Luma
57 Park Ventures Ecoplex
9th Floor, Unit 901 Wireless Road,
Lumpini, Pathumwan, Bangkok 10330 Thailand

Asia Care Plus
Laos
Application Form
(Individuals & Families)
2020

CHECKLIST:
Please send to the following:

- ☐ Fully completed application form in *BLOCK CAPITALS*
- ☐ Copy of first page of passport/ID of each member
- ☐ Documents related to medical history (if any)

Please be reminded to:

- ☐ Answer all questions, if not applicable write "N/A"
- ☐ Sign with handwritten signature on page 5
- ☐ Sign your initials on the bottom of every page

WHAT WOULD YOU LIKE TO DO?

Not yet a member of Luma
☐ Apply for Asia Care Plus

Already a member of Luma
☐ Update my details Policy No: _____
☐ Add an additional dependent to my current policy Please fill in section B, H & I
☐ Change my personal details. Please proceed to section A & I

A PLANHOLDER DETAILS

☐ Mr. ☐ Mrs. ☐ Miss. ☐ Other (specify) _____

First Name: _____ Surname: _____

Date of Birth: D D M M Y Y Y Y Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Other _____

ID No./ Passport No: _____ Nationality: _____ Country of Residence: _____

Mobile Number: (include country code): _____ Email Address: _____ Language: _____

Occupation: _____ JobTitle: _____ Industry: _____

HOME ADDRESS: _____
City: Country: Postal Code:

BILLING ADDRESS: _____ Company: _____
City: Country: Postal Code:

B ELIGIBLE FAMILY MEMBERS TO BE COVERED WITH YOU

Add Dependent (s)	*Family Member 1*	*Family Member 2*	*Family Member 3*	*Family Member 4*
First name:				
Surname:				
ID:				
Gender:	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Marital Status:				
Date of birth:	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y
Nationality:				
Relationship to planholder:				
Occupation / Industry:				

C YOUR PLAN

Plan Start Date: D D M M Y Y Y Y

Plan	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Zone	☐ A	☐ B	☐ C			
Deductibles	☐ Nil	☐ $ 500	☐ $ 1,000	☐ $ 6,000		

D METHOD AND FREQUENCY OF PREMIUM PAYMENT

Bank Transfer

E BANK DETAILS FOR CLAIM REIMBURSEMENT

Account holder's name: Bank name:

Bank address: Country:

Account no: SWIFT or sort code:

F DOCTOR'S / MEDICAL PRACTITIONER'S DETAILS

Please give details of your most frequented hospital, current doctor or the one who is most familiar with your family's medical history.

Name: Hospital/Clinic/Practice:

Telephone: Fax: Email:

Address:

City: Country: Postal Code:

G YOUR CURRENT INSURANCE POLICY

Please tell us about your current insurance policy if you would like to have a continuous transfer of your benefits. Waiting periods apply for certain medical conditions, meaning that you will have no coverage for these conditions until the end of the waiting periods. However, waiting periods may be waived if you hold an insurance policy with a similar cover to Asia Care Plus, with no break of cover. Benefits in your current policy must be equal / higher than those of Asia Care Plus in order for waiting periods to be waived.

Name of current insurer: Policy No:

Name of current plan: End Date:

MEDICAL HISTORY

	Planholder	Family Member 1	Family Member 2	Family Member 3	Family Member 4
Height (cm)					
Weight (kg)					
Blood pressure (Optional)					

*Please reply to the questions below with either **yes** or **no**. If the response given is **yes**, please provide full details in the relevant sections below, clearly stating the person to which the information relates. Any extra information regarding the state of your health may be added on additional sheets of paper and attached to this form.*

1 Does your present state of health prevent you from performing your full time profession/ occupation?

	Planholder	Family Member 1	Family Member 2	Family Member 3	Family Member 4
Therapeutic Part Time Leave	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Total leave of absence					
Reason(s)					

2 Have you undergone or been advised to undergo surgery, other than for the extraction of the appendix, tonsils or andenoids?

	Planholder	Family Member 1	Family Member 2	Family Member 3	Family Member 4
Details of surgery	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Date(s)					

3 During the past five years, have you been prescribed sick leave or a medical treatment exceeding five days (excluding common colds and flu treatments)?

	Planholder	Family Member 1	Family Member 2	Family Member 3	Family Member 4
Please give reason	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Nature of treatment					
Which circumstances apply					

4 Have you received care or undergone medical tests – (excluding common colds and flu treatments) - during the past five years in a medical establishment (hospital, clinic, convalescent home, physiotherapy, dietary needs or treatment center, sanatorium)?

	Planholder	Family Member 1	Family Member 2	Family Member 3	Family Member 4
Date(s) (Please attach photocopies of post-operative and cell reports)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

5 During the past ten years, have you experienced any of chronic or serious illnesses (including but not limited to diabetes, hypertension, stroke, heart disease, depression, inflammatory disease, cancer, leukemia or other blood illness)?

	Planholder	Family Member 1	Family Member 2	Family Member 3	Family Member 4
Please indicate which illness and state clearly all relevant details (date, duration, treatment, recovery date, after-effects, comments)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

H MEDICAL HISTORY

	Planholder	Family Member 1	Family Member 2	Family Member 3	Family Member 4
6 Have you had a screening for AIDS, hepatitis virus or for one of the human immuno-deficiency viruses?					
Date	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Nature of the test					
Result					
7 Have you had any after-effects resulting from an accident or illness?					
Description	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Date of event					
Nature of effect					
Recovery date					
After-effects					
8 Do you suffer from a disability or are you entitled to a disablement pension (civilian or military) or old age pension?					
Nature of disability	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Nature of pension of annuity					
Rate (Please attach notification)					
9 Have you ever been accepted on special conditions or refused personal accident, life or health insurance?					
Reason for and date of rejection	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10 Are you or have you been lately suffering from any sign or symptom (pain, lumps, bleeding, etc.)?					
If yes, please describe	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
11 Are you or have you been lately undergoing any investigation or taking any medication or receiving any form of treatment recommended or prescribed?					
If yes, please describe	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

I DECLARATION AND AUTHORIZATION

- I hereby apply for coverage on behalf of all the family members named in this Application Form.
- I acknowledge that "the Insurer" as mentioned hereafter refers to Lanexang Assurance Public Company.
- I acknowledge that "the Company" as mentioned hereafter refers to the Third-Party Administrator (TPA) appointed by The Insurer and acting on its behalf. The Insurer has appointed LUMA as the Third-Party Administrator for the servicing and administration of this policy, including but not limited to Underwriting, Enrollment (including collecting the insurance premiums and issuing the policy and all related materials), Customer Service, Claims Validation and for certain cases Claims Payment.
- I declare that I have read and accepted the Policy Wording, including but not limited to the Terms and Conditions, Definitions, Waiting Periods, Insuring Agreements and Exclusions of this Policy. I am fully aware that the content of the Policy is part of the agreement and establish the contract between myself and the Insurer. I therefore understand that coverage shall be provided according to this agreement.
- I declare that the information presented in this application, including the information concerning any persons named in this application, is accurate and complete, although certain disclosures may not be provided in my own handwriting. I understand that it is against the law for me and my eligible family members to intentionally provide inaccurate, incomplete or misleading information in order to defraud the Insurer and that any fraudulent disclosures will result in various forms of penalties, including but not limited to termination of coverage, specific exclusions or premium loading. If the Insurer or the Company have already paid for any Benefits, the Insurer can enforce its rights for a return of such payment whether in whole or in part.
- I understand that, should there be any changes regarding the information in this application form, such as a family member's state of health, I must inform the Company immediately.
- I authorize any doctor who has ever provided treatment or given advice to any persons named in this application to disclose information to the Company regarding the treatment that are related to any claim under this Plan. I have obtained the consent of all persons to be enrolled to disclose their healthcare information in accordance with this authorization.
- I declare that I have read and understood the Cancellation and Termination rights, and Legal notices included in the Policy Wording.
- I understand that if I do not pay for my premium in due time and do not provide an alternative method of payment upon request, the Insurer cannot be liable for coverage and therefore will not pay for any claims.
- I agree that I am liable to all claims paid for my plan which have resulted from any medical treatment deemed as non-covered claims.
- I understand that if I do not repay for funds expended in good faith by the Company for any medical treatment that is not covered under the Policy, subsequent valid claims may be compromised to compensate for the outstanding funds and/or my plan may be suspended until the outstanding amounts have been paid in full.
- I acknowledge that, if the Company discovers any of my claims to be fraudulent, my Policy may be immediately terminated.
- I understand that in any Covered Person breaks any terms and conditions of this Policy that the Company has reasons to believe are essential, the Company may refuse to pay for the Benefits or recover from the Covered Person the amount the Company have already paid for the Covered Person. The Company may decide to make waivers in certain cases, but this does not mean that the Company would make similar waivers in any subsequent breach of that term and/or condition.
- I understand that in case of a claim where the original receipt has been submitted to another third party for part payment of a claim the Company will accept a copy provided that the third party authenticates the receipt as being original and indicates the amount which has been paid to the Covered Person by the third party.
- I understand that if any Covered Person is covered by a Government program or another policy (employer, educational institution, professional associations, etc.), the combined payments for coverage of the benefit shall not exceed the actual expenses. The reimbursement of the benefit will be at the insured's discretion whether to reimburse from which policy first.
- I understand that the medical information of any persons named in this application form will be exchanged between the Company, the Insurer and the medical professionals within its network.
- I authorize the Company to send documents concerning this Policy to the home and/or billing address and email address I have provided to my intermediary's address.
- I understand that my phone conversations with representatives of the Company may be recorded for the purposes of training and quality management.
- I understand that this Insurance Policy is tacitly renewed each year regardless of each Covered Person's age or state of health. I acknowledge that the insurance premium applied to the plan chosen is based on age bands, and that the premiums are readjusted by the Insurer each year according to the medical inflation and other factors having an influence on the view of the risk by the Insurer, such as but not limited to the overall risk profile of a group of Covered Persons insured under the same plan. The Company will inform the Insured with all the importance information including any change in the Policy terms and conditions, exclusion, or coverage prior to the Renewal Date.
- I acknowledge that in order to be eligible to this policy, all the covered persons must be aged less than 71 years old at the initial effective date of the policy, and live at least 185 days per year in the Primary Area of Coverage as described in the Certificate of Insurance (Primary Area of Coverage: Bangladesh, Bhutan, Brunei, Cambodia, East Timor, India, Indonesia, Laos, Malaysia, Maldives, Myanmar, Nepal, Pakistan, Philippines, Sri Lanka, Thailand, Vietnam). I understand that if I, or any family members named in this Application Form live outside of the Primary Area of Coverage more than 185 days per year, the Insurer has the right to terminate the Policy.
- I agree to the declaration above and understand that this Application Form is forming part of the Policy, which includes the Application Form, Certificate of Insurance, Table of Benefits covered, and Policy Wording.
- I understand that regardless of the premium payment period agreed by The Insurer and me, the premium payment needs to be received by The Insurer within 30 days from policy effective start date. The Insurer reserves the right to change the policy effective start date if the premium is received after 30 days from the policy effective start date.

Signature (Insured/ Main applicant):

Date: D D M M Y Y Y Y

Name:

FOR INTERMEDIARY ONLY

☑ Agent ☐ Broker **License No. :**

Contact Person: Mr. Fabrice Decico **Company Name:** J&C Insurance

Phone Number: +856 20 77 125 000 **E-mail address:** insurance@jclao.com