Golden Care® TravelCover Schengen

YOUR HEALTH INSURANCE AROUND THE WORLD

A SUBSCRIBER

Name and reference code of broker (if applicable) ....

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

1 • Subscriber

a - ☐ Mr ☐ Mrs ☐ Miss ☐ Other ....

b - Last name: ....

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

d - Gender: ☐ Female ☐ Male

e - Date of birth: Day: .... Month: .... Year: ....

f - Nationality: ....

g - Address of usual residence: ....

Postcode/City: .... Country: ....

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

2 • Your postal address

Address: ....

Postcode/City: .... Country: ....

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

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

Email: ....

B COVER

1 • Deductible of CHF : ☐ 100

2 • Effective date of the contract: Day: .... Month: .... Year: ....

3 • Length of the contract (number of days): ☐ 3 ☐ 8 ☐ 10 ☐ 15 ☐ 22 ☐ 31 ☐ 45 ☐ 62 ☐ 92

4 • Country of departure: ....

C PERSONS TO BE INSURED

Member(s)	Surname	First name(s)	Gender M/F	Residence	Nationality	Date of birth	Premium CHF
Subscriber: Do you want to be insured? ☐ Yes ☐ No							
Insured 1			☐ M ☐ F				
Insured 2			☐ M ☐ F				
Insured 3			☐ M ☐ F				
Insured 4			☐ M ☐ F				
Insured 5			☐ M ☐ F				
						Total premium in CHF	

D PREMIUM PAYMENT

☐ Payment to be settled in full

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SousTravelCoverSchengen-GB-CHF-2017-GHAI

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E 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 attached. This information is compulsory for the assessment of your application.

General information	**Subscriber**	**Insured 1**	**Insured 2**	**Insured 3**	**Insured 4**	**Insured 5**
1. Surname						
2. First name(s)						
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 ☐

Medical history						
6. 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 ☐

Current condition						
7. 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 ☐

Future treatment / Investigations						
8. Are any medical or surgical procedures recommended, scheduled and/or contemplated ?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

F STATEMENT

I hereby apply on behalf of those persons mentioned for subscription to the Golden Care Plan, Underwritten by Global Health and Accident Insurance Limited which is regulated by Guernsey Financial Services Commission (licence number : 2291879). I declare on behalf of the persons to be insured:

- I understand the answers given are confidential and shall be used by Golden Care Services to determine the acceptance of this application and will constitute the basis of this contract;
- I certify that the answers are accurate and, to the best of my knowledge, full and complete, and I am not aware of any circumstance that would influence the evaluation of this insurance application by Golden Care Services;
- I understand any false or inaccurate declaration would lead to a retroactive withdrawal of benefits and the immediate cancellation of the Plan;
- I am aware the Plan shall take effect from 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°GCCHTSC009EN, 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 understand that the refusal by any Insured, Physician or Medical Institution to provide medical information in connection with a request for reimbursement of a claim will result in the claim being disallowed and the Insurer will have no further obligations towards such persons;
- I have read and fully understood the principal exclusions of the plan, specifically those related to pre-existing conditions as well as those relating to a trip undertaken with the intention of obtaining medical treatment;
- I understand that I must notify Golden Care Services of any change in my health or of any change in the information provided that occurs between the time this form is completed and the time cover comes into effect, and that failure to do so may result in the rejection of a claim or my insurance cover being void.

Signature of subscriber: .... Date : Day .... Month .... Year ....

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