MEGA INTERNATIONAL Health Care

Application for Benefit Upgrade

Policy Number:			
Name of Insured:			
Job Title:			
Email			
Date of Birth (dd/mm/yyy):	Gender: ☐ Male ☐ Female	Height (cm):	Weight (kg):
Upgrade to:			

Dependants

Name	Date of Birth (dd/mm/yyyy)	Gender (M/F)	Height (cm) / Weight (kg)	Relationship

1. Have you or any of your Dependents consulted a Physician in the past 2 years? ☐ No ☐ Yes (explain)
2. Are you or any of your Dependents under treatment, special diet, or medication for any Illness, injury, or medical condition?
   ☐ No ☐ Yes (explain)
3. Have you or any of your Dependents been advised to undergo any test, treatment, special diet, medication, procedure, check-up, or hospitalisation that has not yet been completed?
   ☐ No ☐ Yes (explain)
4. Disabilities that you and/or your Dependent(s) have suffered from prior to this upgrade application.
5. Is there any current pregnancy? ☐ No ☐ Yes (provide expected due date)

I hereby declare that all answers to the foregoing questions are correctly recorded, and that they are full, complete, and true.

Signature of the Insured / Main Applicant
(Signature by Policyholder if the Insured Person is a Minor)

Date

Note: Disabilities existing prior to this Upgrade Application shall be covered according to the Terms & Conditions of the preceding medical plan unless the Company has been notified on this application of the Disabilities and said Disabilities are accepted at the higher benefit level in writing by the Company.

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MEGAINSURANCE

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