Anmeldeformular für Einzelpersonen

Individual Application Form

A. Applicant Gesuchsteller

1) Family Name: Familienname _____ 2) First Name: Vorname _____

3) Date of Birth: Geburtsdatum _____ 4) Nationality: Staatsangehörigkeit _____

5) Place of Birth: Geburtsort _____

6) Social Security Number (if any): Number: Sozialversicherungsnummer (wenn vorh.) _____ Country: ... des Landes _____

7) Are you eligible for any Social Security or government plan or do you have any other medical insurance in force today? Haben Sie Anspruch auf gesetzl. Krankenversicherungsleistungen oder sind Sie z.Z. privat krankenversichert?

☐ NO ☐ YES if YES, please ge details: wenn ja, Einzelheiten: _____

8) Occupation (please give full description): Beschäftigungsart, Beruf (präzisieren) _____

9) Family Status: Zivilstand ☐ Married verh. ☐ Divorced gesch. ☐ Single ledig ☐ Other: andere (z.B. in Lebenspartnerschaft u. dgl.) _____

10) Vital Facts: persönl. Angaben Sex: ☐ Male M ☐ Female W Height: Körpergrösse _____ (cm/ft) Weight: Körpergewicht _____ (kg/lb)

11) Broker (if any): Makler SIO SwissInsuranceOnline GmbH

12) Referral (how did you hear about us): Wie wurden Sie auf uns aufmerksam? _____

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B. Contact Details Kontaktadressen

PRINCIPAL RESIDENCE *(where you are living or intend to live)*
Ihre Hauptadresse (wo Sie z.Z. leben oder zu leben gedenken)

1) Address: _____

Postal Code: _____
Land, PLZ
Country: _____

2) Telephone (include country dialling code)
Telefon inkl. Ländervorwahl
Home: _____
Office/Mobile: _____

3) Fax: _____

4) E-mail: _____

OTHER RESIDENCE *(if applicable)*
Ihre Zweitadresse (wenn vorh.)

1) Address: _____

Postal Code: _____
Land, PLZ
Country: _____

2) Telephone (include country dialling code)
Telefon inki. Ländervorwahl
Home: _____
Office/Mobile: _____

3) Fax: _____

4) E-mail: _____

5) Where would you like your policy documents to be sent? wohin können wir Ihre Versicherungsdokumente senden? ☐ Principal Residence Hauptadresse ☐ Other Residence Zweitadresse

How would you like your policy sent? Welche Versandart wünschen Sie? ☐ Airmail (standard) Luftpost (standard) ☐ Courier (US$/EUR€ 75 or GBP£ 40 surcharge) Kurier (USD/EUR 75 extra)

6) Where are you currently located should we need to contact you for more information? wo können wir Sie erreichen, falls wir zusätzliche Auskünfte benötigen? ☐ Principal Residence Hauptadresse ☐ Other Residence Zweitadresse

C. Spouse or Partner and/or Dependent Children To Be Insured

Mitzuversichernder Ehegatte oder Lebenspartner sowie unter elterlicher Sorge stehende Kinder

SPOUSE or PARTNER *(Include your spouse or partner and any dependent children under age 21, or under age 25 if unmarried and a full-time student.)*
Ehegatte oder Lebenspartner, (einschlissliche Kinder bis z. 21. bzw. ledige Jugendliche in Ausbildung bis zum 25. Altersjahr)

1) Family Name: Familienname _____ 2) First Name: Vorname _____

3) Date of Birth: Geburtsdatum _____ 4) Nationality: Staatsangehörigkeit _____

5) Place of Birth: Geburtsort _____

6) Social Security Number (if any): Number: Sozialversicherungs-Nr. (wenn vorh.) _____ Country: ...des Landes: _____

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

C. Spouse or Partner and/or Dependent Children To Be Insured continued ... *Mitzuversichernde Personen (Fortsetzung...)*

7) Is your spouse or partner eligible for benefits from any Social Security or government plan or employer plan or does she/he have any other medical insurance in force today? ☐ NO ☐ YES if YES, please give details: _____
Hat Ihr Ehegatte oder Lebenspartner Anspruch auf gesetzliche Krankenversicherungsleistungen oder des Arbeitgebers oder sind andere Krankenversicherungen zurzeit in Kraft?

8) Occupation (please give full description): _____
Beschäftigung, berufl. Tätigkeit (bitte vollst. Angaben)

9) Vital Facts: Sex: ☐ Male ☐ Female
persönl. Angaben M W

Height: _____ (cm/ft) Weight: _____ (kg/lb)
Körpergrösse Körpergewicht

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DEPENDENT CHILDREN ***(For children age 21 or older, please attach proof of schooling)*** *Kinder unter elterlicher Sorge (für Kinder von 21 u. mehr Jahren bitte Ausbildungsnachweis beilegen)*

	Name	Date of Birth *Geb.Dat.*	Sex (M/F)	Height (cm/ft)	Weight (kg/lb)	Full-Time Student (Y/N) *Vollzeitausbildung (ja/nein)*
1)						
2)						
3)						
4)						
5)						

Are any of the dependent children eligible for benefits from any Social Security or government plan or does she/he have any other medical insurance in force today? ☐ NO ☐ YES *wenn ja; bitte nähere Angaben* if YES, please give details: _____
Ist eines der hier angemeldeten Kinder gesetzlich krankenversichert oder hat eine andere zurzeit in Kraft stehende Krankenversicherung?

D. Medical Cover Required *gewünschte Versicherungsdeckung*

1) **Choose the area of cover you require:** *Wählen Sie den geogr. Deckungsbereich*
☐ World-wide cover Excluding USA *weltweit ohne USA* ☐ World-wide cover Including USA *weltweit inkl. USA*
Alle Versicherungspläne schliessen volle Deckung für medizinische Evakuation, Nothilfe, Unfall ein auf Reisen (inkl. USA)
All plans automatically include full cover for medical evacuation, assistance, accident and emergency, whilst travelling anywhere in the world (including USA).

2) **Choose the Currency you wish your plan to be in:** ☐ US Dollar (USD$) ☐ Euro (EUR€) ☐ Sterling (GBP£)
Wählen Sie die Währung, in welcher Sie die Police führen möchten

3) **Choose the plan most suited to your needs:** *Bezeichnen Sie den von Ihnen bevorzugten Versicherungsplan*
☐ **Plan 1 - HEALTHCARE EXECUTIVE**
☐ **Plan 2 - HEALTHCARE PREMIUM**
☐ **Plan 3 - HEALTHCARE PLUS**
☐ **Plan 4 - HEALTHCARE STANDARD**
☐ **Plan 5 - HEALTHCARE EMERGENCY PLUS**

Wählen Sie den von Ihnen gewünschten Selbstbehalt
Choose the Excess Option you wish to include: *ohne (nur für Premium und Executive Plan)*
☐ Zero Deductible (only applicable to Premium and Executive Plans)

*The Deductible for the **Emergency Plus Plan** is set at US$/EUR€ 2,000 or GBP£ 1,400.*
Der Selbstbehalt für den Emergency Plus Plan beträgt fest USD /EUR 2'000)
☐ US$/EUR€ 250 or GBP£ 175 Deductible
Selbstbehalt
☐ US$/EUR€ 1,000 or GBP£ 700 Deductible

Choose your Co-Pay: ***This is limited to the first USD$/EUR€ 20,000 or GBP£ 16,500 of covered expenses.*** ☐ Nil ☐ 10% ☐ 20% ☐ 30%
Wählen Sie Ihre Selbstbeteiligung (beschränkt auf die ersten USD / EUR 20'000)

Preferred start date: _____
Startdatum der Versicherung

E. Optional Cover *optionale Zusatzleistungen*

1) **PERSONAL ACCIDENT COVER** *Zusatzdeckung für nichtmedizinische Unfallfolgen (Tod, Teil- u. Vollinvalidität)*

All applicants over the age of 18 are automatically insured for Personal Accident cover up to USD$/EUR€ 25,000 or GBP£ 15,000. However, you can opt to have this increased in increments of USD$/EUR€/GBP£ 10,000 up to USD$/EUR€ 125,000 or GBP£ 115,000. (This option is not available to children under the age of 18). This amount must be in the same currency as your Plan above.
wählen Sie die Zusatz-Deckung für sich selbst und/oder den Partner
Alle Versicherten über 18 Jahre sind mit einer Versicherungssumme von USD / EUR 25'000 gedeckt. Diese Summe kann in Schritten von 10'000 bis zu maximal 125'000 erhöht werden.
Please select additional amounts of cover required: Policyholder: _____ Spouse/Partner: _____

2) **DENTAL COVER** *Zahnversicherung*

Please select the members that require Dental Cover: *Wählen Sie die Personen, welche Zahnversicherung wünschen:*
☐ Policyholder *Sie* ☐ Spouse/Partner *Ehegatte/Partner* ☐ Child1 ☐ Child2 ☐ Child3 ☐ Child4 *(Kinder 1 - 4)*

3) **TRAVEL OPTION** *optionale Reiseversicherung*

Please select the members that require Travel Cover: *Wählen Sie die Personen, welche die Reiseversicherung wünschen:*
☐ Policyholder ☐ Spouse/Partner ☐ Child1 ☐ Child2 ☐ Child3 ☐ Child4

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

die Übersetzung der Gesundheitsfragen finden Sie im Downloadbereich der Webseite

F. Health Declaration Gesundheitserklärung

STATEMENT OF HEALTH BY APPLICANT (to include Spouse or Partner and/or Dependent Children listed in Section C). ALL QUESTIONS MUST BE COMPLETED. FAILURE TO INCLUDE ALL MATERIAL MEDICAL INFORMATION OR PROVIDING FALSE INFORMATION MAY RESULT IN CANCELLATION OF COVER OR DENIAL OF CLAIM PAYMENT AT TIME OF CLAIM.

Please check (√) box if any person for whom application is being made (including yourself, spouse or partner and dependents) has been advised, counseled, tested, diagnosed, treated, hospitalised, or recommended for treatment within the last 5 years for the following: (If you answer YES to any question, please circle the condition to which you are referring and give complete details in Section G).

HEALTH HISTORY

1) Do you or any of your dependents named in this application have any physical defect or infirmity? ☐ YES ☐ NO
2) Have you or any of your dependents suffered from any recurring illness or injury or taking prescribed drugs on a regular basis, whether or not medical attention was sought? ☐ YES ☐ NO
3) Have you or any of your dependents undergone a surgical operation or do you have reason to believe that a surgical operation will be required in the future? ☐ YES ☐ NO
4) Have you or any of your dependents consulted with a medical practitioner in the last two years or will need to do so in the foreseeable future? ☐ YES ☐ NO
5) Are you or any of your dependants involved in hazardous or dangerous activities or sport? If YES, please state activities and sports below. ☐ YES ☐ NO

(Eligible claims for Hernia and Kidney Stones will be subject to a 50% copay if claimed within the first 30 days. Any treatment or diagnosis of cancer within the first 30 days of the policy inception date will not be covered.)

Additional information or observations: _____

_____

G. Details to Health History

GIVE DETAILS ON EACH ITEM CHECKED (√) "YES" IN SECTION F.

Question Number	Person Affected	Condition / Diagnosis	Treatment (Surgeries / Medications)	Treatment Dates (From / To)	Ongoing or Date of Recovery	Name, Location or Telephone Number of Physician, Hospital / Institution

(If more space is needed, attach a separate page which must be signed and dated)

H. Additional Health Insurance Information *Zusätzliche Gesundheitsinformationen*

1) Family Doctors *(if any)* *Hausarzt (wenn bestehend)*

Name: _____
Address: _____
Telephone: _____
Fax: _____
E-Mail: _____

Additional Family Doctors *(if any)* *weiterer Hausarzt (wenn vorh.)*

Name: _____
Address: _____
Telephone: _____
Fax: _____
E-Mail: _____

2) Current Cover

If you, your spouse or partner, and/or your dependent children are insured today, it is in your interest to send us a copy of your current policy, because the HealthCare International waiting periods may be removed if there is a "continuity" of cover between your current policy and the HealthCare International policy. If we remove the waiting period, we will confirm this to you in writing.

Current Policy and Insurer: _____ Expiration Date: _____

3) Additional Information ***Please provide any additional information on a separate sheet of paper.***

PLEASE COMPLETE IN BLOCK LETTERS AND CONTINUE ON THE NEXT PAGE

Verbindlicher Text von HealthCare International; auf eine Übersetzung wird aus Gründen der Rechtssicherheit und zur Vermeidung von Missverständnissen verzichtet.

I. Representations, Acknowledgments and Authorisations *Zusicherungen, Kenntnisnahmen und Ermächtigungen*

I apply for ANNUAL coverage as indicated herein, for which I am or may become eligible under the agreement. I acknowledge that should I cancel my plan part way through the policy year, I may still be liable to pay the balance of the premium if I have elected to pay the premium by instalments. I have read all the statements made herein, and represent that they are true and complete to the best of my knowledge and belief. I understand that failure to disclose information in this application may be the basis for cancellation of my HealthCare International membership or claims denial.

I hereby declare that I have read the information leaflet and that I have been informed of the terms and conditions of the insurance plan. I accept these terms and conditions and declare that to the best of my knowledge and belief, the statements made in this Application Form are true and complete.

I agree that there shall be no insurance until this application has been accepted by the Insurer, the first full premium has been paid and received by HealthCare International.

I authorise any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, insurance company or other person or firm to provide HealthCare International or their authorised representative information, including copies of records, concerning advice, care, or treatment provided to me and/or my dependents, including without limitation, information relating to all medical and mental illness or use of drugs or alcohol.

I understand that such information will be used by Us for the purpose of evaluating my application for health insurance, or by Insurer representatives involved in evaluating, determining, or administering claims for insurance benefits for me or my dependents. I understand that I or any authorised representative will receive a copy of this authorisation upon request.

I understand that upon receipt of a certificate of insurance and associated documents, if I am not entirely satisfied, I can cancel this application and receive a full refund of the premium I have paid provided that I do not submit any claim or use the policy in any way (e.g. visa application). I also acknowledge that the documents must be returned to HealthCare International within 14 days of the date of issue.

HealthCare International confirm that in accordance with the European Union Data Protection legislation, personal data and information that you give us and that we hold on file for you, will not be given to any hospital and/or medical provider in connection to any claim or services provided by us. You also have the right to consult and rectify any error in the files the insurer holds on your behalf.

I authorise you to charge my card account unspecified amounts in respect of the premium for my annual HealthCare Plan as and when the premiums become due, until this instruction is countermanded by myself in writing. I understand that I will be notified at least 4 weeks in advance of my renewal date of the renewal premium amount.

Date Signed: _____ Signature of Applicant: _____

Datum der Unterzeichnung *Unterschrift des Antragstellers*

J. Method of Payment *Zahlungsmodalitäten*

Please choose how often you would like your premium collected. *in welchen Zeitabständen möchten Sie die Prämie bezahlen?*

Mit Kreditkarte

1) **By Debit / Credit Card:** ☐ AMEX ☐ MasterCard ☐ VISA ☐ Diners Club ☐ *andere* Other: _____

Zahlungsweise Period of Payment: ☐ *monatl.* Monthly ☐ *quartalsweise* Quarterly ☐ *halbjährlich* Six Monthly ☐ *jährlich* Annually

Name des Karteninhabers Card Holder's Name: _____ *Karten-Nummer* Card Number: _____

Verfalldatum Expiry Date: _____ *Betrag* Amount: _____

Rechnungsadresse (wenn anders als Hauptadresse) Billing Address (if different to Principal Residence): _____

(siehe auch die Bankzahlungsinformationen auf unserer Downloadseite)

2) **By Bank Transfer:** Provisional cover can only commence when the transfer has been completed. **(Annual Payments only)**

Please instruct your bank to make sure that the transfer identifies you as the source beneficiary of the transfer, and the CM/Policy Number.

Account Name: HealthCare International Bank: HSBC Address: 20 Eastcheap London EC3M 1ED, UK

Accounts:

Currency:	Sort Code:	Account:	IBAN:	SWIFT/BIC:
US Dollar ($)	400515	59763170	GB79MIDL40051559763170	MIDLGB22
Euro (€)	400515	59763197	GB29MIDL40051559763197	MIDLGB22
Sterling (£)	400231	81392816	GB47MIDL40023181392816	MIDLGB2106G

3) **By Cheque:** Made payable to HealthCare International **(Annual Payments only)**

Please put your name, address and CM/Policy Number on the back of the cheque. Provisional cover cannot commence until the cheque has cleared. Please note that for the time being we can only accept cheques drawn on banks with a UK banking licence – if you are not sure if your bank has a UK banking licence please check with your bank first.

Please Send Application Form To The HealthCare International UK Administration Office

Faxen Sie das ausgefüllte und unterzeichnete Formular an Swissinsurance: +66 (0)38 301 167

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