GlobalHealth®

Individual & Family Application

Please include in this form details and information about all individuals who are to be insured under your Individual/ Family medical policy.

Proposer's Details

First Name(s):

Family Name:

Date of Birth (ddmmyyyy): Gender (M/F): Smoker: Y ☐ N ☐

Passport/ID Number: Nationality:

Occupation (specify nature of duties):

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

Marital Status: Relationship to Policyowner: ☐ Self ☐ Spouse ☐ Child

Usual Country of Residence:

Address:

Postal Code: City:

Country:

Telephone: Fax:

Email:

Note: Explanation of Benefits (EOBs) and/or claim enquiries may be sent to this email address.

Mailing Address (if different from residential address)

Address:

Postal Code: City:

Country:

Plan Selection (please tick relevant boxes)

	A	AA	AAA
	Hospitalisation & Out-patient Surgery only	Hospitalisation & Out-patient Surgery only	Hospitalisation & Out-patient Surgery plus Out-patient
Plan Requested	☐	☐	☐
Area of Cover	☐ Worldwide (only for AA & AAA)	☐ Worldwide excluding North America & the Caribbean	
Annual Deductible	☐ Nil ☐ US$500 ☐ US$1,000 ☐ US$2,000 ☐ US$5,000		
Optional Dental	☐ Yes ☐ No Annual deductible does not apply to the Dental Benefit		
Optional Maternity	☐ Yes ☐ No Maternity Benefit is applicable only to the adult female between 18 and 45 years of age and has selected a AAA Nil Deductible Plan.		

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Family Members to be Insured

Details	Dependent 1	Dependent 2	Dependent 3	Dependent 4
Family Name				
First Name				
Relationship to Applicant	☐ Spouse ☐ Child	☐ Spouse ☐ Child	☐ Spouse ☐ Child	☐ Spouse ☐ Child
Marital Status				
Nationality				
Usual Country of Residence				
ID/Passport No.				
Date of Birth (dd/mm/yy)				
Gender	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F
Height (cm) & Weight (kg)				
Smoker	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Occupation (specify nature of duties)				

Please use a separate sheet if there is insufficient space

Medical Questionnaire

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 any of the persons to be Insured reside outside the Usual Country of Residence as shown above? If "Yes", please state which country. ☐ Yes ☐ No

_____

2. Does the occupation of any of the persons to be Insured include any activities involving offshore, underwater, underground, or manual work, or work in a remote location? If "Yes", please give details. ☐ Yes ☐ No

_____

3. Have any of the persons to be Insured previously applied for or held a GlobalHealth policy? If "Yes", provide policy number. ☐ Yes ☐ No

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4. Do any of the persons to be Insured have health insurance with another 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

_____

5. Have any of the persons to be Insured 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

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6. Within the last five years, have any of the persons to be Insured experienced, been treated for, sought advice on, or had symptoms relating to any of the following conditions?

If the answer is "Yes" to any of the following, **please write** the medical condition and complete the relevant questionnaire where indicated. For other medical conditions, please provide details in the table on page 4.

a) Cancer, leukemia, tumors, cysts or a growth of any kind? (If "Yes", please complete the **Tumor/ Cyst** Questionnaire) ☐ Yes ☐ No

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b) Asthma, persistent cough, coughing of blood, pneumonia, chest or breathing complaints, chronic bronchitis, chronic sinusitis, allergies, deviated nasal septum, tuberculosis, or any disease or disorder of the lungs? (If "Yes", please complete the **Respiratory** Questionnaire) ☐ Yes ☐ No

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c) Chest pain, raised blood pressure, raised cholesterol, heart murmur or heart condition, breathlessness, abnormal heart rate, rheumatic fever, varicose veins, or circulatory disorder? (If "Yes", please complete the **Cardiovascular** Questionnaire) ☐ Yes ☐ No

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

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

f) Jaundice, hepatitis of any form or any disease or disorder of the gall bladder, pancreas or liver? ☐ Yes ☐ No

g) Diabetes, thyroid disorders or any other endocrine disorders? ☐ Yes ☐ No

h) Anaemia, thalassaemia, haemophilia, or any other disease or disorder of the blood? ☐ Yes ☐ No

i) Disease of the brain or nervous system, stroke, epilepsy, paralysis, weakness of a limb or prolonged headache? (If "Yes", please complete the **Cerebrovascular/Nervous System** Questionnaire) ☐ Yes ☐ No

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

k) Back or neck pain or strain, spinal condition, sciatica, slipped disc, whiplash, gout, arthritis, bone fracture, joint injury e.g. knee, elbow, wrist, shoulder, hallux valgus (hammer toes) or any symptoms of a muscle disorder? (If "Yes", please complete the **Musculo-Skeletal** Questionnaire) ☐ Yes ☐ No

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

m) HIV, AIDS (Acquired Immuno Deficiency Syndrome), AIDS related condition or had any positive blood test for HIV (also called AIDS or HTLV-III) virus? ☐ Yes ☐ No

n) Psoriasis, eczema, dermatitis, acne or any other skin condition? ☐ Yes ☐ No

o) Ear discharge, nose bleeds, double vision, impaired sight, hearing or speech or any other disease or disorder of the ear, eye, nose or throat? ☐ Yes ☐ No

p) Any other ailment, impairment, injury, accident, condition(s), medical investigations, or hospital treatments not mentioned above? ☐ Yes ☐ No

q) **(Females only)** Pregnancy or any complications of pregnancy, abnormal smear test or any gynaecological disorder e.g. fibroid and/or cyst of the female reproductive system? If "Yes", please complete the **Gynaecological** Questionnaire) ☐ Yes ☐ No

If the answer was "Yes" to any of the above questions, please give details, except if a questionnaire was required.

Applicant's Name	Q. No.	Date of first consultation	Details of medical conditon, including nature of treatment, results of investigations and whether fully recovered?	Full name & address of doctor, hospital or health professional consulted	Is follow up treatment required and if so, when?

(please use an extra sheet if more space is required)

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7. Other than for those medical conditions mentioned above, has this person been admitted to hospital for treatment or observation or undergone any surgical procedure in their lifetime or suffered from any other ailment, impairment, injury, accident or condition(s)? If "Yes", please provide full details, including the date, diagnosis and nature of treatment or surgical procedure. ☐ Yes ☐ No

_____

8. Are any of the persons to be Insured 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

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9. Have any of the persons to be Insured been advised to have or do they intend to seek any medical advice, 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

_____

10. Please provide the following information about your/your family's current usual doctor/personal physician/ medical centre or hospital:

Name: _____

Address: _____

Email: _____ Telephone: _____ Fax: _____

How long has this person been under this Physician's care: _____

Date of last attendance & reason: _____

Intermediary's access to documents

☐ In the event that I am represented by an intermediary, I hereby accept that my intermediary will get access to my documents online on his/her personal and password protected Producer Corner

Declaration by Proposer

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.

_____

Printed Name/Title 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.

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Payment Options (Please select one)

☐ **Cash (US$ only)**
Please pay in person at Pioneer Head Office, 3rd Floor, 108 Paseo de Roxas St., Legaspi Village, Makati City. Please bring a copy of the debit note(s).

☐ **Bank Transfer**
For direct premium remittances, please send full payment (inclusive of all bank charges) to:

Bank: Banco De Oro
Account Holder: Pioneer Life Inc.
Account No.: 105390-03193-9
Swift Code: BNORPHMM

Note
1. All bank charges (outbound and inbound) will be borne by the remitter
2. Please indicate your Policy Number as payment details to your bank
3. Please email the bank remittance advice or instructions slip with your Policy Number to PLI_cashier@pioneer.com.ph for our accounting records and to issue an Official Receipt

☐ **Credit Card**
Premiums may be paid by Credit Card using the Credit Card Authorization below:

Credit Card Authorization

I/We, the undersigned, authorize you to charge the following credit card for payment of GlobalHealth insurance premiums as stated below:

Policyowner: _____

Policy Number (if known): _____

Phone: _____ Email: _____

☐ Visa ☐ Mastercard ☐ American Express ☐ JCB

Card Number: _____ Expiry Date: _____

Card Holder's Name: _____

Issuing Bank: _____

Amount US$: _____

Signature: _____ Date: _____

Please note:
1. Card payment and effectiveness is subject to credit card centre's approval.
2. Please attach photocopies of the following:
   a. front and back of the credit card
   b. two (2) valid IDs.

Producer Information (if applicable)

Producer Name: _____ Producer Code: _____
Address: _____
Phone No.: _____ Fax No: _____
Email: _____

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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