Application form Groups – Medistar

1. Policyholder details

Please use capitals to complete this form.

Company name

Address

Postal code | Town / City | Country/State

Do you currently have a health insurance policy? ☐ Yes, please provide details ☐ No

Name of insurer | Client no

Name of scheme

Do you upgrade your current health cover?

☐ Yes, please complete the Medical Questionnaire [1]

☐ No, please complete the Switch declaration form[2] and provide an insurance certificate of your previous insurer for each employee insured

1 Upgrade of your current health cover is subject to a Medical Questionnaire for companies with 2-9 employees. For companies with over more than 10 and up to 50 insured employees, medical history can be disregarded.

2 Transfer of your current health cover is subject to a Switch declaration form for companies with 2-9 employees. For companies with more than 10 and up to 50 insured employees, medical history can be disregarded.

2. Details of principal company contact person

Last name | First name

Title

Address (only if different from the principal company address)

Postal code | Town / City | Country / State

Telephone | Fax

Email

3. Policy start date

Start date (d - m - y)

4. Plan details

Please tick your choice.

Area of cover ☐ Worldwide ☐ Worldwide excl. USA ☐ Africa/India/Pakistan/Sri Lanka/Bangladesh

Plan type ☐ Primary ☐ Advantage ☐ Elite

Dental option [3] (only possible within advantage and elite) ☐ Yes ☐ No

Settlement notes online ☐ Yes ☐ No

If yes, please specify:

preferred language ☐ EN ☐ ES ☐ FR

email address for reception of your online settlements

3 The Additional Insurance Dental Care can only be taken out in addition to the Core Plan.

5. Employees to be insured under the plan (please contact us in case you need assistance)

For all employees to be covered under the plan, an Excel sheet must be completed to specify the personal details and the exact cover, needed for the employee and the possible family members. The Excel sheet should include:

- per person: family name, first name, sex, date of birth, relation (employee, partner, parent or child), start date of cover, home country, host country, nationality, passport no, Goldstar no;
- per family: email, language for correspondence with regard to medical claims (EN, FR, DE, NL, ES or IT), bank account details (IBAN and BIC code) for reimbursement of claims;
- office address.

6. Payment details

Please tick to indicate the payment frequency and method you will use.

Mode of payment	☐ Cheque	☐ Bank Transfer	☐ Credit card
Frequency of payment	☐ Annual	☐ Half yearly [4]	
Currency of payment	☐ Sterling	☐ US Dollar	

4 Payment is subject to a 3% surcharge.

7. Invoicing address (only if different from the principal company address)

Company name

Address

Postal code Town / City

Country/State

VAT no.

8. Declaration

1. I hereby apply for cover on behalf of all the persons named in this application form.
2. I declare that the answers given are to the best of my knowledge full, true and complete and have checked and found correct any answers and statements in this application that are not in my own handwriting.
3. I accept that this policy will be subject to the policy terms and conditions effective at the time of policy commencement. I confirm that I have read and understand the full definitions, benefits, exclusions and conditions of this policy.
4. I confirm and agree that the personal information collected or held by Cigna and/or Goldstar Healthcare Ltd., whether contained in this application form or otherwise obtained may be used by Cigna and/or Goldstar Healthcare Ltd., or disclosed to or transferred to any organisation for the purpose of 1) assessing this application and providing on-going insurance and customer service, 2) processing and giving effect to credit card payment, 3) providing marketing material in respect of insurance related services of Cigna or it's associated companies and 4) processing claims or analysing the insurance.
5. I further accept that where funds have been outstanding to Cigna for a period in excess of 15 days from notification my policy will be suspended automatically, without refund of premium.

Date Signature policyholder

Please send this form to:

Goldstar Healthcare Ltd.
5th Floor, Mayfair Suites, Parklands Road, PO Box 1017, 00606 Sarit Centre, Nairobi, KENYA
Tel. + 254 20 375 4770 / 4779 / 4782 • Fax + 254 20 375 4784 • cigna@goldstarhealthcare.com

5.47.305invc (0814)