Generali Worldwide

Group Health Insurance – Standard Health Insurance Contract – Health Insurance Application Form

NOTE THE INFORMATION ON THIS FORM IS TREATED AS CONFIDENTIAL
Please complete all sections in BLOCK CAPITALS or tick the boxes, where appropriate.

Please check the appropriate boxes:

Individual Coverage ☐ Group Coverage ☐ Name of Group: _____

Employed ☐ Unemployed ☐ Self Employed ☐ Retired ☐

Proposed Effective Date of Policy M M D D Y Y (MM/DD/YY)

PART A. APPLICANT INFORMATION

	Name			Date of Birth	Sex M/ F	Height Feet/ Inches	Weight Lbs/ Oz	Immigration Status
	Last	First	Middle					
Applicant								

Postal Address:

E-mail Address:

Physical Address:

Telephone:

Fax:

Beneficiary:

Relationship:

Date of Birth: M M D D Y Y (MM/DD/YY)

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PART B. EMPLOYER INFORMATION

Name of Employer: | Employer #:

Postal Address:

E-mail Address:

Physical Address:

Telephone:

Fax:

Employer's Signature: | Date: M M D D Y Y (MM/DD/YY)

PART C. ELIGIBLE DEPENDENTS

Relationship	Family Members Names			Date of Birth	Sex M/ F	Height Feet/ Inches	Weight Lbs/ Oz	Immigration Status
	Last	First	Middle					
Spouse								
Child 1/ Dependent Offspring								
Child 2/ Dependent Offspring								
Child 3/ Dependent Offspring								

Is your spouse employed?: Yes ☐ No ☐

If Yes, please provide name of employer:

Are medical benefits available from any other approved insurer to any person listed above (Part A and/or Part C)? Yes ☐ No ☐

If Yes, please provide name of approved insurer and telephone information:

Approved Insurer: | Telephone:

Has any person listed above (Part A and/or Part C) had continuous coverage for a period of not less than one year? Yes ☐ No ☐

If Yes, please state the name of the Approved Insurer:

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PART D. MEDICAL QUESTIONNAIRE

In the last twelve months has any person listed above (Part A and/or Part C) ever been advised to or received medical consultation, care, treatment or taken medication in relation to any of the following:

1. Heart or circulatory system (including but not limited to infarction, heart attack, angina, rheumatic fever, cardiac defect, arrhythmias, diseases of veins, arteries or valves, stroke) and/or any other symptom regarding circulatory system or heart. Yes ☐ No ☐

2. Sexually transmitted diseases or Human Immunodeficiency Virus (HIV) or Acquired Immuno Deficiency Syndrome (AIDS) or ARC (AIDS related complex). Yes ☐ No ☐

3. Neurological System (including but not limited to convulsions epilepsy, paralysis, Multiple Sclerosis, cerebral infarction (stroke), Alzheimer's disease, dementia) and/or any other symptom regarding the neurological system, which if referred to a doctor would result in a diagnosis. Yes ☐ No ☐

4. Liver disorders (including but not limited to fatty liver, cirrhosis, hepatitis) and/or any other symptom regarding the liver, which if referred to a doctor would result in a diagnosis. Yes ☐ No ☐

5. Kidney/ Renal disease or failure Yes ☐ No ☐

In the last twelve months has any person listed above (Part A and/or Part C) ever:

6. Been treated for Cancer? Yes ☐ No ☐

If Yes, please explain:

7. Been treated for Diabetes (sugar)/ Hypertension (high blood pressure)? Yes ☐ No ☐

If Yes, please explain:

8. Been treated for Respiratory conditions? Yes ☐ No ☐

If Yes, please explain:

9. Had an organ Transplant? Yes ☐ No ☐

If Yes, please explain:

10. Had major surgery? Yes ☐ No ☐

If Yes, please explain:

11. Are you currently on medications? Yes ☐ No ☐

If Yes, please specify:

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12. Females only: Are you pregnant? Yes ☐ No ☐

If Yes, please specify the number of weeks gestation:

Has any approved insurer within the last twelve months:

13. Declined an application for health insurance? Yes ☐ No ☐

14. Required an increased premium or imposed special condition? Yes ☐ No ☐

15. Cancelled or refused to renew an existing health insurance policy? Yes ☐ No ☐

Declaration

I hereby declare that the answers given and recorded herein are, to the best of my/our knowledge, complete and true as at this date.

I hereby authorize any registered medical practitioner, healthcare facility or approved insurer which has copies of my health records to release such information to

Generali Worldwide (name of approved insurer).

A photocopy of this signed authorization shall be as valid as the original.
I understand and agree that any injury that occurred within twelve months before the date of this application or any sickness, the signs of which first appeared on or before the date of this application, are not covered by this contract unless fully disclosed on this application. Failure to disclose such information could result in denial of a claim and the cancellation of coverage.
I understand and agree that coverage shall not become effective until accepted by the approved insurer.
I understand that any changes in my health status after submission of application and prior to approval of coverage must be reported to the approved insurer.
In signing this document, you are deemed to have given consent to the processing of the data set out in the document by Generali Worldwide and its affiliates, authorised agents and representatives in any jurisdiction. The information provided by you may include "sensitive personal data" relating to physical or mental health or conditions that will be processed on a confidential and secure basis for the purposes of the provision of care and treatment, which may in certain circumstances include the management of healthcare services. Any sensitive data provided by you about yourself (or any other person) will be processed only in relation to the relevant contract of medical insurance and any directly associated activities which may include but not be limited to assessing risk, insurance underwriting, claims processing and settlement. Sensitive personal data will be shared with other entities within the Generali Group and other authorised third parties and may be transferred to one or more foreign jurisdictions where it is necessary for the management, administration or performance of the relevant contract of insurance and the servicing of claims and settlements, for medical reasons in the vital interest of the subject of the sensitive personal data, or for legal or regulatory purposes under the provisions of applicable law. Sensitive personal data will not be otherwise disclosed to any party without your specific written consent.

Signature of Applicant: Date: M M D D Y Y (MM/DD/YY)

Signature of Dependent (if applicable): Date: M M D D Y Y (MM/DD/YY)

THIS APPLICATION WILL BE VALID FOR 30 DAYS FROM THE DATE OF SIGNATURE.

For Office Use Only
Comments from Approved Insurer

FAILURE TO DISCLOSE RELEVANT DETAILS OR GIVING MISLEADING INFORMATION MAY CAUSE YOUR APPLICATION TO BE DEEMED NULL AND VOID.

Office: Generali Worldwide, Citrus Grove Building, Ground Floor, 106 Goring Ave, George Town, Cayman Islands.
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generali-healthcare.com
Generali Worldwide is a trading name of Utmost Worldwide Limited
Registered Head Office address: Utmost Worldwide Limited, Utmost House, Hirzel Street, St Peter Port, Guernsey, Channel Islands GY1 4PA.
Regulated in Guernsey as a licensed Insurer by the Guernsey Financial Services Commission under the Insurance Business (Bailiwick of Guernsey) Law, 2002 (as amended).
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