SWISS GLOBAL INSURANCE

Application Form

To be completed by the applicant and to be sent 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 / 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: ____/01/_____ 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.		____/01/_____		
2.		____/01/_____		
3.		____/01/_____		
4.		____/01/_____		
5.		____/01/_____		
6.		____/01/_____		

Place and Date of signature of application form: _____ _____/01/_____

Signature of Applicant: _____

SWISS GLOBAL INSURANCE

APPLICANT`S MAILING ADDRESS

Address in country of expatriation:

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 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: _____/01_____/_____ Subscriber's signature : _____
preceeded by "Read and Approved"

Confidential Medical Questionaire
c/o Swiss Global Insurance

	Have you, or any person named in page 1 been treated for, or have had a history of: (Please tick if Yes)	APPLICANT	DEPENDENT 1	DEPENDENT 2	DEPENDENT 3	DEPENDENT 4
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	Musle 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 neurogical 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 médical supervision (therapy, médical care) and/or are you taking prescribed médication (other than contraceptives) ?	☐	☐	☐	☐	☐
13	Have you been or are you scheduled to be hospitalised for surgery, illness or any other reason (exclusive of caeserean 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)					

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

Date: _____/ 01 /_____

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

Confidential Medical Questionaire
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 ?
APPLICANT					
DEPENDENT 1					
DEPENDENT 2					
DEPENDENT 3					
DEPENDENT 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

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

Date: _____/_01_____/_____

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 ☐ Mastercard

Card-Number: _____ _____ _____ _____ Valid to: 01 / 2015 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: _____/ 01 /_____

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