



StudentCover/ Swiss Zone

YOUR HEALTH PARTNER AROUND THE WORLD

PROPOSAL FORM N° CHG001/99999

Courtier :

Name of the school :

SUBSCRIBER & PERSON TO BE INSURED

Mr. Mrs. Miss. Country of origin :

Family Name : Email :

First Name : Address of correspondence in Switzerland : C/o

Single Married Divorced Widow

Birth Date : / / (day / month / year) Zip Code : City : Region :

Nationality : Phone : Fax :

PREMIUM / TERM

Effective date of the contract : 01 / /

Length of the contract : 1 year

Payment frequency for 1 year contract : Yearly Half-Yearly Quarterly Monthly

Option : A (standard room) B (private room)

Total premium in CHF :

BANK RELATION

Bank name : City : Bank Account n°.....

Account beneficiary : Bank Clearing n°.....

Address of beneficiary : City : Swiss Postcard Account :

MEDICAL QUESTIONNAIRE – SEE OVER =>

STATEMENT

I hereby apply to enrol the person to be insured in the Golden Care StudentCover Plan insured by GENERALI Assurances Générales SA, and I declare that :

- *I understand that failure to disclose any material fact that may influence the assessment or acceptance of my application for insurance may invalidate the contract, shall be considered retroactively as a waiver of benefits and shall lead the Insurer to cancel the Plan immediately upon being informed of this material fact.*
- *I am aware that the Plan shall be effective at the date mentioned on the Certificate of Insurance which shall be issued after acceptance of my application form and after the premium is received by Golden Care service.*
- *I consent to Golden Care Service seeking information from any medical practitioner who has attended the person to be insured whether this be before or after a claim has been filed.*
- *I have read and approved the Plan General Conditions REF. GCCHST004GB specifically related to the Golden Care StudentCover Plan, and, should I act on his/her behalf, that I have provided the person to be insured with a copy of above, according to the obligations set forward by "la Loi fédérale sur les Contrats d'Assurance (LCA)".*

Signature : _____ Place : _____ Date : ____ / ____ / ____

Proposition N° CHG001/99999

Date de naissance : / /

MEDICAL QUESTIONNAIRE

1. Weight (kg) : _____ 2. Height (cm) : _____
3. Blood pressure : normal If not, what is your blood pressure :
- | | Yes | No |
|---|--------------------------|--------------------------|
| 4. Has your weight varied more than 5kg in the last 12 months ?
If yes, how much and why ?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you consulted a physician over the last 3 years, for anything other than a check-up or a minor affection ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you already been hospitalised : | | |
| a- in the medical department ? | <input type="checkbox"/> | <input type="checkbox"/> |
| b- in the surgical department ? | <input type="checkbox"/> | <input type="checkbox"/> |
| c- in the neuropsychiatry department ? | <input type="checkbox"/> | <input type="checkbox"/> |
| d- in a centre for detoxification and rehabilitation from drug abuses ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has already an abnormality been noticed in biological test ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Was an affection of respiratory or cardiovascular organs found ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you already consulted any medical doctor for a mental illness or a psychological disturbance ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Was a psychic illness or neurological or muscular disease found ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you presently under medical treatment for a mental illness or a psychic disturbance ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Was any illness of the digestive or urologic and reproductive organs found ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Was any illness of the metabolism system (diabetes or lipids disturbances..) and the blood system found ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Was any disease of the skin (eczema, acne or cancer), of the eyes or the ears found ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Was any other disturbance, disease or sickness unmentioned above found ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Are you presently under treatment / under medical control or taking any medicine ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you have any neo natal malformation / or any chronic / or any congenital disease ? Do you suffer from the sequels of any disease or accident ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Will you have to be surgically operated on or to undergo any medical complementary examinations during the following months ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you suffer or have you suffered or are you pre disposed to the diseases of the following organs : | | |
| a- the bones, the articulations or the muscles ? | <input type="checkbox"/> | <input type="checkbox"/> |
| b- the back ? | <input type="checkbox"/> | <input type="checkbox"/> |
| c- the kidneys, the genital organs, the bladder or the prostate ? | <input type="checkbox"/> | <input type="checkbox"/> |
| d- the central nervous system ? | <input type="checkbox"/> | <input type="checkbox"/> |
| FOR WOMEN : | | |
| 20. Have you had difficulties during any pregnancy or any delivery ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Are you pregnant or do you think to be pregnant ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you suffered from any gynaecologic disease / breast cancer ? | <input type="checkbox"/> | <input type="checkbox"/> |

Signature : _____ Place : _____ Date : _____ / _____ / _____

