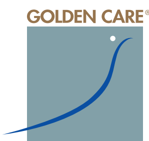

Golden Care® Application Form

YOUR HEALTH INSURANCE AROUND THE WORLD

○ StudentCover

Name and reference code of Golden Care counsellor : ....

A PERSON TO BE INSURED

Name of the school : ....

1 • Person to be insured

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

c - Surname : ....

d - First name(s) : ....

e - Gender : ☐ Female ☐ Male **f -** Date of birth : Day : .... Month : .... Year : ....

g - Country of birth: .... **h -** Nationality : ....

2 • Your postal address

Address of correspondence in Switzerland : C/o ....

Zip : .... City: .... State : ....

Tel : .... Email: ....

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

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

Email : ....

4 • Preferred language of correspondence

☐ English ☐ French

B PREMIUM / TERM

Specify the effective date desired: 01/ Month :.................... Year:.................... Length of the contract : 12 months

☐ YEARLY, as CHF....................

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

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

☐ MONTHLY, as CHF.................... every month

☐ A (standard room) ☐ B (individual room)

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31 Boulevard Helvétique – 1207 Geneva, Switzerland – Tél. +41 22 786 12 00 – Fax +41 22 786 12 20
E-mail : goldencare@goldencare.ch – Web : www.goldencare.ch

SousSTUDENTGB-2017-GHAI

Golden Care® Application Form

C HEALTH QUESTIONNAIRE

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		
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, by how much and why ?	Yes ☐	No ☐
Medical history		
5. Have you consulted a physician over the last 3 years, for anything other than a check-up or a minor affection ?	Yes ☐	No ☐
6. Have you already been hospitalised : a. in the medical department ? b. in the surgical department ? c. in the neuropsychiatry department ? d. in a centre for detoxification and rehabilitation from drug abuses ?	Yes ☐ ☐ ☐ ☐	No ☐ ☐ ☐ ☐
7. Has already an abnormality been noticed in biological test ?	Yes ☐	No ☐
8. Was an affection of respiratory or cardiovascular organs found ?	Yes ☐	No ☐
9. Have you already consulted any medical doctor for a mental illness or a psychological disturbance ?	Yes ☐	No ☐
10. Was a psychic illness or neurological or muscular disease found ?	Yes ☐	No ☐
11. Are you presently under medical treatment for a mental illness or a psychic disturbance ?	Yes ☐	No ☐
12. Was any illness of the digestive or urologic and reproductive organs found ?	Yes ☐	No ☐
13. Was any illness of the metabolism system (diabetes or lipids disturbances…) and the blood system found ?	Yes ☐	No ☐
14. Was any disease of the skin (eczema, acne or cancer), of the eyes or the ears found ?	Yes ☐	No ☐
15. Was any other disturbance, disease or sickness unmentioned above found ?	Yes ☐	No ☐
16. Are you presently under treatment / under medical control or taking any medicine ?	Yes ☐	No ☐
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 ?	Yes ☐	No ☐
18. Will you have to be surgically operated on or to undergo any medical complementary examinations during the following months ?	Yes ☐	No ☐
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 ? b. the back ? c. the kidneys, the genital organs, the bladder or the prostate ? d. the central nervous system	Yes ☐ ☐ ☐ ☐	No ☐ ☐ ☐ ☐
For women		
20. Have you had difficulties during any pregnancy or any delivery ?	Yes ☐	No ☐
21. Are you pregnant or do you think to be pregnant ?	Yes ☐	No ☐
22. Have you suffered from any gynaecologic disease / breast cancer ?	Yes ☐	No ☐

Statement : I hereby apply to enrol the person to be insured in the Golden Care StudentCover Plan and I declare 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 Services related to my application for insurance ;
- I understand any false or inacurate declaration shall be considered retroactively as a waiver of benefits and shall lead to the immediate cancellation of the Plan ;
- 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 Services.
- I consent to Golden Care Services 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 general conditions of the StudentCover Plan n°GCCHST008EN, Underwritten by Global Health and Accident Insurance Limited, which is regulated by Guernsey Financial Services Commission (licence number : 2291879)

Signature :

.... Date : Day .... Month .... Year ....

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