



PARTNER CODE 007

# Application form

Ref.



Powered by Inedita Sarl  
Chemin du Chêne 7d | 1020 Renens | T +41 22 354 02 40  
[info@inedita.ch](mailto:info@inedita.ch) - [www.inedita.com](http://www.inedita.com)





## You affiliation in 4 steps



Step 1

**Complete, date and sign your application form and send it to:**

Inedita Sarl  
Chemin du Chêne 7d  
1020 Renens - Suisse



Step 2

**Analysis of your affiliation by Unirisc SA**

If accepted, Unirisc will confirm your affiliation to the Swiss Student Care Offer



Step 3

**Following your affiliation** you will receive the following documents via email:

- your insurance certificate
- the General Terms and Conditions of your Insurance
- a practical guide relative to your health and your cover



Step 4

**You will receive your OFAC card by post** within a couple of weeks that must be presented during any medical consultations to avoid paying advance costs

Gain flexibility, save time and make your life easier by subscribing online!



EASE OF USE



QUICK PROCEDURE



SECURE PAYMENT



[www.inedita.com](http://www.inedita.com)



PLEASE WRITE IN CAPITAL LETTERS

INSURED

Title  Mrs/Miss  Mr

Last Name [Grid]

First Name [Grid]

Date of birth [D][D] / [M][M] / [Y][Y][Y][Y]

Nationality [Grid]

Marital status  Single  Married

Occupation  Student  PhD Student  Trainee

Phone number + [ ][ ] / [Grid]

Email [Grid]

School [Grid]

Language of correspondence  French  English  German

Address in Switzerland

Street [Grid]

Postcode [ ][ ][ ] City [Grid]

Canton [Grid]

Address outside Switzerland

Street [Grid]

Postcode [ ][ ][ ] City [Grid]

Country [Grid]

## SELECTION OF YOUR COVER PACKAGE

I choose my health cover depending on the annual deductible amount and the payment frequency of my premiums.

### YOUR PACKAGE

HEALTH COMFORT offer	Payment frequency		
	Quaterly	Biannual	Annual
Annual deductible amount			
CHF 0	CHF 281 <input type="checkbox"/>	CHF 560 <input type="checkbox"/>	CHF 1'112 <input type="checkbox"/>
CHF 100	CHF 251 <input type="checkbox"/>	CHF 500 <input type="checkbox"/>	CHF 994 <input type="checkbox"/>
CHF 300	CHF 221 <input type="checkbox"/>	CHF 440 <input type="checkbox"/>	CHF 876 <input type="checkbox"/>

Required start date  /  /

Subject to acceptance and payment of the premium. Start date no earlier than the day after the date the application form is received by Unirisc SA

<b>ASSISTANCE</b> Worldwide assistance and repatriation cover, baggage handling and legal protection abroad	INCLUDED
<b>PUBLIC LIABILITY</b> Worldwide cover capped at CHF 3'000 000	INCLUDED

### YOUR OPTIONS FOR A COMPLETE COVER

<b>HEALTH PREMIUM Option</b> Private room in case of hospitalization in Switzerland*	Quaterly + CHF 191 <input type="checkbox"/>	Biannual + CHF 380 <input type="checkbox"/>	Annual + CHF 757 <input type="checkbox"/>
<b>HOUSEHOLD</b> Cover for your accomodation in Switzerland capped at CHF 35'000 / claim*	Quaterly + CHF 22.50 <input type="checkbox"/>	Biannual + CHF 45 <input type="checkbox"/>	Annual + CHF 90 <input type="checkbox"/>

Required start date  /  /  Subject to acceptance and payment of the premium. Start date no earlier than the day after the date the application form is received by Unirisc SA

\* subject to prior questionnaire

<b>CAPITAL IN CASE OF ACCIDENT</b> Worldwide risk capital accident cover in case of disability or death	Quaterly + CHF 75 <input type="checkbox"/>	Biannual + CHF 150 <input type="checkbox"/>	Annual + CHF 300 <input type="checkbox"/>
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## CALCULATION OF PREMIUM

Choice of payment frequency  Quaterly  Biannual  Annual

The payment frequency must be similar for all subscribed covers. Note that payment of your first premium is necessary to release your benefits if your application is validated. See in page 7 to define your payment method

Amount of the periodical payment:

..... + ..... + ..... + ..... = .....

HEALTH COMFORT    OPTION PREMIUM    HOUSEHOLD    CAPITAL ACCIDENT    **Total due**

## SIGNING THE APPLICATION

I hereby acknowledge having read and approved the General Terms and Conditions and being duly authorized to subscribe to this offer. I certify that the answers provided on this form and on the health declaration are correct, true and complete, failing which, any omission may lead to the cancellation of the insurance policy and the insurer's refusal to provide benefits.

Signed on:  /  /

Insured's signature

PLEASE WRITE IN CAPITAL LETTERS

## HEALTH DECLARATION

**Please note:** It is in your interest to complete this form fully and truthfully so that the insurer can correctly assess the insurance risk. Where appropriate, and in strict compliance with legislation on data protection, this information will be used to enable our doctors and our emergency and call center operators to assist you as effectively as possible during your stay and your trips. The insurer's medical examiners reserve the right to request further medical examinations, relative to the information given at the time of joining the contract. This health declaration is valid for 6 months. You can therefore only fill and sign this questionnaire during the 6-months period before the start date of the contract.

### Question 1

Are you currently in good health?  YES  NO  
If not, please provide further details

.....  
.....

### Question 2

Have you been hospitalized in the last 5 years or is it planned for you to be admitted in a hospital in the next 6 months?  
 YES  NO

If yes, please provide further details about the reason and the date of each hospitalization

.....  
.....

### Question 3

Are you undergoing any treatment?  YES  NO  
If yes, please indicate your current treatment

.....  
.....

### Question 4

Are you taking any medication?  YES  NO  
If yes, please list them

.....  
.....

### Question 5

For women: are you pregnant?  YES  NO

**Question 6**  
What is your current weight?   Kg

**Question 7**  
What is your current height?    cm

I hereby certify that I have answered to all the questions accurately and honestly and have neither included nor omitted anything which might mislead the insurers of the present policy. I hereby release service providers, health insurers, medical examiners and other competent entities from their legal or contractual duty of confidentiality towards Unirisc SA and other insurance providers in accordance to the insurance applied for by myself, and authorize them to provide the necessary information in connection with the insurance applied for (for risk assessment and clarification of any breach of the duty of disclosure).

Signed in  on  /  /

Signature of the insured must be preceded by the words  
**"Read and approved"**

.....  
.....



PLEASE WRITE IN CAPITAL LETTERS

### HOUSEHOLD QUESTIONNAIRE

To complete only if you subscribe the household insurance

#### Question 1

Are you currently or were you previously covered by a household insurance?

YES     NO

If yes, please indicate the name of the insurance company

.....  
.....

#### Question 2

Is this policy going to be cancelled or is it already cancelled?

YES     NO

If yes, please provide further details regarding the cancellation date and the reason

.....  
.....

#### Question 3

Did another insurance company refuse to cover this risk?

YES     NO

If yes, please provide further details regarding the reason

.....  
.....

#### Question 4

Where there any compensated claims during the last 5 years?

YES     NO

If yes, please provide further details regarding the claims

.....  
.....

I hereby certify that I have answered all the questions accurately and honestly and have neither included nor omitted anything which might mislead the insurers of the present policy.

Signed in  on  /  /

Signature of the insured must be preceded by the words  
**"Read and approved"**



PLEASE WRITE IN CAPITAL LETTERS

## MEDICAL EXPENSES REIMBURSEMENTS PROCEDURE

All reimbursement are made by bank transfer.

### Your bank details:

IBAN

To complete only if the bank account holder is different from the insured

Title  Mrs  Mr

Last Name

First Name

Street

Postcode  City

Country

Depending on your bank account location, bank charges may apply to your reimbursement

## SELECTION OF PAYMENT METHOD

### FIRST PREMIUM

Please tick only one payment method

**Banking transfer** to the order of Unirisc

IBAN Unirisc SA

Important: Please indicate the name of the bank account holder  
(if different from the person to be insured)

**Payment by pay-in slip**

Please complete the pay-in slip attached to this application and give it to your Swiss bank  
If you have no bank account in Switzerland, you may give the completed pay-in slip to any  
post office and pay by cash

### NEXT PERIODIC PREMIUMS

Please tick only one payment method

**Banking transfer** to the order of Unirisc

IBAN Unirisc SA

Important: Please indicate the name of the bank account holder  
(if different from the person to be insured)

**Payment by pay-in slip**

After acceptance of your application, we will send you the pay-in slip. You shall give the pay-in  
slips to your Swiss bank within a month of receiving them. If you have no bank account in  
Switzerland, you may give the completed pay-in slip to any post office and pay by cash.

**Payment by direct debit mandate**

Debit of my bank account (LSV+)  Debit of my postal account (Direct Debit)

Signed on:  /  /

Insured's signature



Submit your application form,  
it's easy!



FILL OUT



DATE AND SIGN



SEND

Please send your completed application form to:

INEDITA Sarl  
Chemin du Chêne 7d  
1020 Renens  
Tél: +41 (0)22 354 02 40  
info@inedita.ch - www.inedita.com