MEGA INTERNATIONAL Health Care

Policy Application
Individual and Family

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. Contact Information and Basic Details

Proposer's Details **Contact information of the person who will own the policy**	Family Name:	
	First Name(s):	
Date of Birth (ddmmyyyy):	Gender: ☐ Male ☐ Female	Height (cm): Weight (kg):
Marital Status:	Smoker: ☐ Yes ☐ No	
ID/Passport Number:	Nationality:	
Occupation:		
Residential Address:		
Tel:	Mobile:	
Policyholder Correspondence Address (if different from above):		
Tel:	Fax:	
Email: **Important**: This email will be used for sending claims-related communication (which may include sensitive medical information) and to register your online GlobalHealth account.		

Family Members to be Insured	**Spouse/Partner**	**Child 1**	**Child 2**	**Child 3**
		Important: Unmarried children proposed for insurance must be aged 18 or under. Unmarried children over 18 in full-time education can be covered up to 23 years old.		
Family Name:				
First Name(s):				
Date of Birth (ddmmyyyy):				
Gender:	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Marital Status				
Nationality:				
ID/Passport Number:				
Smoker:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Occupation:				
Height (cm) & Weight (kg):				

Please use separate sheet if necessary.
Important: Please advise us if any Family Members to be Insured do not live at the Proposer's Residential Address.

2. Choose Your Cover

Step 1: Select your Core Cover
The following core modules form the base of your Mega International Healthcare policy. Each member has the flexibility to choose the cover they want.

If dependants will have the same cover as the Proposer, please tick here ☐ and complete cover options for the Proposer only.

Core Modules	Proposer	Spouse/Partner	Child 1	Child 2	Child 3
Hospital and Surgical	☐ Comprehensive ☐ General ☐ Base	☐ Comprehensive ☐ General ☐ Base	☐ Comprehensive ☐ General ☐ Base	☐ Comprehensive ☐ General ☐ Base	☐ Comprehensive ☐ General ☐ Base
	• This module forms the base of your Mega International Healthcare policy to ensure that you enjoy extensive cover for hospital treatment and out-patient surgery.				
Annual Deductible	☐ Nil ☐ US$1,500 ☐ US$5,000	☐ Nil ☐ US$1,500 ☐ US$5,000	☐ Nil ☐ US$1,500 ☐ US$5,000	☐ Nil ☐ US$1,500 ☐ US$5,000	☐ Nil ☐ US$1,500 ☐ US$5,000
	• Your selected deductible applies to the Hospital & Surgical module and Outpatient modules, if chosen.				
Area of Cover	☐ Worldwide excluding USA ☐ Worldwide	☐ Worldwide excluding USA ☐ Worldwide	☐ Worldwide excluding USA ☐ Worldwide	☐ Worldwide excluding USA ☐ Worldwide	☐ Worldwide excluding USA ☐ Worldwide
	• Worldwide excluding USA – this option excludes treatment in the USA. Losses arising from Sudden Illness or Accidental Injury which occurs in the USA are covered during the first 30 Travel Days up to US$50,000 of any Policy Year. • Worldwide – this option includes treatment in the USA. • The area of cover chosen will apply to all modules selected.				

Step 2: Select any Optional Modules that you wish
The following modules are optional. Each member has the flexibility to choose the cover they want.

If dependants will have the same cover as the Proposer, please tick here ☐ and complete cover options for the Proposer only.

Optional Modules	Proposer	Spouse/Partner	Child 1	Child 2	Child 3
Outpatient	☐ Plus ☐ Mid	☐ Plus ☐ Mid	☐ Plus ☐ Mid	☐ Plus ☐ Mid	☐ Plus ☐ Mid
	• Your selected deductible applies to the Plus and Mid Outpatient module.				
Maternity	☐ US$10,000 ☐ US$5,000	☐ US$10,000 ☐ US$5,000	☐ US$10,000 ☐ US$5,000	☐ US$10,000 ☐ US$5,000	☐ US$10,000 ☐ US$5,000
	• **Important:** Only available to females between 19 and 45 years of age who have selected Hospital & Surgical & Outpatient plan with a nil deductible.				
Dental & Optical	☐ 20% coinsurance ☐ Nil coinsurance	☐ 20% coinsurance ☐ Nil coinsurance	☐ 20% coinsurance ☐ Nil coinsurance	☐ 20% coinsurance ☐ Nil coinsurance	☐ 20% coinsurance ☐ Nil coinsurance
	• The Mega International Healthcare Dental module provides up to US$1,000 per year for minor dental treatment and up to US$2,500 for a range of major dental services. • You have a choice between a 20% coinsurance or nil coinsurance for major dental treatment. • Exams and prescription lenses or contact lenses are covered up to US$300 per year. • Your selected deductible does not apply.				

3. Insurance Details

Have you ever applied for, been covered under, or held a GlobalHealth policy? If "Yes", please give details:	☐ Yes	☐ No
Do you currently have health insurance with another company and indicate if it will be continued (and if not, as of what date)? If "Yes", please give details:	☐ Yes	☐ No
Have you ever had a policy or application for life, sickness, accident disability, critical illness or medical insurance refused or cancelled, or had any special terms imposed? If "Yes", please give details:	☐ Yes	☐ No

4. Medical Details/History

Please indicate if you or any person to be insured have or have had any of the signs, symptoms, illnesses or disorders below by ticking the appropriate box.

Signs, Symptoms, Illnesses or Disorders	Proposer	Spouse/Partner	Child 1	Child 2	Child 3
a) Cancer, leukaemia, tumour, blood disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Asthma, chronic bronchitis, allergies, tuberculosis, any other disease or disorder of the lungs	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) Chest pain, raised blood pressure, heart condition, circulatory disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) Indigestion, gastric ulcer, haemorrhoids	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) Spinal condition, bone fracture, joint injury, back pain	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) Malaria, dengue fever, other tropical illness	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) HIV/AIDS	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) Diabetes, Liver disorder, Hepatitis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) Disease of brain, nervous system, stroke	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) Mental health problem, anxiety, addiction	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l) Gynaecological disorder, complicated pregnancy, abnormal smear test result	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
m) Eczema, dermatitis, disorder of eyes, ears	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
n) Any other disorder/injury	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If you answer "Yes" to any of the above, please provide details in the table below. You may be required to provide a further medical questionnaire or medical reports, depending on the severity of the condition declared.

Applicant's Name	Question No.	Date of first consultation	Details of Medical condition, including nature of treatment, results and if you have fully recovered?	Name & Address of doctor, Hospital or health professional consulted	Do you require any follow up treatment or consultation, if so when?
		ddmmyyyy			☐ Yes ☐ No ddmmyyyy
		ddmmyyyy			☐ Yes ☐ No ddmmyyyy

Please provide more details on a separate sheet if required.

1)	Have you or any person to be insured been in Hospital for treatment or undergone any procdedure, scans, test as an outpatient? If "Yes", please provide the date, diagnosis and nature of the treatment.	☐ Yes ☐ No
2)	Are you or any person to be insured currently taking any medication? If "Yes", please state your dosage, the approximate cost of medication and the name of the drug.	☐ Yes ☐ No
3)	Please enter the following details about your usual/family doctor. If you do not have a usual/family doctor, please provide the names, addresses and contact information of any medical provider you have seen in the last 3 years. Use a separate sheet if necessary.	
Name:		
Address:		
Tel:	Fax:	
Email:		

5. Additional space for further remarks

You may use this space for any further comments about any medical conditions you have or have suffered from. Please remember to enclose any supporting documents with your application.

6. Desired Commencement Date

(ddmmyyyy)

Important: This Individual and Family Application Form is valid for 28 days from date of receipt by Mega International Healthcare. We cannot backdate cover.

7. Intermediary Access

Would you like your insurance intermediary to have access to your policy details and claims transactions through their online account?
☐ Yes ☐ No

Do you authorize us to discuss claims details and medical information with your insurance intermediary?
☐ Yes ☐ No

8. Choose your Payment Method

☐ **Bank Transfers**
Please send full payment (inclusive of all bank charges and surcharges) to:

Beneficiary Bank (USD Account)

Bank Name : Bank Mega First Bank Account : 01.901.2011.00118.0 Account Name : PT. Asuransi Umum Mega Account Address : Jalan Kapten Tendean 12-14A Menara Bank Mega, 18th Floor Jakarta 12790 Swift Code : MEGAIDJA Bank Address : Jalan Kapten Tendean Kav. 12-14A Menara Bank Mega Jakarta 12790	Bank Danamon 3596375554 PT. Asuransi Umum Mega Jalan Kapten Tendean 12-14A Menara Bank Mega, 18th Floor Jakarta 12790 BDINIDJA Jalan Kapten Tendean Kav. 12-14A Menara Bank Mega Jakarta 12790

Note:
1. All bank charges will be borne by the remitter.
2. Please indicate your Policy Number as a payment detail to your banker.
3. Please fax +62 21 7917-5024,7917-5018 or email (megaindoapp@globalhealthasia.com) the bank remittance advice or instruction slip with your Policy Number to Mega Insurance email accounting records and to issue an Official Receipt.

☐ **Credit Card**
Additional costs may be incurred if you choose payment using Credit Card

I/we, the undersigned, authorize you to charge the following credit card for payment of Mega insurance premiums.	
Credit Card: VISA	Currency: USD
Card No.:	Expiry Date (mm/yy):
Issuing Bank:	
Cardholder's Name:	
Do you wish to opt for automatic credit card billing for future renewals? ☐ Yes ☐ No I also authorize Mega Insurance, until further notice in writing, to charge this credit card with unspecified amounts in respect of annual premium payments as and when these become due. Mega Insurance will inform us in advance of any premium adjustments.	
Signature to authorize credit card payment:	Date:

9. Declaration by Proposer

I/We declare that the statements contained in this application form are correctly recorded, and that they are full, complete and true. I/We further declare that I have not withheld any material fact and that except as declared herein, all persons to be insured are currently in good health. I/We will notify Mega Insurance/GlobalHealth immediately if after signing this application and before a policy is issued I/We become aware of material facts not disclosed in this form, or if the health of any person to be insured changes such that any answer on this form is not full complete, and true. If a policy is issued to me, this proposal and the statements made herein shall form the basis of the policy between me/us and Mega Insurance. I understand that no insurance shall be in force until and unless the application has been accepted and the appropriate premium paid.

I/We agree that any information collected or held by Mega Insurance/GlobalHealth (whether contained in the Application or otherwise obtained) may be used and disclosed by Mega Insurance/GlobalHealth Asia to its associated individuals/companies or any independent third parties (within or outside Indonesia) for any matters relating to this application, any policy issued and to provide advice or information concerning products and services which Mega Insurance/GlobalHealth believes may be of interest to me/us and to communicate with me/us for any purpose.

I/We hereby declare that I/We have received, read and understood, or have been advised of and understand, the contents of the brochure and any information material relating to this insurance product.

I/We am/are aware that I/We can seek advice from a qualified advisor before I/We sign this enrolment form. Should I/We choose not to, I/We take sole responsibility to ensure that this product is appropriate to my financial needs and insurance objectives.

I/We authorise Mega Insurance/GlobalHealth to release the names, dates of birth, sex, passport and/or identification number, any information provided on the application and any records Mega Insurance/GlobalHealth may have regarding the Insured person(s) shown on the Namelist to hospitals, clinics, laboratories, physicians, specialists, dentists, chiropractors, acupuncturists, physiotherapists, or other medical practitioners for the purpose of providing direct bill paying services for the insured person(s). By signing this Authority and Release Form, I/We also acknowledge the specific Policy term listed below:

Right of Recovery: In the event of authorisation of payment and/or payment is made by Mega Insurance/GlobalHealth for a claim which is not covered under this Policy or when the limit of liability for this insurance is exceeded, Mega Insurance/GlobalHealth reserves the right to recover the said sum or excess from you. This recovery includes but is not limited to deducting the payments owed from other claims made by you during the policy period. If the amount owed remains outstanding for more than 90 days, then Mega Insurance/GlobalHealth reserves the right to suspend the direct billing service to you without further notice.

Name and Title:	**Signature:**	**Date:**

Producer Details (for official use only)

Producer Name:
Producer Code:
Company Name:
Tel:
Email:

Or Stamp Above

Please Send Completed Form to:

PT. Asuransi Umum Mega
Attn: Mega International Health Care Applications
Jalan Kapten Tendean Kav. 12-14A
Menara Bank Mega Lt. 18
Jakarta 12790
Tel: +62 21 7917 5858 / +62 21 7917 5859
Fax: +62 21 7917 5024 / 7917 5018
Email: megaindoapp@globalhealthasia.com
www.megainsurance.co.id
www.globalhealthasia.com
Policies are underwritten and issued by PT. Asuransi Umum Mega

10. Claim Payment Declaration

I, the undersigned:

Policyholder :

Policy Number :

I hereby certify that my claim payments are to be transferred to the account below and that the details are correct:

Account name :

Bank Name :

Branch :

Bank Address :

Country :

Account Number :

Swift Code :

Relationship with Policy Holder :

I will be fully responsible for any errors in the details supplied above. .

Signed this day (dd/mm/yyyy) in Jakarta
Best Regards,

Stamp duty & Wet Signing

(Policy Holder Name)