Individual 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 ask sales representative/broker for the policy wording and detailed explanations of the policy wording, particularly in terms of important contents such as benefits and exclusions before applying. Before completing this application, please ensure that the sales representative has explained the policy wording; that you have carefully read the relevant insurance contents and policy wording; and that you have fully under stood important issues like benefits, exclusions, honest disclosure and contract cancellation.

2. The Application Form, and other files deemed necessary by the Insurer (hereinafter "application files") are the basis for the Insurer to issue the Insurance Contract and will be an important part of the Insurance Contract. The Policyholder and the Insured should disclose honestly, and the Insurer agrees to keep all application files confidential.

3. The application form may only be signed by the policyholder. No other party or person may sign on behalf of the policyholder.

4. By completing and signing the application files, you acknowledge that you have fully read, and understand the policy wording and agree to abide by it.

5. You and your dependents (if any) must reside during the policy period within Asia-Pacific area for at least 8 months. Please inform brokers/agency/sales representative and the Insurer if you are unsure or not able to meet the residential requirement.

6. The purpose of the Medical Questionnaire is to evaluate the health conditions of you and your dependents (if any). To determine coverage, please answer the questions below as truthfully and thoroughly as possible. Pre-existing conditions, if any, will not be covered unless approved by the insurer. 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."

7. 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 representative. Otherwise, the Company has the right to cancel direct billing services or even cancel the contract with no refund of premium.

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

Applicant Signature

Date (MM/DD/YYYY)

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

Checklist:

☐ Application Form ☐ Passport/ID copies of all insured members

☐ Bank Account Details ☐ Medical Records (if applicable)

SECTION 1. DETAILS OF POLICY HOLDER

Last Name:_____ First Name: _____ ☐ Male ☐ Female

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): _____

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

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

*Please allow at least 5 working days (from date of submission of application form) for enrollment and payment.

SECTION 3. COVERAGE

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

☐ N/A

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)

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

Optional Benefits: ☐ Maternity (not available for individual female applicant and IP only plans)
☐ Supplemental Benefits Package
☐ Global Personal Accident Cover

You	☐ $30,000	☐ $40,000	☐ $50,000	☐ Other Insured Amount: _____
Spouse/Partner	☐ $30,000	☐ $40,000	☐ $50,000	☐ Other Insured Amount: _____
Dependants	☐ $30,000	☐ $40,000	☐ $50,000	☐ Other Insured Amount: _____

Please answer the following questions if you had opted for Personal Accident Cover (for all included in PA cover).
1. Is your occupation 100% office-based? ☐ Yes ☐ No
If No, please provide full details on the type and frequency of out-of-office activities required by your job: _____

_____

2. Do you engage in hazardous sports or activities which are likely to cause bodily injury or death such as but not limited to horse riding, scuba diving, mountaineering, rock climbing, bungee jumping, parachuting? ☐ Yes ☐ No
If Yes, please provide full details on the type and frequency of such activities: _____

_____

Please read through PA policy wording for exclusions. Cover for hazardous sports / activities or occupations may be subjected to a premium loading or decline for coverage.

SECTION 4. PAYMENT

Payment Frequency: ☐ Annually

Payment Method: ☐ Cash ☐ Cheque ☐ Bank Transfer

*Please address cheque to TOKOJAYA LAO ASSURANCE CO., LTD.

SECTION 5. CLAIM REIMBURSEMENT

Reimbursement Method:

☐ Cash
☐ Cheque-Payee's Name: _____
☐ Bank Transfer
Account Holder's Name: _____ Account No.: _____
Account Holder's Phone No.: _____
SWIFT Code/ABA Code/IBA No.: _____
Name of Bank and Branch: _____
Bank Address: _____

SECTION 6. 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?										
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?										

	Policy Holder		Spouse / Partner		Dependant 1		Dependant 2		Dependant 3	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
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, recta l 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?										
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 7. DECLARATION

1. I declare that I have answered all the questions truthfully and to the best of knowledge. If this form has been completed 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 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 understand and accept that for all Insured, no benefit will be payable to any pre-existing condition which is not approved by the Insurer.

I understand and accept all items stated in the policy wording.

Signature of Applicant/Primary Insured

Date (MM/DD/YYYY)

Please return completed and signed Form(s) to TOKOJAYA LAO ASSURANCE CO., LTD. for enrollment.