International Healthcare Plan – Application Form

Please read through the following before completing this application and complete in BLOCK CAPITALS.

All information supplied will be treated in strict confidence. **You** must disclose all material facts. Failure to do so may invalidate the **Policy**. A material fact is one which is likely to influence the assessment and acceptance of this application (e.g. a pre-existing health condition or involvement in hazardous activities). If **You** are in any doubt whether a fact is material, it should be disclosed.

As the **Policyholder**, **You** should answer all the questions and sign the declaration on behalf of all persons included in this application. A copy of this application can be supplied to **You** on request within three months of completion. **You** should keep a record of all information (including copies of all letters) supplied to **Us** for the purpose of entering into this contract.

Please return this completed form to **Us** or **Your** broker.

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Jl. Asia Afrika No.8
Gelora Bung Karno
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Section 1 – Applicant's Details (First Person)

Applicant's / Policyholder's **Name (if different from the name of First Person)**				
Family Name				Title
First Name(s)				
Marital Status	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)
Industry	Occupation		Job Title	
Nationality (Country of Passport)	Passport No./ ID Card Number	**Country of Residence**		
Residential Address		Correspondence Address		
Town/City		Town/City		
Country/State		Country/State		
ZIP/Postal Code		ZIP/Postal Code		
Home Telephone		Business Telephone		
Mobile		Fax		
Home E-mail		Business E-mail		

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Section 2 – Dependant's/Other Insured Person's Detail (Please note children to be included under this plan must be under 18 years of age, or 23 years of age or under if they are in full-time education and are fully dependant upon **You**. If **You** have any further **Dependants**, please provide details on a separate sheet.)

Dependant 1	Family Name				First Name(s)	
	Other Initials	Title		Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)
	Relationship to Applicant				Date of Birth (Day/Month/Year)	
	Industry	Occupation		Job Title	Nationality (Country of Passport)	Passport No/ ID Card No.
Dependant 2	Family Name				First Name(s)	
	Other Initials	Title		Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)
	Relationship to Applicant				Date of Birth (Day/Month/Year)	
	Industry	Occupation		Job Title	Nationality (Country of Passport)	Passport No/ ID Card No.
Dependant 3	Family Name				First Name(s)	
	Other Initials	Title		Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)
	Relationship to Applicant				Date of Birth (Day/Month/Year)	
	Industry	Occupation		Job Title	Nationality (Country of Passport)	Passport No/ ID Card No.
Dependant 4	Family Name				First Name(s)	
	Other Initials	Title		Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)
	Relationship to Applicant				Date of Birth (Day/Month/Year)	
	Industry	Occupation		Job Title	Nationality (Country of Passport)	Passport No/ ID Card No.

Section 3 – Commencement Date (Subject always to **Section 11** of this application form, the **Commencement Date** of this **Policy** will be the date on which this application is accepted in writing by **Us**. If **You** wish **Your** cover to start later, please indicate below. Please note the **Commencement Date** can be no more than 30 days from the date of completion of this application by **You**. Under no circumstances will **Policies** be backdated.)

Commencement Date (Day/Month/Year)

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Section 4 – Options (The table below is for guidance only. Please refer to the full **Benefit Schedule** and **Policy Wording** for a detailed description of the **Benefits** of each plan option.)

A) Product (This plan enables **You** to choose various options to suit **Your** personal requirements. Please clearly check the option **You** have selected. **Your Policy** will be issued on this basis.)

Benefits	Major Medical OPTION 001	Foundation OPTION 002	Lifestyle OPTION 003	Lifestyle Plus OPTION 004
Standard **Excess**	NIL	$100	$100	$100
Maximum **Benefit** per **Insured Person** per **Period of Cover**	$1,600,000	$1,600,000	$1,600,000	$1,600,000
In-Patient and **Day-Patient** Care	Full Refund	Full Refund	Full Refund	Full Refund
Oncology, CT and MRI Scans	Full Refund	Full Refund	Full Refund	Full Refund
Complications of Pregnancy	Full Refund	Full Refund	Full Refund	Full Refund
Parent Accommodation	Full Refund	Full Refund	Full Refund	Full Refund
Evacuation	Full Refund	Full Refund	Full Refund	Full Refund
Out-Patient Care	Subject to Limits	Full Refund	Full Refund	Full Refund
Emergency Dental **Treatment**	Full Refund	Full Refund	Full Refund	Full Refund
Daily Hospital Cash **Benefit**	Subject to Limits	Subject to Limits	Subject to Limits	Subject to Limits
AIDS/HIV	Subject to Limits	Subject to Limits	Subject to Limits	Subject to Limits
Extended **Evacuation**	Optional	Optional	Full Refund	Full Refund
Routine Management of **Chronic** Conditions	No Cover	No Cover	Subject to Limits	Subject to Limits
Routine Pregnancy and Childbirth	No Cover	No Cover	No Cover	Subject to Limits
Routine and Restorative Dental Care	No Cover	No Cover	No Cover	Subject to Limits
Your Selection – please check **Your** choice	☐	☐	☐	☐

ALL limits and **Excesses** expressed in $ shall in all instances mean US$.

B) Excess (Please select where **You** wish to change from the standard **Excess** applicable by checking the appropriate box.)

Nil	Standard	☐	☐	☐
$50	N/A	☐	☐	☐
$250	N/A	☐	☐	☐
$500	N/A	☐	N/A	N/A
$1,000	☐	☐	N/A	N/A
$2,000	N/A	☐	N/A	N/A
$5,000	☐	☐	N/A	N/A

C) Additional (Please check Your choices.)

USA **Elective** Treatment - [005]	N/A	☐	☐	☐
Direct Settlement Network - [008] *Only available with standard **Excess**.* *Available in certain countries.* *Please check with **Your** local sales centre.*	N/A	☐	☐	☐
Extended **Evacuation** - [009]	☐	☐	N/A	N/A

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Section 5 – Premium Payment (Please check which payment method and payment frequency **You** require and complete all details relevant to that method.)

☐ a) **Bank Transfer.** Please ensure the name of the **applicant** (as declared in **Section 1** of this form) is clearly stated on any transfer. **Our** bank details for bank transfer are available on request by contacting **Our** Jakarta office. **We** cannot accept liability for any bank transfer which does not clearly identify the **applicant**.

☐ b) **Credit Card** ☐ VISA ☐ MasterCard ☐ AMEX

1. Credit Card Number: | | | | | | | | | | | | | | | | |
2. Cardholder's Name (as shown on card): _____
3. Expiry Date (Month/Year): _____
4. Cardholder's Statement Address: _____
5. Cardholder's Authorisation Signature: _____
6. Signature Date (Day/Month/Year): _____

For payment method by b, please note **Your** premium will be collected on receipt of this application, which may be in advance of the **Commencement Date**. This is dependent on what time of the month **Your** billing takes place.

Cardholder's Authorisation Signature	Date (Day/Month/Year)
E-mail (where signing online)	

Section 6 – Medical Practitioner Details (Please give the details, including name, address and qualifications of **Your** usual **Medical Practitioner**, and in respect of anyone else included in this application. Please use a separate sheet if this space is insufficient.)

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Section 7 – Pre-existing Condition(s)

Benefits will not be available for any **Medical Condition** or **Related Condition** for which **You** have received medical **Treatment**, had symptoms of, or to the best of **Your** knowledge existed, or sought **Advice** prior to **Your Date of Entry**, until two consecutive years have elapsed, after the **Date of Entry**, during which no **Treatment** or **Advice** was given in respect of that **Medical Condition** or any **Related Medical Condition**.

Section 8 – Medical Questionnaire

Please reply to the following questions by checking Yes or No. Where You have checked Yes, please provide details.

	Yes	No
a. Have **You**, or anyone included in this application, been admitted to **Hospital** or other similar establishment in the last five years?	☐	☐
b. Have **You**, or anyone included in this application, been prescribed with a course of any drugs or medication, or **Treatments** for a period in excess of seven days in the last two years?	☐	☐
c. Have **You**, or anyone included in this application, any known or foreseeable need to consult with a **Medical Practitioner** or any other health care professional and/or to be required to be prescribed any drugs or medication and/or to be admitted to a **Hospital** or other similar establishment?	☐	☐
d. Are **You**, or anyone included in this application, suffering from any disability, abnormality, recurrent illness, major illness or injury, not already noted above?	☐	☐

Please use this space to provide any additional information, or a separate sheet of paper if there is insufficient space.

Section 9 – Broker Name/Stamp

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Section 10 – Declaration

My spouse, competent adult **Dependants**, and I (those who are applying for coverage under this Application) authorise any physician, healthcare professional, **Hospital**, and other healthcare institution ("Providers"), to disclose, to the extent allowed by applicable law, to Aetna International or an affiliated entity ("Aetna"), information concerning the medical history, services, supplies, or **Treatment** provided to anyone listed on this Application, including those services involving dental, substance abuse and HIV/AIDS ("healthcare information").

I confirm and agree that personal information and/or healthcare information collected or held by Aetna International, whether contained in this Application form or otherwise obtained, may be disclosed worldwide to Aetna affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants, and governmental authorities with appropriate jurisdiction, when necessary for care or **Treatment**, payment for services, and activities related to the operation of my health plan.

I understand that Aetna International may rely on such information to: 1) underwrite this application for coverage, make eligibility, risk rating, **Policy** issuance and enrollment determinations for all of the applicants; 2) administer claims and determine or fulfill responsibility for coverage and provisions of **Benefits**; 3) administer coverage; and 4) conduct other insurance operations, like marketing and publicity, according to applicable laws and regulations.

I have discussed the terms of this authorisation with my spouse and competent adult **Dependants**, and I have obtained their consent to the release of their healthcare information pursuant to this authorisation. I understand that I may decline to provide Aetna International with consent to process my personal or healthcare information; however, this may result in declination of coverage.

I understand that I may review and offer corrections to my personal or healthcare information, to the extent allowed by law, receive a copy of this authorisation upon request, and that a photocopy is as valid as the original; and I may revoke this authorisation at any time, to the extent it has not been relied upon by Aetna International or other party. I also have the right to opt out of any direct marketing campaigns.

This authorisation shall remain valid for the term of this coverage or for so long as allowed by law.

I understand it is unlawful for me or my **Dependants** to knowingly provide false, incomplete or misleading facts or information to Aetna International for the purpose of defrauding or attempting to defraud Aetna International. Penalties may include imprisonment, fines, denial of coverage, rescission of **Benefits**, and legal damages.

I acknowledge that Aetna International participating providers are independent contractors and are not agents or employees of Aetna International or any affiliated Aetna Entity.

I understand and accept **Section 8** on Pre-existing Condition(s).

I declare that the answers given are to the best of my knowledge full, true and complete and have checked and found correct any answers and statements in this application that are not in my own handwriting.

I have declared all material facts which relate to this application.

I declare that I have read and understand the documents **'*Policy Wording*'** and **'*Benefit Schedule*'** and agree to accept and conform to the terms of the **Policy**, unless I cancel this **Policy** within 15 days from the **Commencement Date**. I am satisfied that the product selected meets my requirements at this time.

I agree that where **Medical Treatment** is received within the **Provider Network** by myself or any of my **Dependants** and it is substantiated that the **Treatment** or **Medical Condition** is not refundable within the terms and conditions of the **Policy**, that I, as the **Policyholder**, shall be fully responsible for reimbursement to Aetna International within 14 days of receipt of notice of such non-refundability of all funds expended in connection with any claim for such medical **Treatment**.

I understand and confirm that where I have not made repayment of funds disbursed by Aetna International in respect of such medical **Treatment** not covered by the **Policy**, the **Policy** shall be suspended until the date of my full settlement of all outstanding amounts due from me to Aetna International and in the event that funds so due from me to Aetna International have been outstanding and unpaid for a period in excess of 14 days, exclusion 1 of the **Policy Wording** shall be re-applied to the **Policy** with effect from the date of full receipt by Aetna International of the funds concerned in which event any suspension of the **Policy** pursuant to this subclause shall be lifted with effect from such full receipt date. In no event shall any claim for **Treatment** received during the period of suspension be made or met.

I further accept that where funds have been outstanding to Aetna International for a period in excess of 15 days from notification, my **Policy** will be cancelled as if I had no cover in place from the start, without refund of premium.

Policyholder's Signature	Date (Day/Month/Year)

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