Your International Healthcare Partner

International Private Health Insurance

APPLICATION FORM
HEALTHCARE PLAN

CHOOSE THE PLAN YOU APPLY FOR

YELLOW	SUNRISE	HONEY	MARIGOLD	SAFFRON
O	O	O	O	O

SECTION A

YOUR PERSONAL DETAILS

Mr. / Mrs. / Ms.												
First Name												
Family Name												
Date of Birth	**Day**			**Month**			**Year**					
City and country of birth												
Gender	**M**		**F**									
HOME COUNTRY												
COUTRY OF RESIDENCE												
Coordinates in Poland/ Romania/ Hungary / Bulgaria												
Correspondence Address												
Home phone no.							**Mobile phone no.**					
E-mail / E-mail												
BUSINESS SECTION												
Occupation							**Name of company**					
Business Phone no.							**Fax Phone no.**					
E-mail							**Nationality**					

MediSky International sp. z o.o., ul. Trębacka 4, 00-074 Warsaw, Poland
T.+ 48 22 826 11 46, F.+ 48 22 826 11 46, E. office@medisky.pl

SECTION B

PEOPLE TO BE INSURED WITH YOU / DEPENDANTS

Mr. / Mrs. / Ms.														
First Name														
Family Name														
Date of Birth	**Day**			**Month**			**Year**							
Gender	**M**		**F**											
Relationship to you														

Mr. / Mrs. / Ms.														
First Name														
Family Name														
Date of Birth	**Day**			**Month**			**Year**							
Gender	**M**		**F**											
Relationship to you														

Mr. / Mrs. / Ms.														
First Name														
Family Name														
Date of Birth	**Day**			**Month**			**Year**							
Gender	**M**		**F**											
Relationship to you														

Mr. / Mrs. / Ms.	
First Name	

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Family Name															
Date of Birth	**Day**			**Month**			**Year**								
Gender	**M**		**F**												
Relationship to you															

Mr. / Mrs. / Ms.															
First Name															
Family Name															
Date of Birth	**Day**			**Month**			**Year**								
Gender	**M** **M**		**F** **K**												
Relationship to you															

SECTION C

YOUR PAYMENT DETAILS

Your currency	**EUR**		
How will you pay?	**Quarterly** O	**Semi-annually** O	**Annually** O
Extended Area of Coverage	**Israel** O		

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SECTION D

YOUR DECLARATION

Please read the following declarations carefully and only sign below if you understand and accept them.

a) I hereby apply for membership to the MediSky International Health Plan insured by MGEN.
b) I hereby declare that the information provided as well as my replies to the questions above, for me and for any member of my family, are true and accurate to the best of my knowledge, and that I have neither declared nor omitted to declare anything that may mislead the Insurer, and understand that I may be held responsible in case of false declaration, omissions or inexact replies.
c) I confirm that I have received, read and understood the full definitions, benefits, exclusions and conditions of this policy.
d) I accept that this policy will be subject to the standard policy terms and conditions effective at the time of policy commencement.
e) I acknowledge that MediHelp/ MediSky reserves the right to cancel the membership of this Plan if any amount due is not paid by on the due date.
f) I hereby authorie MediHelp/ MediSky to act for and on behalf of all persons named in the form in relation to the administration of this policy which may include the disclosure of sensitive medical information, provided by myself, my attending physician, or any medical provider. This authorization will remain in place until I provide a written request to the Insurer to revoke it.
g) I declare that I give full access to MediHelp/ MediSky to all my medical data, hospitalization notes, other documents related to underwriting objectives and claims assessment.

Printed name

_____

I, the undersigned, declare that the information supplied is accurate and up-to-date and I filled it in myself.

Signature _____

Date _____

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