Corporate Medical Questionnaire

GlobalHealth®

One Medical Questionnaire must be submitted for each person to be covered by a GlobalHealth policy.

Proposer's Details

Company:

Employee Name

Employee Name:

Applicant Details

This is the Medical Questionnaire of:

First Name(s):

Family Name:

Date of Birth (ddmmyy): Gender (M/F): Marital Status:

Passport/ID Number: Nationality:

Occupation (specify nature of business & duties):

Height (cm): Weight (kg): OR Height (feet): ft in Weight (pounds):

Relationship to Employee: Self ☐ Spouse ☐ Child ☐

Usual Country of Residence:

Address:

Postal Code: City:

Country:

Telephone: Fax:

Email:

(Electronic EOB and claims related enquiries may be sent to this email address)

Important note about filling in this form:
The answers you give to the questions contained in this Application will form the basis of any insurance policy issued, and will be incorporated into the contract. It is essential that you give accurate, truthful, and complete information for all persons to be insured, as inaccuracies may jeopardize coverage or invalidate a claim.

1. Does this person's occupation include any activities involving offshore, underwater, underground, or manual work, or work in a remote location? If yes, please give details. Yes ☐ No ☐

2. Has this person previously applied for or held a GlobalHealth policy? If "Yes", please provide policy number. Yes ☐ No ☐

3. Does this person have health insurance with another insurance company? If "Yes", please attach a copy of the policy and benefit schedules, and indicate if the other coverage will be continued if the GlobalHealth application is approved. Yes ☐ No ☐

4. Has this person ever had a policy or application for life, sickness, accident disability, critical illness or medical insurance refused, postponed, declined, withdrawn, or had any special terms (including extra premium or exclusions) imposed? If "Yes", please provide full details. Yes ☐ No ☐

5. Has this person been in a hospital for treatment or observation or undergone any surgical procedure in their lifetime? If "Yes", please provide the date, diagnosis, and nature of treatment. Yes ☐ No ☐

6. Within the last five years, has this person suffered from, been treated for, sought advice on, or had symptoms relating to any of the following conditions:

a) Cancer, leukaemia, tumour of any kind (benign or malignant) or blood disorder? Yes ☐ No ☐

b) Asthma, chronic bronchitis, chronic sinusitis, allergies, deviated nasal septum, tuberculosis, or any disease or disorder of the lungs? Yes ☐ No ☐

c) Chest pain, raised blood pressure, heart condition, rheumatic fever, varicose veins or circulatory disorder? Yes ☐ No ☐

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d) Indigestion, gastric or duodenal ulcer, hernia, haemorrhoids or any disease or disorder of the bowel? Yes ☐ No ☐

e) Kidney stones, urinary tract infections or complaint, venereal disease, or any disease or disorder of the kidney, bladder, prostate or genito-urinary tract? Yes ☐ No ☐

f) Diabetes or any disease or disorder of the gall bladder, pancreas or liver, including Hepatitis B or Hepatitis C? Yes ☐ No ☐

g) Disease of the brain, nervous system, stoke, epilepsy? Yes ☐ No ☐

h) Mental health disorder, depression, anxiety, nervous condition, stress, post traumatic stress disorder, behavioural problem, alcohol or drug addiction? Yes ☐ No ☐

i) Back or neck pain or strain, spinal condition, sciatica, whiplash, arthritis, bone fracture, joint injury e.g. knee, elbow, wrist,shoulder, hallux valgus (hammer toes) or experienced any symptoms of a muscle disorder or gout? Yes ☐ No ☐

j) Malaria, dengue fever, typhoid or any other tropical disease? Yes ☐ No ☐

k) HIV, AIDS (acquired immune deficiency syndrome), AIDS related condition or had any positive blood test for the HIV (also called AIDS or HTLV-III) virus? Yes ☐ No ☐

l) Pregnancy or any complications of pregnancy, abnormal smear test or any gynaecological disorder? (female only) Yes ☐ No ☐

m) Psoriasis, eczema, dermatitis or other skin condition or any disease or disorder of the eyes or ears? Yes ☐ No ☐

n) Any other ailment, impairment, injury or condition(s) not mentioned above? Yes ☐ No ☐
If yes to any of the above questions, please provide full details and include all relevant up-to-date medical reports. (Attach separate sheet if necessary)

7. Is this person taking any medication or receiving any form of treatment at the present time? If "Yes", please provide the medical condition, name of medication and dosage, and/or treatment. Yes ☐ No ☐

8. Has this person been advised to have or do they intend to seek any medical advise, test, investigation, surgical procedure, hospitalization, or treatment in the near future? If "Yes", please provide the medical condition, attending physician, and recommended treatment. Yes ☐ No ☐

9. Please provide the following information about this person's current usual doctor/personal physician/ medical centre or hospital:

Name:
Address:
Telephone: Facsimile: Email:
How long has this person been under this Physician's care:
Date of last attendance & reason:

Declaration by Applicant

I/we hereby apply for a policy to be issued based on the statements contained herein and declare that all answers to the foregoing questions are correctly recorded, and that they are full, complete and true. I/We agree to disclose to the Insurer and its medical advisers all material facts and matters of which I/we are aware and execute any document to empower the Insurer to obtain relevant information from any doctor, hospital, or other source. Except as declared herein, all persons to be insured are currently in good health. I/We agree that if the health status of the above intended insured person changes after this application is signed and before the Insurer issues a policy I/We shall immediately notify the Insurer of the change. I/we agree that the policy as issued including all schedules, endorsements, and this application shall form the whole contract and that no insurance shall be in force until and unless the application has been accepted, and the appropriate premium paid.

Signature

Date

DATA PRIVACY: It is hereby declared that as a condition precedent to the liability of the Insurer, the Insured Individual(s) has agreed that any personal information collected or held by the Insurer is provided and may held, used and disclosed by the Insurer to individuals/organizations associated with the Insurer or any selected third party (within or outside the Philippines) for the purpose of processing the application and providing subsequent services for this and other financial products and services, direct marketing, data matching, and to communicate with the Insured Individual(s) for such purposes. The Insured Individual(s) has the right to obtain access to and to request correction of any personal information held by the Insurer concerning the Insured Individual(s). Such request can be made to Pioneer Life Inc.

NOTE: Under Republic Act 9160 (Anti-Money Laundering Act) as amended by Republic Act 9194 and pertinent regulations, all insurance companies are required to satisfactorily establish the identities of all its customers. Hence, Pioneer Life Inc. reserves the right to not accept and process any application for insurance if the customer fails to provide sufficient evidence to establish his identity.

Please send completed form to:
Pioneer Life Inc.
Attn: GlobalHealth Asia
108 Paseo de Roxas, Legaspi Village, Makati City 1229, Philippines
Tel: +852 2523 8778 Fax: +852 2526 0769 Email: pliapp@pioneer.com.ph

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