SWISS GLOBAL INSURANCE

Application Form

To be completed by the applicant and to be send to: info@swissglobalinsurance.com
or by mail to: Swiss Global Insurance c/o Swiss Health International, 14 Rue du Rhône, 1204 Genava, Switzerland

Family Name: ____ **First Name:** ____

Effective Date of Coverage must be on the 1st of each month: 01 / ______ / ______

SWISS GLOBAL INSURANCE Plan: ☐ **Diamond** ☐ **Platinum** ☐ **Classic** ☐ **Essential**

Zone of coverage:
☐ Zone A: worldwide coverage including USA & Canada, excluding Switzerland (Premiums in USD)
☐ Zone B: worldwide coverage excluding USA & Canada, including Switzerland (Premiums in CHF)
☐ Zone C: worldwide coverage excluding USA, Canada, Switzerland (Premiums in EUR)

APPLICANT DETAILS:

Gender: ☐ Male ☐ Female Date of Birth: ____/_______/______ Nationality: ___________________________

Family status: ☐ Single ☐ Married ☐ Divorced ☐ Other Occupation: ___________________________

Are you (or your spouse) eligible for benefits from any Social Security or government plan reimbursement, or do you have any other group medical insurance in force today ? ☐ Yes ☐ No

If Yes, please describe: ____

Country of your Social Security plan: ______________________________ Social Security ID Number(s): __________________

SPOUSE (or Partner) and dependent CHILDREN to be covered:
If you have dependent children aged more than 21, please join to this form a certificate of attendance at school or university

Familiy Name	First Name	Date of Birth	Gender (M or F)	Spouse/Child (S or P)
1.		____/_______/_______		
2.		____/_______/_______		
3.		____/_______/_______		
4.		____/_______/_______		
5.		____/_______/_______		
6.		____/_______/_______		

Place and Date of signature of application form: ________________________________ _____/_______/_________

Signature of Applicant: ________________________________

SWISS GLOBAL INSURANCE

APPLICANT`S MAILING ADDRESS

Address in country of expatriations:

1.____
Street

____
Street

__________________ ________ ____________
City Postal code Country

2. Mobile phone number: ______________________

Home phone number: ________________________

Office phone number: ________________________

3. Email: __________________________________

Address in home country:

1.____
Street

____
Street

__________________ ________ ____________
City Postal code Country

2. Mobile phone number: ______________________

Home phone number: ________________________

Office phone number: ________________________

3. Email: __________________________________

PAYMENT OF PREMIUMS

Payment frequency: ☐ Quarterly ☐ Half - Yearly ☐ Yearly

Would you like to do your payment by: ☐ Credit card ☐ Bank Transfer

If you choose payment by credit card, please fill the debit authorization form (page 4)

REIMBURSEMENTS OF CLAIMS

Please complete your full bank details for your claim refunds:

Currency of your bank account: ____________________ Account Beneficiary Name:___________________________

For bank-to-bank transfers, please complete the following and attach a deposit slip

Account N°: ___________________________________ Name of Bank: _____________________________________

IBAN ____ BIC – €, ABA – US$): _______________________________

Address of Bank: ____
City Postal / ZIP Code Country

STATEMENT

I hereby certify that the foregoing declarations are accurate, complete and fair and have been correctly written to the best of my knowledge and belief. I have been informed and I accept that any intentional withholding of significant information or false declaration by me or on my behalf may lead to the cancellation of the insurance cover. I may examine and correct any personal information in the files maintained by SWISS GLOBAL INSURANCE on my behalf. For underwriting and claim purposes, I hereby authorize any physician who has examined me to transmit medical data to the physician of the Insurer and/or its Plan Administrator.
I accept these terms and conditions and I wish to be covered by this policy.

Date: ______/________/________

Subscriber's signature : ________________________________
preceeded by "Read and Approved"

Confidential Medical Questionaire
c/o Swiss Global Insurance

*APPLICANT´S FAMILY NAME:*___________________________________ *FIRST NAME:*______________________________

All questions must be answered. Check by "Yes" or "No" to all questions	Applicant	Spouse / Partner	Child 1	Child 2	Child 3	Child 4
Weight (kg) (if spouse is pregnant, give the weight prior to pregnancy)						
Heigh (cm)						
1.Are you currently on full or partial sick leave due to an illness or accident ?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Over the past three years, have you ever been on sick leave for more than 30 consecutive days?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2. Are you currently under medical supervision (therapy, medical care) and/or are you taking prescribed medication (other than contraceptives)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
3. Are you entitled to military or civil disability pension of more than 15 percent?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
4. Over the past 5 years, have any of your medical or viral tests yielded abnormal results?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
5. Have you undergone surgery over the past 10 years or are you scheduled to do so in the future (exclusive of caesarean sections or appendectomies, or varicose veins, tonsils, adenoids or gallbladder removals).	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6. Have you, over the past 10 years, been hospitalised in a hospital, clinic, health care facility or thermal cure institution or are you scheduled to do so in the next 12 months?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
7. Over the past 10 years, have you ever suffered from an illness or condition that required medical supervision (therapy, medical care, medication) for more than 30 consecutive days?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
8. Are you currently receiving dental care or are you scheduled to do so over the next 24 months?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Further details concerning questions 1 – 8 answered with "Yes":

Person	Question	Type of illness, drugs, injury, symptoms, examination (what was diagnosed	Treatment / symptoms from – to (month-year)	Name and address of doctors, hospitals; who can provide further information?	When did treat ment/ symptoms cease?

STATEMENT

I hereby certify that the foregoing declarations are accurate, complete and fair and have been correctly written to the best of my knowledge and belief. I have been informed and I accept that any intentional withholding of significant information or false declaration by me or on my behalf may lead to the cancellation of the insurance cover. I may examine and correct any personal information in the files maintained by SWISS GLOBAL INSURANCE on my behalf. For underwriting and claim purposes, I hereby authorize any physician who has examined me to transmit medical data to the physician of the Insurer and/or its Plan Administrator.

I accept these terms and conditions and I wish to be covered by this policy.

Date: ______/________/________

Subscriber's signature : ______________________________________
preceeded by "Read and Approved"

SWISS GLOBAL INSURANCE

CREDIT CARD DEBIT AUTHORIZATION FORM

Cardholder's address for the credit card

Street: ______________________________

____

City: ______________________________

Postal Code: ______________________________

Country: ______________________________

PAYMENT OF PREMIUMS

Payment frequency: ☐ Quarterly ☐ Half - Yearly ☐ Yearly

Would you like to do your payment by: ☐ VISA ☐ Mastecard

Card-Number: _______ _______ _______ _______ Valid to: ______ / _______ CVC: ________

Card holder's name: ____
Please type name exactly same as written on your credit card

CREDIT CARD DEBIT AUTHORIZATION STATEMENT

I authorize SGI SA to debit my credit card account with unspecified amounts in respect of my current and renewal premium payments as and when these become due, until further notice. I understand that SGI SA will give me due notice of renewal and that the premiums may vary each year.

Date: ______/________/________

Cardholder's signature : ______________________________
preceeded by "Read and Approved"