Group Health Plan Application Form

Notice

1. In order for you to fully understand the insurance applied for and so as to protect your rights and interests, please ensure that you have carefully read the relevant insurance contents and policy wording and that you fully understand important issues like benefits, exclusions, honest disclosure and contract cancellation before completing this application.
2. The Application Form, List of Insured Members and other files deemed necessary by the Insurer (hereinafter "application files") are basis for the Insurer to issue the Insurance Contract and will be an important part of the Insurance Contract. The Policyholder and Insured should disclose honestly, and the Insurer agrees to keep all application files confidential.
3. The Application Form should be stamped by the Policyholder and signed by the legal representative or authorized person of the Policyholder. All application files should be stamped. All acts of the authorized person fully represent the Policyholder's will.
4. If you fill in and sign/stamp the application files, it should be regarded that the Policyholder fully understands the policy wording and agrees to abide by it.

SECTION 1. APPLICANT DETAILS

Company or Group Name: _____

Mailing Address: _____

Telephone: _____ Fax: _____

Name of Administrator/Director: _____

Email Address: _____

Name and Position of Contact Person: _____

Email Address: _____

SECTION 2. COVERAGE

Are you presently insured with another insurance company ☐Yes ☐No If yes, please provide the following details:

Name of Company: _____ Plan: _____ Expiration Date (MM/DD/YYY): _____

Would you like your policy to commence immediately upon acceptance? ☐Yes ☐No

If No, please specify commencement date (MM/DD/YYYY): _____

Medi+ Plan: ☐ Classic ☐ Advance ☐ Premier

Deductibles: ☐ $100 per annum ☐ $500 per annum ☐ $750 per annum ☐ $1,000 per annum
☐ $50 per claim ☐ $100 per claim ☐ $250 per claim
☐ Policy Co-Payment _____%
☐ N/A

Area of Coverage

Classic		Advance		Premier
IP only	IP and OP	IP only	IP and OP	IP and OP
☐ Area 2	☐ Area 2	☐ Area 1	☐ Area 1	☐ Area 1
☐ Area 4	☐ Area 4		☐ Area 3	☐ Area 3
	☐ Area 5		☐ Area 4	☐ Area 4
	☐ Area 6		☐ Area 5	☐ Area 5
			☐ Area 6	☐ Area 6

Area 1 – Regional
Area 2 – South East Asia (excludes Singapore)
Area 3 – Asia Pacific (excludes non-network hospitals in Singapore)
Area 4 – Asia Pacific+ (includes all hospitals in Singapore)
Area 5 – International+
Area 6 – Worldwide
(Please refer to footer for list of countries in each Area of Coverage)

Optional Benefits: ☐Maternity
☐Vision
☐War and Terrorism
Wellness ☐$250 ☐$500
Dental ☐$320 ☐$640 ☐$1,200 ☐$1,500 ☐$2,000 ☐$2,500 ☐$3,800
Global Personal Accident Cover ☐$50,000 ☐$100,000 Other Insured Capital: _____

Special Request: _____

List of Countries in each Area of Coverage
Regional: Cambodia, Thailand, Vietnam, Malaysia
South East Asia Excluding Singapore: Cambodia, Thailand, Vietnam, Malaysia, Brunei, Indonesia, Myanmar, Philippines, Laos, Korea, Japan
Asia Pacific: Bangladesh, Bhutan, Brunei, Cambodia, Hong Kong, India, Indonesia, Japan, Laos, Macau, Mainland China, Malaysia, Maldives, Mongolia, Myanmar, Nepal, North Korea, Pakistan, Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Thailand, Timor-Leste, Vietnam, Australia, New Zealand, Solomon Islands, Tuvalu, Marshall Island, Palau, Kiribati, Vanuatu, Micronesia, Papua New Guinea, Fiji, Tonga, Nauru, Samoa
International: All countries except U.S.A.
Worldwide: All countries

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Group Health Questionnaire

The purpose of the Health Questionnaire is to evaluate health conditions for the primary insured and each of his/her dependents, if any. To determine the underwriting conditions, please answer the questions below truthfully. Pre-existing conditions means any Illness or Injury, physical or mental condition, for which an Insured Person receives any diagnosis, medical advice or treatment, or has taken any prescribed drug, or where distinct symptoms were evident prior to the effective date.

Please truthfully answer YES or NO to each of the following questions for the primary insured and each of his/her dependents, if any. For each YES answer, please explain and provide details:

1. Currently on sick leave? ☐YES ☐NO
2. Unable to be fully active in work, or reduced work load due to sickness during the last year? ☐YES ☐NO
3. Been diagnosed with, treated for any of the following catastrophic illnesses: ☐YES ☐NO
   a. Cardiovascular disease - includes coronary artery disease, congenital heart disease, chronic pulmonary heart disease, myocardial infarction, aortic aneurysm.
   b. Neurological conditions - includes stroke, brain aneurysm, Alzheimer's disease, Parkinson's disease, Syringomy elia, Multiple Sclerosis.
   c. Hematologic disease - includes leukemia, lymphoma, aplastic anemia, ITP, hemophilia.
   d. Pulmonary diseases - includes chronic obstructive pulmonary disease, primary pulmonary hypertension.
   e. Digestive diseases - includes liver cirrhosis, severe hepatitis.
   f. Autoimmune diseases - includes systemic lupus erythematosus, systemic scleroderma, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS), and all diseases caused by and/or related to the HIV virus.
   g Others - includes all cancer, major organ failure /transplant, cystic fibrosis, Peutz-Jeghers syndrome, III-degree burns.

For any YES answer, the corresponding insured needs to fill in the Group Health Plan Member Health Statement as truthfully and thoroughly as possible.

Statement

The Policyholder declares that during the policy period, none of the Primary Insured or their dependents have been diagnosed with or treated for any of the above 7 catastrophic conditions. During the Effective Period of the Policy, the Policyholder, all Primary Insured and/or their dependents are responsible for providing all detailed information on the above mentioned catastrophic conditions. If due to any reasons whether by intention, gross negligence or otherwise, the Policyholder and/or any Primary Insured and/or their dependents fail to inform all material facts, the Insurer reserves the right to further investigate whether catastrophic conditions are pre-existing conditions, and may re-underwrite or not cover the conditions stated above of the Primary Insured and/or their dependents for whom the Policyholder does not inform the Insurer according to the facts. The Policyholder will assume all liabilities for any disputes arising hereto between the Insurer and the Primary Insured and/or their dependents.

During the policy period, the Policyholder certifies that the applications of policy changes such as addition, deletion, cancellation, etc. made from the fax or email stated in the Application are valid. For the same changes, the Policyholder will provide additional written application with company stamp. The Policyholder will assume relevant legal liabilities. If the fax or email stated in the Application changes, the Policyholder will provide written Authorization Change Notice.

I hereby acknowledge the reality and validity of the above information and the attached enrollment form.

Signature

Stamp

Date (MM/DD/YYYY)

Notes: Please check the service charge and middle bank charges before you complete the Wire Transfer. If the service charge and/or middle bank charges are deducted from the payment, you are responsible for the charges.