GROUP HEALTH PLAN MEMBER HEALTH STATEMENT

Dear Member,

Greetings! Below, please find the Member Form, which consists of a Member Information Form and a Medical Questionnaire. Only one Application needs to be completed for you and your dependent(s), if any. Upon completion, please sign the bottoms of Pages 1 and 4 and return all forms to us.

The purpose of the Medical Questionnaire is to evaluate the health conditions for you and your dependents and determine coverage, please answer the questions below as truthfully and thoroughly as possible. Preexisting conditions are subject to underwriting. For the purpose of your health insurance, Pre-existing conditions are defined as “any Illness or Injury, physical or mental condition, for which an Insured Person received any diagnosis, medical advice or treatment, or had taken any prescribed drug, or where distinct symptoms were evident prior to the effective date.”

Upon receiving your insurance premium, you and your dependents if any will be given an insurance card. The insurance card can be used at our “direct billing providers” where the provider sends claims to us for direct settlement. However, if a direct billing provider is used, for any expenses not eligible to be covered by the policy and not collected by the provider, you should pay the corresponding expenses to the Company within 30 days from the day of notification by the Company or its behalf. Otherwise, the Company has the right to cancel direct billing services or even cancel the contract with no refund of premium.

You and your dependents must reside in Cambodia for at least 8 months. Please inform our sales representative or Forte Insurance if you are unsure about meeting residential requirement.

I hereby acknowledge that I have read, understand and agree to the terms and conditions stated above.

Applicant Signature

Date (MM/DD/YYYY)

FORTE TOKO ASSURANCE

MSH

Please complete this form in **BLOCK LETTERS,** and tick in boxes where applicable.

Checklist:

☐ Health Statement Form ☐ Passport/ID copies of all insured members
☐ Bank Account Details ☐ Medical Records (if applicable)

SECTION 1. DETAILS OF POLICY HOLDER

Last Name: _____ First & Middle Name: _____ Gender (M/F): _____
Date of Birth (MM/DD/YYYY):_____ Height (cm): _____ Weight (kg): _____
Nationality: _____ ID or Passport No.: _____ Marital Status: _____
Phone Number: _____ Fax:_____ Email: _____
Occupation: _____ Employer: _____
Residential Address: _____

_____
Postal Code: _____ City:_____ Country: _____
Address for correspondence (if different from residential address): _____

_____
Postal Code: _____ City: _____ Country: _____
Emergency Contact Person: _____ Relationship: _____
Phone Number: _____ Email: _____

SECTION 2. DEPENDANTS TO BE INCLUDED IN YOUR PLAN

	Spouse/Partner	Dependant 1	Dependant 2	Dependant 3
Last Name				
First Name				
Gender (M/F)				
Date of Birth (MM/DD/YYYY)				
Height (cm)				
Weight (kg)				
Nationality				
ID or Passport No.				
City of Residence				
Occupation				
Relationship to policyholder				
Phone Number				

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): _____

SECTION 3. MEDICAL QUESTIONAIRE

Please tick YES or NO to each of the following questions for each person named in your application. If you answered YES to any question, please provide full details. Have you or your dependants:

	Policy Holder		Spouse/ Partner		Dependant 1		Dependant 2		Dependant 3	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
1. Been admitted to a hospital/other medical facility or had surgery?										
2. Been disabled and/or incurred medical costs exceeding USD$6,500										
3. Been told that there was any abnormity during checkup										
4. Suffered from a disease or an accident entailing 30 days or more sick leave and/or medical treatment										
5. Received any disability pension or work accident pension?										
6. Been told that it may be necessary to be admitted to the hospital or have surgery in the future?										

	Policy Holder		Spouse/ Partner		Dependant 1		Dependant 2		Dependant 3	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
7. Had any health problems or complaints, been diagnosed with, or had treatment for any of the following:										
A. Repeated pharyngalgia, chronic cough, expectoration, hemoptysis, asthma, difficulty breathing, bronchiectasis, pneumothorax, emphysema, tuberculosis, pleurisy, chronic bronchitis, or other diseases of the respiratory system?										
B. Back pain, frequent urination, urgency of urination, pain in urination, difficulty urinating, blood or protein in the urine, abnormal amount of urine, nocturia, swelling in the face, kidney and urinary tract stone, nephritis, nephropathy, renal cyst, hydronephrosis, or other urinary system problems?										
C. Chronic loss of appetite, belch, nausea, vomiting, abdominal distention, abdominal pain, constipation, diarrhea, hematemesis, melena, hematochezia, jaundice, difficulty swallowing, ulcer, colitis, stomach problems, hernia, rectal problems, HBV Carrier, liver disorders, gall bladder disorder, pancreas problems or other digestive system problems?										
D. Palpitation, tachypnea after exercise, hemoptysis, edema or varicose veins of lower extremity, chest discomfort or pressure, syncope, rheumatic fever or heart murmur, arrhythmia, myocarditis, cardiovascular disease, myocardial infarction, stroke, aneurysm, coronary heart disease, hypertension, hyperlipaemia, or other circulatory system disorder?										
E. Fatigue, dizziness, nosebleed, subcutaneous, hemorrhage, purpura, pain in bone, anemia, or other blood system disorders?										
F. Arthritis, gout, neck pain, back and lumbar pain, cervical vertebral disease, lumbar vertebral disease, myophagism, nervous lesion or musculoskeletal/joint problems?										
G. Abnormal appetite, hyperhidrosis, polydipsia, polyuria, tremor on hands, obesity, pigmentation, amenorrhea, diabetes, thyroid diseases, or other metabolism and endocrine system problems?										
H. Dizziness, vertigo, syncope, hypomnesis, disturbance of vision, insomnia, disturbance of consciousness, tremor, convulsions, seizure, paralysis, sensory abnormity, epilepsy, loss of consciousness or other nerve system disorder?										
I. Prostate disorder, mastalgia, mastitis, irregular menstruation, menorrhagia, dysmenorrheal, endometriosis, abnormal growth in the uterus, ovarian cyst, infertility, or other diseases of the male/female reproductive organs including venereal diseases?										
J. Cancer, tumor or mass, polyps, cysts, enlarged glands, lymph nodes or organ, disorders of the skin or pigmentation, abnormal growth in the breasts or any related conditions?										
K. HIV infection, AIDS, AIDS-related complex or other immune deficiency disorders, infection problems or venereal diseases?										
L. Alcohol or substance abuse, mental/nervous, behavioral, emotional, or eating disorders?										
M. Cataracts, glaucoma, or any eye disorder, hearing loss, or any ear/ nose/throat disorder?										
N. Disabling illness, physical defect, suffers from the consequences of accident, congenital disease, hereditary disease, genetic defect? Do you or your dependants have any family medical history?										

	Policy Holder		Spouse/ Partner		Dependant 1		Dependant 2		Dependant 3	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
O. Are you or your dependants:										
a. Currently pregnant?										
b. Have any complications of pregnancy?										
c. Expects a child by either natural or artificial means? d. Advised to seek treatment, medication, diagnostic test or surgery for infertility?										
e. Been treated for infertility?										
P. Other than previously stated:										
a. Smoke more than 15 cigarettes per day or use tobacco in any form?										
b. Within the past 5 years, gained or lost more than 12kg (25lbs) in 12 months?										
c. Any other medical condition that has not been disclosed above? If so, please describe in details below										

Please provide explanation for any YES answers below. Medical report may be required.

Qn No.	Name	Date	Condition	Treatment	Current Status

SECTION 4. DECLARATION

1. I declare that I have answered all the questions truthfully and to the best of my knowledge. If this form has been com pleted on my behalf, I agree to the truthfulness of the responses given. I understand that any incorrect or incomplete answer or the concealment of any facts relevant to this insurance may invalidate this policy. I also understand that the insurer shall be entitled to retain all premiums paid during the policy year by virtue of a breach of this declaration.
2. I am also aware that I have to notify the insurer of any fact material to this insurance, which arises between the date of this declaration and the inception of this policy.
3. I agree to accept the insurer's standard form of policy for this type of insurance and have read and understood the important notice.

Signature of Applicant/Primary Insured

Date (MM/DD/YYYY)

Please return completed and signed Form(s) to Forte Insurance for enrollment.