

Please complete all sections of this form in BLOCK CAPITALS and specify your choices by ticking the relevant boxes



PT. API Health Consultants
Nakula Plaza B1
Jalan Nakula
Legian, Bali, Indonesia
Tlp - 62 - (0) 361-737317
Ref: RX

If you have any queries
Please call us: +62 (0) 21 788 39121
You can fax this form to: +62 (0) 21 782 9332
or send to: C/ Global Assistance & Healthcare®
Graha Simatupang Tower 1D
8th Floor, JL. Letjend. T.B
Simatupang Kav 38
Jakarta 12540, Indonesia

1. Your personal details

Please keep us informed of your change of address:

Title: _____ Surname: _____
 First/middle name[s]: _____
 Date of birth [DD/MM/YY]: _____ Gender [M/F]: _____
 Correspondence address: _____

 Telephone no: _____ Fax no: _____
 Mobile no: _____ E-mail address: _____
 Please tick this box if you have a residence in the USA:
 Occupation: _____ Name of company/employer: _____
 Nationality: _____ Country of residence: _____

2. Your choice of Mediksure cover

Bronze Plan Gold Plan Platinum Plan
 Date you wish cover to commence [DD/MM/YY]: _____

3. Additional family members to be covered

Please note, family members means spouse and/or unmarried children under 21 years of age.

	Title	First name and other initials	Surname	Relationship to you [wife, husband, etc]	Date of Birth		
					Day	Month	Year
1							
2							
3							
4							

4. Your doctor

Please give details of your regular doctor, or doctor with whom you have had the most recent contact.

Name: _____
 Address: _____

 Telephone no: _____ Fax No: _____
 E-mail address: _____

5. Data protection notice

Purpose: Personal data collected on you and where appropriate your family will be used Expacare Insurance Services and our third-party 24 hour administration service to administer your plan, process your claims and may be used to detect and prevent fraud or improper claims.

Medical information: Medical information will be kept confidential. It will only be disclosed to those involved in your treatment of their agents and an analysis of your claims may be sent to your company if you are on a group-scheme. Claims information may be discussed with your agent where you have requested the advisor to assist you.

Telephone calls: Your calls may be recorded and monitored.

Research: Data may be used by Expacare Insurance Services for product development.

Names and Address: Neither Expacare Insurance Services nor its 24 hour assistance company and claims administration service will disclose the names and addresses of members to other organisations.

6. Confidential Medical History

Please ensure that you fully disclose any known or suspected conditions and symptoms experienced by anybody included in this application.

This applies even if professional advice has not yet been sought. Typical examples are varicose veins, allergies, backache, bunions, piles, gynaecological problems (including any irregularities of menstruation), any ear, nose or throat problems or any pains, swellings or lumps.

Please consider the following six questions as they apply to each of the people named. Answer each question by clearly ticking one of the corresponding YES/NO boxes	APPLICANT Name		1ST DEPENDANT Name		2ND DEPENDANT Name		3RD DEPENDANT Name		4TH DEPENDANT Name	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has any in-patient stay in a hospital or nursing home taken place within the last four years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has any specialist been consulted within the last four years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has any doctor been consulted and/or provided prescriptions for any drugs or medication within the last two years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does any chronic/long term medical or dental condition exist or is there any other known disability, abnormality or recurrent illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is there any known or foreseeable need to consult any doctor or any other health professional?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you currently taking any medication or is there any foreseeable need take any medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

This part applies if you have indicated any "yes" replies above. Please disclose all medical conditions [or undiagnosed conditions] to which these replies are intended to apply. Use column three to list them separately and give the further information required by Columns 4 to 6.

1. Name	2. Relevant box numbers	3. Medical condition requiring treatment	4. Treatment and consultations received [with dates]	5. Need for any more treatment or advice	6. Present state of health

If there is insufficient space, please use a separate sheet and indicate that you have done so by ticking this box.

7. Duty of disclosure

We would like to take this opportunity to remind you of your continuing duty to disclose as detailed below:-

In addition to providing all basic information necessary to enable us to place the risk, you must ensure that you are complying with your legal duty of disclosure of all material matters relating to risk. In particular, you must satisfy yourself as to the accuracy and completeness of the information you provide to insurers. In this respect, you must provide all information relating to a risk, whether favourable or not, which would influence the judgement a prudent insurer in determining whether he will take the risk, and if so, for what premium and on what terms.

If all such information is not disclosed by you, insurers have the right to avoid the contract from its commencement which may lead to claims not being met.

8. Declaration

I hereby apply to be enrolled on the plan together with the persons to be insured listed overleaf. I declare that to the best of my knowledge on behalf of all persons to be insured under this application that I have read and understood fully the plan exclusions. I/we declare that the information given on this form is true and complete and I/we understand that the benefits will not apply to treatment for expenses arising from medical conditions which originated or were known to exist before enrolling on this plan. I/we authorise any doctor who has attended to me/us to release any information the insurer may require. It is agreed that this declaration and information given in this application shall form the basis of the contract(s) between the Insured Person(s) and the Insurer. I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998 on behalf of myself and any family members specified on this form, for Expacare Insurance Services to process our personal information with respect to our membership and confirm that I have brought the Data Protection Notice to the attention of these family members. I/we understand that cover will start when the application has been accepted and premium received.

Signed: _____

Date: _____