GOLDEN CARE®

Golden Care® Application Form

YOUR HEALTH INSURANCE AROUND THE WORLD

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 - Firstname(s): .....

e - Gender: ◯ Female ◯ Male

f - Date of birth: 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

Address: .....

CP / City: ..... Country: .....

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

Pers.: ..... Prof.: ..... Fax: .....

Email: .....

4 • Preferred language of correspondence

◯ English ◯ French

B COVERAGE

1 • Choose your Plan and deductible

ExecutiveCover, with a deductible of CHF: ◯ 75 ◯ 400 ◯ 800 ◯ 1500 ◯ 4000 ◯ 8000 ◯ 15 000

EveriCover, with a deductible of CHF: ◯ 75 ◯ 400 ◯ 800 ◯ 1500 ◯ 4000 ◯ 8000 ◯ 15 000

HospiCover, with a deductible of CHF: ◯ 75 ◯ 400 ◯ 800 ◯ 1500

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)

Month: - Year: -

4 • Do you currently have a health insurance coverage?

If yes, please specify: .....

C PERSONS TO BE INSURED

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

- Area 1: Worldwide limited to 30 days per year in the United States 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 student status.
- 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 will be charged the adult rate.

	Surname	First name(s)	Gender M/F	Nationality	Date of Birth	Area of coverage	Premium CHF
Subscriber: Do you want to be insured ◯ Yes ◯ No				If yes, select your area of coverage		◯ 1 ◯ 2	
Spouse			◯ M ◯ F			◯ 1 ◯ 2	
Child 1			◯ M ◯ F			◯ 1 ◯ 2	
Child 2			◯ M ◯ F			◯ 1 ◯ 2	
Child 3			◯ M ◯ F			◯ 1 ◯ 2	
Child 4			◯ M ◯ F			◯ 1 ◯ 2	

Amount of the EveriCover Plus option: ..... Total premium in CHF: .....

D PREMIUM

◯ YEARLY, as CHF .....

◯ HALF-YEARLY, as CHF ..... every 6 months

◯ QUARTERLY, as CHF ..... every 3 months

◯ MONTHLY, as CHF ..... every month

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E 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 Services requires that you mention the specifications asked for in the medical declaration joined. This information is compulsory for the assessment of your application.

General informations	Subscriber	Spouse	Child 1	Child 2	Child 3	Child 4
1. Surname						
2. First name						
3. Weight (kg)						
4. Height (cm)						
5. Blood pressure Normal If not, what is your blood pressure ?	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
6. Occupation (if applicable)						
7. What is your daily consumption of : a. tobacco ? b. alcohol ?						
8. Has your weight varied in the last 12 months ? If yes, by how much and why ?	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
9. Has any applicant ever been denied medical or dental insurance, or offered coverage with an exclusion ?	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
Medical history						
10. Within the last 3 years have you consulted with a physician or received medical treatment other than a routine check-up which has been completely clear?	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
11. Have you ever been admitted to any : a. hospital ? b. nursing home ? c. special clinic ?	Yes ○ No ○ Yes ○ No ○ Yes ○ No ○	Yes ○ No ○ Yes ○ No ○ Yes ○ No ○	Yes ○ No ○ Yes ○ No ○ Yes ○ No ○	Yes ○ No ○ Yes ○ No ○ Yes ○ No ○	Yes ○ No ○ Yes ○ No ○ Yes ○ No ○	Yes ○ No ○ Yes ○ No ○ Yes ○ No ○
12. Have you been informed of abnormalities in laboratory tests performed in the last 3 years?	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
13. For women : Have you ever had any complications of pregnancy or childbirth ?	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
Current condition						
14. Are you currently under medical supervision or taking prescribed medications for any condition ?	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
15. 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 ○
Future treatment / Investigations						
16. Are any medical or surgical procedures recommended, scheduled and/or contemplated ?	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
17. Is there any oral /dental condition needing treatment (other than normal cleaning & routine examinations) ?	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
Attending physician						
18. Name, email, and number of the doctor who holds your medical records.						

ESTABLISHMENT OF THE BENEFICIAL OWNER'S IDENTITY The undersigned hereby declares: (mark with a cross where appropriate)

☐ that I am the beneficiary of the insurance policy and of the beneficial owner of all transactions in this respect.

☐ that I am not the beneficiary of the insurance policy : the beneficiary (full name reference and address, copy of passport) :

Statement : I hereby apply to be enrolled in the Golden Care Plan together with the persons on the present form. I declare in the name of these persons :

- 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 Services 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°GCCH008EN or GCCHEX005EN, Underwritten by Global Health and Accident Insurance Limited which is regulated by Guernsey Financial Services Commission (licence number : 2291879). The general conditions form the basis of the contract between the insurer and the insured person(s);
- I am aware Golden Care Services may require medical reports or a medical examination at my expense before assessment of my application ;
- I authorise Golden Care Services to obtain from doctors, insurers and other service providers, and to pass on to the same, information, including personal data, necessary for the evaluation of the insurance risk and for the management of the contract thereof ;
- 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 I must notify Golden Care Services of any change in health or of any change to the information provided which takes place between the time this form is completed and the time coverage becomes effective, 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 be insured :

Date : Day - Month - Year -

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