



TravelCover

YOUR HEALTH PARTNER AROUND THE WORLD

PROPOSAL N°
 Broker:

SUBSCRIBER

Mr. Mrs. Miss. Address of correspondence:

Family Name: Zip code :

First Name: City: Country:

Birth Date / / (Day / Month / Year) Address in the country of departure:

Nationality: Zip code :

Tel: Fax: City: Country:

PERSONS TO BE INSURED

Fill in the following chart:

- Zone 1: Insurance cover in the Schengen zone, included Switzerland and Liechtenstein
- Zone 2: World wide Insurance cover, except United States, Singapour and Japan
- Zone 3: World wide Insurance cover, without any restriction

Member	Family Name	First Name	Date of birth	Protection zone	Premium (CHF)
Subscriber					
Spouse					
Child 1					
Child 2					
Total (CHF):					

LENGTH

Effective date of the contract: / / (Day / Month / Year)

Length of the contract (in days): 8 10 15 22 31 45 62 92 180

Country of departure:

Destination:

Do you have another health insurance? Yes No If yes:

PAYMENT MODE

According to the general conditions of Insurance article 7.1.1, your Plan shall begin on the effective date specified on your Special Policy Conditions. This date is determined following medical underwriting and final acceptance of your application by Golden Care Service. It is at earliest, at midnight the day after receipt of your premium by Golden Care Service or its authorised agents

I wish to pay by: Crédit Card Transfert Payment Slip

Credit card

Type of card: Visa MasterCard American Express

Card number: Expiry date: / (month/year)

Numbers written on the back of your credit card:

Credit Card holder:

Billing address:

Signature:

STATEMENT

I hereby apply to enrol the persons to be insured in the Golden Care TravelCover Plan insured by INTER PARTNER ASSISTANCE, member of AXA ASSISTANCE GROUP and I declare that:

- I insure that 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 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 persons to be insured whether this be before or after a claim has been filed.
- I have read and approved the Plan General Conditions REF. GCCHTO5 specifically related to the Golden Care Travel Cover Plan, and, should I act on his/her behalf, that I have provided the persons to be insured with a copy of above, according to the obligations set forward by "la Loi fédérale sur les Contrats d'Assurance (LCA)".
- I know that illnesses, accidents, as well as their consequences, which have incurred treatment and/or whose symptoms appeared prior to the date of subscription and/or date of departure and that benefits and guaranties are only valid outside the country of usual residence of the insured persons. These declare that they are in good health, that they are not under any treatment and that they do not travel with the intention of obtaining medical treatment.

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

Place:

Date: / / (Day / Month / Year)