William Hope
ES SALUD

ADMISSION APPLICATION FORM - FOREIGN STUDENTS

Surname / Name:
Passport Number:
Date of Birth:
Marital Status:
Gender ☐ F ☐ M ☐ X
Nationality:
University:
Contact person at the university of origin:
E-mail of the university of origin:
Degree:
Start date of the degree course in Argentina:
Completion date of the degree course in Argentina:

ADDRESS AND CONTACT

Street:
Number:
Floor:
Apt.:
Postal Code:
Town / Province:
Telephone Number:
E-mail:

DATA TO BE COMPLETED BY THE AFFILIATED MEMBER

IMPORTANT

All the information shall be completed in an exact, detailed and precise manner; any omission, false information or alteration may lead to dissolution of the contract. The following form shall be completed by the affiliated member, who should include his/her own information and that of the members of the group as appropriate. This form is to be considered as a guide and it does not exempt the presenting party from reporting other relevant medical history.

ANSWER YES OR NO AS APPLICABLE. YOU AND YOUR GROUP.	AFFILIATED MEMEBER 00
Suffer or have suffered from congenital and hereditary conditions, or live with a disability.	YES ☐ NO ☐
Suffer or have suffered from nose, ear and throat conditions.	YES ☐ NO ☐
Suffer or have suffered from breast conditions.	YES ☐ NO ☐
Suffer or have suffered from pulmonary and respiratory diseases.	YES ☐ NO ☐
Smoke or have smoked. Please indicate the number of cigarettes you have smoked and the number of years as a smoker.	YES ☐ NO ☐
Suffer or have suffered from kidney, bladder, prostate or genital diseases, among others.	YES ☐ NO ☐
Suffer or have suffered from gynecological and obstetric conditions, or are pregnant.	YES ☐ NO ☐
Suffer or have suffered from digestive disorders, ulcers, gastritis, hernias, hepatitis.	YES ☐ NO ☐
Have or have had immunological and/or degenerative deseases, HIV(+)	YES ☐ NO ☐
Have or have had skin conditions.	YES ☐ NO ☐
Have or have had visual disorders, retinal detachments, glaucoma, cataracts, etc	YES ☐ NO ☐
Suffer or have suffered from hematological conditions, anemia, leukemia, lymphomas, node affections, etc	YES ☐ NO ☐
Have or have had diabetesm gout, obesity, disorders, thyroid dysfuction or other endocrinopathies.	YES ☐ NO ☐
Have or have had cardiovascular diseases, high blood pressure, angina, heart attacks, arrhytmias, murmurs, etc	YES ☐ NO ☐
Suffer or have suffered from muscle and bone disorders - including spine, hip and knee disorders - arthritis, osteoarthritis, osteoporosis.	YES ☐ NO ☐
Have any prostheses or indication for prosthesis.	YES ☐ NO ☐
Have neurological (seizures, paralysis, etc.) or psychiatric history, suicide attempts.	YES ☐ NO ☐
Have undergone a surgical intervention and/or had an accident.	YES ☐ NO ☐
Had to be hospitalized.	YES ☐ NO ☐
Are currently under medical control or treatment or have been in the last year	YES ☐ NO ☐
Are taking a medication.	YES ☐ NO ☐
Have lost significant weight over the last years.	YES ☐ NO ☐
Have or have had tumor.	YES ☐ NO ☐
Have a drug addiction (type of drugs)	YES ☐ NO ☐
Please indicate your weight.	Kg:
Please indicate your height.	cm:
Other relevant history: please write any relevant history in the comments section for each member of the family.	YES ☐ NO ☐

If you have answered YES to any of the preceding questions, indicate the member of the family group to which you refer and all the relevant data, including the date on which the event occurred and the treatment received. If you are currently receiving treatment, please indicate the medication and/or treatment you are receiving.

OWNER OBSERVATIONS: _____

I have read and understood that this statement is considered an Affidavit of Health under Law No. 26,682 (and its complementary regulations or future amendments); therefore, I accept that William Hope reserves the right to terminate the affiliation contract due to the falsity or inaccuracy of the data included in it under Art. 9 of Law No. 26,682. Thus, in accordance with what is mentioned in the previous paragraph, I understand that in case of reporting any pre-existing condition at the time of affiliation, this contract will only be valid with the express acceptance of the differential value under Art. 10 and 12 of Law 26,682.

General terms and conditions:
•The provisional card given to the applicant does not prove affiliation until the application has been accepted.
•I agree to report any modification of the data provided for any of the beneficiaries in my family group (relocation, starting a new job or changes in employment status, divorce/dissolution of a relationship, etc.).
•I hereby state that I am aware that William Hope is not responsible for incorrect framing and/or incorrect derivation of contributions.
•The Entity is subrogated in all the rights of the member against any third parties and/or their civil liability insurers whose action or omission have caused injuries to the latter which require the provision of the contracted services.

Family group
•The current or future primary member undertakes to deliver all the necessary documentation for the correct individualization and affiliation of each member.

Spouse:
•If the spouse is employed, retired or self-employed, he/she shall unify contributions with those of the main affiliated member, and should undertake to inform William Hope of any changes that may occur in his/her employment status.

Children:
•The children will be in the family group until they turn 21 years old. They will be able to be part of the group until they are 25 years old if they study. In order to be entitled to this right, study certificates from officially recognized establishments shall be submitted every year.
•In the event that they begin to work, either as an employee or self-employed, they shall leave the family group to establish a new and independent membership. You hereby agree to inform William Hope if this happens.
•Upon reaching 26 years of age, I authorize their automatic continuity outside my family group until it is otherwise informed.

List of medical professionals and coverage:
•I hereby certify that in this act I have received all the information on how to access the list of medical professionals for the plan chosen, which contains the following information: list of providers, scope, coinsurance and the table of benefits of the plan chosen. I have also been informed that referrals will be made, within the proposed service framework, if the complexity exceeds the possibilities of the locality where I reside.
•I have been notified that William Hope reserves the right to modify the provider chart maintaining the proposed services.
•The following are totally excluded from coverage by this entity: benefits not provided for in the Mandatory Medical Program and under Law 24,901; hospitalization of chronic patients with the exception of clinical and/or surgical intercurrencies; practices and/or therapies that have not passed the experimental stage or are not supported by evidence-based medicine studies.
•All benefits that exceed or complement the Mandatory Medical Program, pursuant to Res. 201-02 of the Ministry of Health and its amendments, have a waiting period of 12 months, in accordance with the provisions of Law 26,682 and Reg. Dec. 1993/11.

Change of plan:
•The plan may be modified as of the first day of the following month as appropriate. You shall stay at least one year in the plan chosen.
•In case of plan promotions and demotions, a minimum of one year of permanence in the current plan is necessary, even if it is the plan chosen when joining HOPE or a new plan chosen for any reason. The choice of changing plan affects, without exceptions, the entire family group.

Payment:
•Failure to pay a single monthly fee implies late payment and authorizes William Hope to limit the affiliate's plan benefits to those covered by their contributions or to those provided by the Mandatory Emergency Medical Program without prior notice or notification, according to the Mandatory Medical Program, without prejudice to their right of terminating the affiliation if what is indicated in Art. 9 of Law 26,682 occurs and claiming any damages. Once the affiliation is terminated:

•the Entity may modify the value of the monthly fee of the plans without affecting the balance in the relationship between the parties, with prior authorization by the Superintendency of Health Services, in its capacity as Authority for the Enforcement of Law 23,660 and in accordance with Law 26,682 (Art. 5 sections g) and 17) when such modification is due to variations in the cost structure and actuarial calculation of risks.
•Such modification will be informed no less than 30 business days in advance (from the notification date to the payment due date) and the member, in case of refusing to accept it, may terminate the contract free of charge.

Affiliated company:
•Any modification in the working conditions of the affiliated member shall be reported (employment termination, suspension, licenses, etc.), and the company shall be responsible for the amounts accrued until the corresponding submission.
•If the company is responsible for paying fees for plans that exceed the Mandatory Medical Program chosen for its employees and those in each family group, they shall sign below.
•The company is aware that William Hope is not responsible for the incorrect framing and/or incorrect derivation of contributions.

The undersigned agrees to pay the monthly difference that is generated in the event that the contributions from the National Administration of Public Revenue (AFIP) or the Federal Administration of Public Revenue (ANSES) do not cover the total cost of the fee informed by William Hope.

The plan chosen in this admission form is the one indicated below. The fee bonus will decrease when the affiliate reaches 30 and 36 years of age. From the age of 65, the provisions of Article 12 of Law 26,682 apply. The monthly fee of the plans will be modified depending on the number of members in the group and their age.

The current values of the plan chosen are those mentioned in Table A, which is included below. The difference to be paid will be the aforementioned values minus any contributions (contributions by employees or self-employed workers). This difference is estimated in Table B for illustrative purposes.

For free advice from the Superintendency of Health Services, please call 0800-222-SALUD (72583). Law CABA 1997.

NAME / SURNAME AND SIGNATURE