Cigna

Medistar
INTERNATIONAL HEALTH INSURANCE

Application form individuals – medistar

1. Policyholder details

Please use capitals to complete this form.

Last name	First name
Title	Date of birth (d - m - y) / /
Marital status	Sex ☐ M ☐ F
Occupation	Host country
Does your occupation include aerial, underground, under or above water activities? ☐ Yes ☐ No	
Nationality(ies)	Passport no.

Home country address

Postal code	Town / City	Country / State

Host country address (if different from home country address)

Postal code	Town / City	Country / State

Home telephone	Business telephone
Mobile number	Fax
Home email	Business email

2. Company details (if applicable)

Company name	
Address	
Postal code	Town / City
Country / State	

3. Dependants to be included in the plan

Please enter the details of all dependants to be covered under this policy. This can include your spouse/partner and any children financially dependent on the policyholder and not more than 28 years old.

Last name	First name	Sex ☐ M ☐ F
Date of birth (d - m - y) / /	Relationship	Nationality(ies)
Last name	First name	Sex ☐ M ☐ F
Date of birth (d - m - y) / /	Relationship	Nationality(ies)
Last name	First name	Sex ☐ M ☐ F
Date of birth (d - m - y) / /	Relationship	Nationality(ies)
Last name	First name	Sex ☐ M ☐ F
Date of birth (d - m - y) / /	Relationship	Nationality(ies)
Last name	First name	Sex ☐ M ☐ F
Date of birth (d - m - y) / /	Relationship	Nationality(ies)

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4. Current insurance policy (if applicable)

Have you ever had or do you currently have a health insurance policy? ☐ Yes, please provide details ☐ No

Name of insurer	Client no
Start date (d-m-y)	End date (d-m-y)
Name of scheme	
Do you upgrade your current health cover?	☐ Yes, please complete the Medical Questionnaire ☐ No, please complete the Switch declaration form in section 11 and provide an insurance certificate of your previous insurer

5. Policy start date

Start date (d - m - y)

6. 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 [1] (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			

1 The Additional Insurance Dental Care can only be taken out in addition to the Core Plan on family level, and the minimum contract duration is one year (un less the contract is terminated).

7. 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 [2]	
Currency of payment	☐ Sterling	☐ US Dollar	

2 Payment is subject to a 3% surcharge.

8. Bank account information (for the reimbursement of medical expenses)

Account holder name

Account no. (IBAN no. for European countries)

Full bank name and address

BIC / SWIFT code

ID Bank (if applicable)

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9. 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.
6. In view of a smooth administration of the contract and/or settlement of the insurance claim, and only for that purpose, I hereby give my specific and informed consent to Cigna and Goldstar Healthcare Ltd. to exchange and process medical data concerning myself and/or the members of my family via all channels of communication (article 7 of the Belgian law of 8 December 1992 concerning the private life).
7. This application form is only valid for 60 days. Once the period of 60 days has elapsed, a new application form (and medical questionnaire if applicable) must be completed by the applicant.

Date Signature policyholder

10. Switch declaration form

Only to be filled in if you have indicated 'No' to the last question in section 4.

I certify that in the past five years neither I nor any of my dependants insured currently suffer or have suffered from a condition such as, but not limited to:

- Any form of cancer
- Organ Failure/transplant
- Syndromes in relation to the hematopoletic (blood forming) system
- Coagulation (bleeding) disorders
- Multiple sclerosis
- Cystic fibrosis
- Insullin dependent diabetes
- Cardiovascular diseases
- Infertility
- Chronic hepatitis
- Growth hormone deficiency
- HIV or other syndrome related to immune system
- Acute episodes of a chronic condition within the last 2 years
- Any one claim within last 2 years with value more than £ 2,500
- Any investigations or treatment awaited
- Any inpatient surgery
- Any other significant medical conditions not listed opposite, for example conditions that required a period of hospitalisation, recurrent or continuous medical attention. If you have any doubt whether a condition is material, you should disclose it.

In addition I certify that in the last 5 years neither I nor any of my insured dependants have undergone or been advised to have any diagnostic test, treatment, hospitalisation or surgery which has or has not been done or awaiting the result of such a test.

If any of these conditions or circumstances apply to you or your dependants, please attach medical details as that might be subject to medical underwriting. If you are unsure about your or your dependants' condition, please contact us.

I certify that the statements made by me in answer to the above questions are true, complete and correct to the best of my knowledge and belief. I understand that nullity of the insurance or reduction of the insured capital sum might be applied in the event of claim if it were proved that the person to be insured had established a false declaration.

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

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Medical questionnaire

Please answer each of these questions fully and accurately, for each person included on your application. If the answer to one of the questions below is 'Yes', please provide details in the additional information box on the last page. Please describe your complete medical history for the past 10 years until the date this form is completed. Please include information regarding any chronic or serious medical conditions, regardless of time of occurrence, as this information may impact coverage.

	Policyholder	Partner	Child 1	Child 2
Name				
Date of birth (d - m - y)				
1. Height / weight	cm kg	cm kg	cm kg	cm kg
2.a. Do you currently have any health problems?	Yes No	Yes No	Yes No	Yes No
b. Is your capacity to work reduced?	Yes No	Yes No	Yes No	Yes No
c. Have you ever been unable to work for more than four consecutive weeks during the last five years?	Yes No	Yes No	Yes No	Yes No
3. Do you suffer from or have you suffered from any illnesses, disturbances or problems connected with: **a.** the **respiratory organs**, such as asthma, recurrent or chronic bronchitis, pneumonia, pulmonary tuberculosis or other disorders?	Yes No	Yes No	Yes No	Yes No
b. the **heart or vascular system**, such as high blood pressure, circulatory problems, heart attack, heart defect, heart failure, palpitations, apoplexy, phlebitis, varicose veins or other disorders?	Yes No	Yes No	Yes No	Yes No
c. the **nervous system or a mental disorder**, such as epilepsy, dizziness, paralysis, neuritis, depression or other disorders?	Yes No	Yes No	Yes No	Yes No
Have you ever attempted to commit suicide?	Yes No	Yes No	Yes No	Yes No
d. the **digestive system**, such as hiatus hernia, gastric or duodenal ulcers, or other disorders of the stomach or intestines, such as inflammations, haemorrhages, haemorrhoids, jaundice, diseases of the liver, gall bladder, pancreas?	Yes No	Yes No	Yes No	Yes No
e. the **urinary tract of sexual organs**, such as kidneys, ureters, bladder or prostate, urinary tract, blood or albium in the urine or other disorders?	Yes No	Yes No	Yes No	Yes No
f. the **metabolism or blood**, such as diabetes mellitus, elevated cholesterol, gout, thyroid gland or hormonal disturbances, anemia, coagulation disturbances or other disorders?	Yes No	Yes No	Yes No	Yes No
g. the **immune system or infectious diseases**, such as AIDS, HIV, sexually transmitted diseases, hepatitis, tropical diseases or other disorders?	Yes No	Yes No	Yes No	Yes No
h. the **skin**, such as eczema, allergies, psoriasis, fungal diseases, skin cancer or other disorders?	Yes No	Yes No	Yes No	Yes No
i. the **musculoskeletal system**, (bones, joints, spine, intervertebral discs, muscles, ligaments, tendons), such as disorders of the back, neck and shoulders, arthritis, rheumatism or other disorders?	Yes No	Yes No	Yes No	Yes No

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Name Date of birth (d - m - y)	Policyholder	Partner	Child 1	Child 2
j. the **eyes**, such as decreased visual acuity or refraction power, retinal disease or other disorders?	Yes No	Yes No	Yes No	Yes No
k. the **ears**, hearing difficulties, inflammation or other disorders?	Yes No	Yes No	Yes No	Yes No
l. other illnesses, disturbances or problems not listed above, such as congenital defects, deformities, tumours, cancers, etc?	Yes No	Yes No	Yes No	Yes No
4. Have you had any **accidents**, injuries or poisonings which necessitated a hospital stay or operation?	Yes No	Yes No	Yes No	Yes No
5.a. Have you been examined, received treatment or been operated on in hospital or similar institution?	Yes No	Yes No	Yes No	Yes No
b. Have you been advised to take a rest, diet, withdrawal or other cure, or is such a cure planned?	Yes No	Yes No	Yes No	Yes No
c. Is a hospital stay or operation planned?	Yes No	Yes No	Yes No	Yes No
d. Have you been treated by or consulted any of the following in the last 5 years:				
- psychotherapist? (e.g. psychiatrist, psychologist)	Yes No	Yes No	Yes No	Yes No
- chiropractors, physiotherapists?	Yes No	Yes No	Yes No	Yes No
e. Have you ever been given or prescribed a drug for a period in excess of 4 weeks?	Yes No	Yes No	Yes No	Yes No
f. Have you ever had radiation treatment (x-ray or radioactive substances)?	Yes No	Yes No	Yes No	Yes No
6. Have you undergone any **special examinations**/ tests during the last 5 years, such as x-rays, computed tomography, MRI (magnetic resonance imaging), ultrasound, echo, electrocardiogram, electroencephalogram, endoscopy or other tests?	Yes No	Yes No	Yes No	Yes No
7. Have you had an **AIDS** test that showed an HIV-positive or possibly positive result?	Yes No	Yes No	Yes No	Yes No
8.a. Do you practise sports?	Yes No	Yes No	Yes No	Yes No
b. Do you smoke?	Yes No	Yes No	Yes No	Yes No
c. Do you drink alcohol?	Yes No	Yes No	Yes No	Yes No
d. Do you take painkillers, sleeping tablets, tranquillisers or other medications?	Yes No	Yes No	Yes No	Yes No
e. Do you take or have you taken any narcotics (drugs)?	Yes No	Yes No	Yes No	Yes No
9. a. Which **physician** did you last consult?				
b. Have you consulted any physicians in the last 5 years not already mentioned?	Yes No	Yes No	Yes No	Yes No
c. Which physician is most familiar with your medical history?				
10. For **female persons** only:				
a. are you pregnant? if yes, has the pregnancy been normal to date?	Yes No Yes No	Yes No Yes No	Yes No Yes No	Yes No Yes No
b. have you ever had a gynaecological disorder or a disease of the breast?	Yes No	Yes No	Yes No	Yes No

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Additional information

If you answered 'Yes' to any of the questions above, please provide details here. Please provide the precise question number(s), name of the person, diagnosis, dates and duration of illness/injury/treatment and the names and addresses of attending physicians and medical facilities.

I certify that the statements made by me in answer to the above questions are true, complete and correct to the best of my knowledge and belief. I understand that nullity of the insurance or reduction of the insured capital sum might be applied in the event of claim if it were proved that the person to be insured had established a false declaration.

In view of a smooth administration of the contract and/or settlement of the insurance claim, and only for that purpose, the signatory hereby gives his/her specific and informed consent regarding the processing of the medical data concerning him/herself and/or the members of his/her family (article 7 of the Belgian law of December 8, 1992 concerning the private life).

Date Place

Signature policyholder Signature partner

(Signature must be preceded by the handwritten words: 'Read and approved'.)

Please send this form to:

Goldstar Healthcare Ltd.
5th Floor, Mayfair Suites
Parklands Road
P.O. Box 1017, 00606 Sarit Centre
Nairobi
KENYA

Tel. + 254 20 375 4770 / 4779 / 4782
Fax + 254 20 375 4784
E-mail cigna@goldstarhealthcare.com

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