A+ International Healthcare

Your Insurance Intermediary
BML Services (ehealthscanner.com)

Southeast Asia Plans

Exclusively for residents of Cambodia, Indonesia, Laos, Malaysia, Philippines, Thailand & Vietnam

Application Form
Individuals

Important:

Please complete this application **in block capital letters**. All information supplied will be treated in strict confidence. Please keep a record (including copies of all letters) of all information supplied to us for the purpose of entering into this contract.

Commencement date: The inception date of this policy will generally be the date on which this application is accepted by the Insurers. However, should you require an inception date in the future (to take account of the expiry of current contracts elsewhere) you may do so by completing the commencement date box in section 1. Under no circumstances will policies be backdated from the date of acceptance.

Insurance year is a twelve month period.

This application is valid for 3 months. A fresh application will be required once 3 months has passed.

1 . DETAILS OF PROPOSER (Policyholder)

Family name: _____ Title: _____

First & Middle name: _____ Marital Status: _____

Sex: (M/F): _____ Date of birth: ___ / ___ / _____ (dd/mm/yyyy) Nationality : _____

Residential address: _____

Postal code: _____ City: _____ Country: _____

Address for correspondence (if different from above):_____

Postal Code: _____ City: _____ Country: _____

Contacts :

Phone number: (Office) _____ (Personal) _____

Mobile : (Office) _____ (Personal) _____

Email : (Office) _____ (Personal) _____

Occupation: _____ Nature of business: _____

Commencement date (see above): ☐ ___ / ___ / _____ (dd/mm/yyyy)

☐ Upon acceptance of application

2. DEPENDANTS TO BE INCLUDED IN THIS PLAN

	Spouse / Partner	Dependant 1	Dependant 2	Dependant 3
Family name				
First name				
Middle name				
Other initials				
Sex (M/F)				
Relationship to policyholder				
Date of birth (dd/mm/yyyy)				
Occupation				
Nationality				
Country of residence				

If there is insufficient space for inclusion of all dependants , please provide details on a separate sheet.

3. MEDICAL QUESTIONNAIRE

Please answer each of the questions in the following pages fully and accurately, for each person included on your application. In case you answer 'yes' to any question, please provide details in the additional information box on the next page.
All information supplied will be treated in strict confidence. All material facts relating to these questions must be disclosed. Failure to do so may invalidate the policy. A material fact is one which is likely to influence an insurer in the assessment and acceptance of this application. If you are in any doubt as to whether a fact is material then it should be disclosed. As proposer you should answer all questions and sign the declaration on behalf of all persons to be insured. If your state of health or that of people included in this application changes after the application has been signed and before the policy start date, the Company must be notified immediately of such change.

		Policy Holder		Spouse / Partner		Dependants					
						1		2		3	
1	Height ❑ft ❑cm										
	Weight ❑pds ❑kg										
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
2	Are any persons named in this application planning to undergo or have undergone during the last 10 years a surgical intervention (including any cosmetic surgery or any refractive laser eye surgery) other than appendicitis, amygdalectomy or adenoidectomy?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3	Have any persons named in this application form:										
	a. Been treated in a hospital, clinic, sanatorium, hospice during the last 10 years?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	b. Been advised to have any medical test or investigations?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	c. Had any abnormal medical test results during the last 5 years?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	d. Been tested HIV and / or any type of Hepatitis positive?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	e. Has an application for insurance been turned down or accepted at special terms?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4	Are any of the persons named in this application aware of any symptoms or abnormal signs, which may give rise to a claim?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5	Are any persons named in this application currently taking any drugs or medication for more than 15 days?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6	Have any persons named in this application ever suffered from, been diagnosed with, treated or prescribed drugs for:										
	a. conditions of the eyes, ears, nose or throat?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	b. fainting, blackouts or fits?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	c. any high blood pressure, heart, circulatory or vascular condition(s)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	d. diabetes or any other endocrine disorder?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	e. any rheumatic or arthritic condition(s) (including gout)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	f. any spine, bone, muscle or joint condition(s)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	g. asthma, respiratory, pulmonary or allergic condition(s)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	h. genito-urinary or renal condition(s)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	i. stomach, gallbladder, liver, bowel, perianal conditions (including hemorrhoids,	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	j. cysts, tumors or cancer?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	k. skin condition(s) such as eczema, allergies, psoriasis, fungal diseases, skin cancer, or other disorders?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	l. any gynecological or breast condition(s)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	m. any physical defect, infirmity or congenital illness?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	n. any nervous, mental or psychiatric condition(s)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	o. any alcohol and/or drug dependency problem?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	p. a dyslipidemia (cholesterol, fat in blood)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	q. any neurological conditions, including migraine and/or headaches?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	r. any other type of disease**,** injury or medical condition(s)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7	During the last 5 years have any persons named in this application suffered from an illness or corporal accidents leading to a sick leave or treatment lasting more than 10 days?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8	Have any persons named in this application ever suffered from any pre or post natal complications, complications of childbirth or suffered any miscarriage?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9	Have any persons named in this application ever suffered from any form of physical or cerebral invalidity, or from chronic conditions?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10	**a.** Are you or any persons named in this application pregnant?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	b. If so, are there any complications?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11	Do you smoke?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12	Do you consume any alcohol?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Additional information to Medical Questionnaire

If you answered "Yes" to any of the questions above, please provide details here : the name of the person, the precise question number, diagnosis, dates and duration of illness/injury/treatment and the names and addresses of attending physicians and medical facilities. Also please provide all medical reports available, the lack of which may delay or invalidate this application.

Person	Question Nbr	Details

Please advise which physician is most familiar with your medical history?

	Policyholder	Spouse / Partner	Dependant 1	Dependant 2	Dependant 3
Name					
Tel. Nbr					
Fax					
Email					

Do you, at present, have a medical cover with another insurance company? ☐ Yes ☐ No

If yes, name of company: _____ Plan: _____ Renewal Date: _____

YOUR CHOICE OF COVER (Please tick in box)

4. Medical Plan [1] ❑Essential ❑Essential Plus ❑Serene ❑Serene Plus

5. Currency [2] US$

6. Optional Policy deductibles [1&2]

Essential / Essential Plus: ❑ Nil ❑ 300 ❑ 675 ❑ 1,350

Serene / Serene Plus: ❑ Nil ❑ 300 ❑ 675 ❑ 1,350

7. Zone of treatment [1]

❑ Zone A - Worldwide

❑ Zone B - Worldwide excluding USA / Canada

❑ Zone C - Restricted in Cambodia, Indonesia, Laos, Malaysia, Philippines, Thailand & Vietnam

8. Dental [1&3] ❑ None ❑ Standard ❑ Plus

9. Accidental Death and Dismemberment [4] ❑ With insured capital of _____ (*)

10. Loss of Income [2]

- Temporary incapacity [2,5&7] ❑ With monthly allowance of _____ (*)
- Permanent disability [2,5,6&8] ❑ With insured capital of _____ (*)

(*) Must be in the same currency as the medical policy

[1] These elements must be chosen on a per family basis.
[2] Premiums and claims shall be payable in US$.
[3] Dental insurance can be purchased only in addition to Serene & Serene Plus. They cannot be purchased separately.
[4] The minimum sum insured shall be US$ 67,500 up to a maximum sum insured of US$ 675,000.
[5] The minimum monthly allowance shall be US$ 1,350 up to a maximum of US$ 13,500. The monthly allowance cannot exceed 80% of the gross monthly salary of Insured.
[6] Permanent disability can only be taken out as complementary to temporary incapacity.
[7] Benefits payable up to age 65.
[8] The sum insured shall equal 80% of the pre-disability salary multiplied by 48 months.

11. NOMINATION OF BENEFICIARIES (Only if Option 9 has been chosen)

I declare that in the event of death, any indemnities to which I am entitled by virtue of the A+ International Healthcare cover are to be paid to the listed persons below or, failing this, to my legal heirs. This nomination can only be modified in writing by the undersigned.

Last name	First name	Relation	Proportion of capital (%)

12. PREMIUM PAYMENT

1. Your choice of currency : US$ only

2. Your method of payment ❑ **Annual** ❑ **Semi-annual*** ❑ **Quarterly*** ***(credit card only)***

❑ **Bank transfer**. If selected, please ensure your name is clearly stated on your transfer order and send a copy of transfer order to your Intermediary. Bank details will be provided on the premium invoice.

☐ **Credit card** (Visa, MasterCard only)
If selected, please complete the credit card authorisation form below.

Credit card authorisation ❑ Visa ❑ MasterCard

Credit card number : _____ _____ _____ _____ CVC Code : _____

Expiry date : ____ /_____ (mm/yyyy)

Credit card statement mailing address _____

Exact name on credit card _____

Signature: _____ Date: . ____ / ____ / _____

I hereby authorise A+ International Healthcare, or its agents, as of today and until further notice in writing, to charge my credit card account with unspecified amounts in respect of my premium payments as and when these become due. The Company will inform me in advance of any premium adjustments and I will have the possibility to cancel the policy.

Note: For payment by credit card, your premium will be collected upon receipt of this application which may be in advance of the commencement date. Future premiums will be collected 7 days in advance of the renewal date of this policy.
* surcharges apply

13. Claims Reimbursement

❑ **Bank Transfer - if selected, please complete the following information**

Account Holder's name:

Account No. (IBAN for Euro zone) :

Full bank name and address :

BIC / SWIFT bank code :

Bank ID (If applicable) :

Note: Reimbursements by Telegraphic Transfer are effected in full by the insurer, net of bank charges. However additional bank charges may be passed on to you by your own bank, for which you are liable. Alternatively you may choose reimbursement by cheque which do not incur bank charges. Please tick below.

❑ **Cheque* - Payee's name**: _____

* Please note that bank transfers take up to 72 hours once claim is processed whilst cheques maybe delayed due to postal issues.

14. Declaration by Policyholder

1) I hereby apply for cover on behalf of all the persons named in this application form.
2) I certify that the statements made by me in answering the above questions are true, complete and to the best of my knowledge and belief. I understand that nullity of the insurance or reduction of the insured capital sum might be applied if it were proved that the person to be insured had established a false declaration. I confirm that I have checked and found correct any answers or statements in this application that are not in my own handwriting.
3) I accept that the policy will be subject to the policy terms and conditions effective at the time of commencement. I confirm that I have read and I understand the full definitions, benefits, exclusions and conditions of this policy.
4) In view of a smooth administration of the contract and/or settlement of insurance claims, and only for that purpose, I, the undersigned, hereby give my special permission regarding the processing of the medical data concerning me and/or the members of my family either directly with the Insurers or through A+ International Healthcare and/or its agents (French Law 78-17 of 6 January, 1978, relating to data freedom).
5) I agree to accept and conform to the terms of the policy when issued unless I cancel this policy within 15 days from the commencement date.
6) I certify that I have been made aware of the obligation to respond to the above questions and understand that incomplete or inaccurate answers would lead to the application of the Insurance Code article L 113-8 (contract nullity) or L 113-9 (benefits reduction). I undertake to communicate to the insurer information about the proposed insured and his dependents in strict compliance of the legislation on the processing of personal data in force. This information may be disclosed to authorized professional bodies, as well as all those involved in the management and execution of this contract. I have, as well as the members of the contract, the right to access and correct information concerning ourselves, with the Informations Clients Service - AXA 313 Terrasses de l'Arche 92727 Nanterre Cedex, France. The contract takes effect, subject to the payment of the premium, on the date stated in the policy schedule. This is based on the date of receipt of the application form and the results of the medical questionnaires and any medical reports. The decision of the insurer applies to all members under the same policy.
7) I have read and understood the Important Note below.

Important Note: The policy is written in the English language and is intended for use only by persons who are able to read and understand its terms. Do not sign this application form if you do not understand the policy.

☐ *In an effort to go 'Green' A+ will be sending your policy pack via email. If you wish to receive a hardcopy of your policy pack please tick this box. The Medicard will be sent to you by mail.*

Policyholder's signature _____ Date ____ /____ / _____

Please send this application form back to your insurance broker or directly to the Insurers representative :

A Plus International Holdings Limited
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