Accicover : no deductible

■ **2 • Do you wish to choose the EveriCover Plus option** (if you have selected EveriCover with a CHF 75 or CHF 400 deductible)? Yes No

■ **3 • Specify the effective date desired** (at earliest at noon, the day following the receipt of your application)

Day_1_ Month ___ Year _____ or Day_15_ Month ___ Year _____

■ **4 • Do you currently have a health insurance coverage?** If yes, please specify :.....

C PERSONS TO INSURE

■ **1 • Fill out the section below, after reading the following specifications:**

- Area 1: Worldwide limited to 30 days per year in the United States, Caribbean and Canada,
- Area 2: Worldwide,
- If you wish to insure more than 4 children, please provide the same information as below on a separate sheet,
- If your child is between 21 and 24 years old and a full-time student, he/she benefits from the 0 to 20 year-old premium rate.

Please attach proof of enrolment.

- A child aged between 0 and 20 years old applying alone will be charged the 21 to 24 year-old rate. If several children apply together, the oldest shall be considered as the Subscriber and will be charged the adult rate.

Surname	First name(s)	Gender M/F	Nationality	Date of Birth Day/Month/Year	Area of coverage	Premium CHF
Subscriber: Do you want to be insured <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, select your area of coverage:					<input type="checkbox"/> 1 <input type="checkbox"/> 2	
Spouse		M/F			<input type="checkbox"/> 1 <input type="checkbox"/> 2	
Child 1		M/F			<input type="checkbox"/> 1 <input type="checkbox"/> 2	
Child 2		M/F			<input type="checkbox"/> 1 <input type="checkbox"/> 2	
Child 3		M/F			<input type="checkbox"/> 1 <input type="checkbox"/> 2	
Child 4		M/F			<input type="checkbox"/> 1 <input type="checkbox"/> 2	

Amount of the EveriCover Plus option:

Total premium in CHF.....

D PREMIUM

- QUARTERLY, as CHF.....every 3 months
- HALF-YEARLY, as CHF.....every 6 months
- YEARLY, as CHF



HEALTH QUESTIONNAIRE

This health Questionnaire is not required if you have applied for the AcciCover Plan.
If you wish to insure more than 4 children, please provide the same information on a separate sheet.

If you answer "yes" to any of the following questions, Golden Care Service requires that you mention the specifications asked for in the Medical Declaration joined. This information is compulsory for the assessment of your application.

GENERAL INFORMATION	SUBSCRIBER		SPOUSE		CHILD 1		CHILD 2		CHILD 3		CHILD 4	
1 Surname												
2 First name												
3 Weight (kg)												
4 Height (cm)												
5 Blood pressure												
6 What is your daily consumption of: a tobacco ? b alcohol ?												
7 Has your weight varied in the last 12 months? If yes, how much?												
8 Has any applicant ever been refused medical or dental insurance, or ever had a policy postponed, rated or accepted on special terms?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
MEDICAL HISTORY												
9 Have you consulted with a physician over the last 3 years, for anything other than check-up?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
10 Have you ever been hospitalised? a. in medical department? b. in the surgical department? c. in the neuropsychiatric department?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
11 Have you been informed of abnormalities in laboratory tests performed in the last 2 years?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
12 For women : Have you already had pregnancy or childbirth complications?	Yes	No	Yes	No								
CURRENT CONDITION												
13 Are you currently under medical treatment or control or do you take any medications?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
14 Do you have a birth defect or congenital abnormality or do you suffer from a chronic disease?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
EVOLUTION												
15 Must you undergo surgery or complementary medical tests in the forthcoming months?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
16 Do your teeth need treatment or dental prostheses?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
ATTENDING PHYSICIAN												
17 Name, email, and number of the attending physician(s).												

Statement :

I hereby apply to be enrolled in the Golden Care Plan, insured by GENERALI Assurances Générales SA, together with the persons on the present form. I declare in the name of these persons to insure that:

- I understand the above answers are confidential and shall be used for the underwriting procedure of my application by Golden Care Services,
- The above questions are accurately represented and are, to the best of my knowledge and belief, full, complete and true, and that I do not have any knowledge of any circumstance that would affect the result of the evaluation by Golden Care Service related to my application for Insurance,
- I understand any false or inaccurate declaration shall be considered retroactively as a waiver of benefits and shall lead to the immediate cancellation of the Plan,
- I am aware the Plan shall be effective at the date mentioned on each Insured's Certificate of Insurance, and that the present form together with my/our Medical Declaration, Certificate of Insurance and General Conditions of the Plan n°GCCH004GB, form the basis of the contract between the Insurer and the Insured Person(s),
- I am aware Golden Care Service may require a complementary medical examination at my expense before acceptance of my application,
- I authorise any physician or practitioner who has observed my or examined me for diagnosis, treatment, disease, or ailment to give to Golden Care Services full particulars of these, including my prior medical history,
- I understand that refusal to submit medical information by any Insured or physician, clinic, hospital, or institution shall be considered a waiver of benefits by such Insured and the Insurer shall have no further obligations towards such persons,
- I have read and fully understood the summary of the principal exclusions, and specifically those related to pre-existing conditions.
- I understand that any changes to the information I have provided which take place between the time this form is completed and the time coverage becomes effective, must be notified in writing to Golden Care Services prior to the effective date of this coverage and that failure to do so may result in the rejection of a claim or my insurance coverage being void.

Signature of the subscriber in the name of all the persons to insure :

Date: Day ____ Month ____ Year ____