



Application Form

To be completed by the applicant including copy of your passport and to be returned to: info@swissglobalinsurance.com
or by mail to: Swiss Global Insurance c/o Swiss Health International, 14 Rue du Rhône, 1204 Geneva, 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

Hospi Plan: worldwide coverage excluding Singapore, China, Japan, Switzerland, UK, USA and Canada, valid in case of hospitalization only. 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

Family 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: _____



APPLICANT'S MAILING ADDRESS

Address in country of expatriation:

Address in home country:

1. _____
Street

1. _____
Street

Street

Street

City Postal code Country

City Postal code Country

2. Mobile phone number: _____

2. Mobile phone number: _____

Home phone number: _____

Home phone number: _____

Office phone number: _____

Office phone number: _____

3. Email: _____

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 5)

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 : _____
preceded by "Read and Approved"

Confidential Medical Questionnaire c/o Swiss Global Insurance

	A P P L I C A N T	D E P E N D E N T 1	D E P E N D E N T 2	D E P E N D E N T 3	D E P E N D E N T 4
Have you, or any person named in page 1 been treated for, or have had a history of: <div style="text-align: right;">(Please tick if Yes)</div>					
1 Diabetes, thyroid and other endocrine disorders (including obesity)					
2 Heart or circulatory disorders (including high blood pressure)					
3 Cancer, tumour or growth (including polyps or breast lumps)					
4 Muscle and skeletal problems (including back pain, traumatism, joint pain or problems)					
5 Asthma, allergies, breathing or respiratory disorders (including chest infections, shortness of breath, tuberculosis)					
6 Gall bladder, stomach, intestinal, gastric or liver problems (including irritable bowel disease, Crohn's disease, hernia or haemorrhoids)					
7 Urinary or reproductive disorders (including fertility, periods or prostate problems)					
8 Brain or neurological disorders (including epilepsy, strokes, shingles or nerve pain)					
9 Skin problems (including eczema, allergic reactions, cysts, dermatitis or psoriasis)					
10 Blood infective or immune disorders (including High cholesterol, anemia, malaria ou HIV)					
11 Do you have any illness, condition or symptom not already mentioned above ?					
12 Are you currently under medical supervision (therapy, medical care) and/or are you taking prescribed medication (other than contraceptives) ?					
13 Have you been or are you scheduled to be hospitalised for surgery, illness or any other reason (exclusive of caesarean sections or appendectomies, or varicose veins, tonsils, adenoids or gallbladder removals) ?					
14 Are you currently pregnant ?					
15 Are you currently receiving dental care or are you scheduled to do so over the next 24 months?					
16 Weight (kg)					
17 Height (cm)					

STATEMENT

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

Date: ____/____/____

Subscriber's signature : _____
preceded by "Read and Approved"

Confidential Medical Questionnaire c/o Swiss Global Insurance

Further details concerning questions 1 – 15 answered with “Yes”

	Question Number	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 treatment / symptoms cease ?
A P P L I C A N T					
D E P E N D E N T 1					
D E P E N D E N T 2					
D E P E N D E N T 3					
D E P E N D E N T 4					

FRAUD NOTICE

Any person who (1) dishonestly files an application for insurance or a claim under a policy containing information he knows to be untrue or misleading; or who (2) in making an application for insurance or claim under a policy dishonestly fails to disclose information which has been asked for, may commit fraud. We will investigate any claims or applications for insurance which we have grounds to believe may be fraudulent. Committing fraud may result in your policy being terminated and any claims you make under not being paid, We may, for the purposes of the detection and prevention of fraud, share information relating to suspected fraud with other insurance companies and/or with law enforcement authorities.

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 : _____
preceded by "Read and Approved"



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 Mastercard

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.

I agree that credit card payments are subject to a fee of 3% per transaction.

Date: ____/____/____

Cardholder's signature : _____

preceded by "Read and Approved"