MyMaxicare Application Form

DISTRIBUTION CHANNEL INFORMATION
AGENT/BROKER CODE:
BUSINESS PARTNER MERCHANT CODE:

NOTE:
- PLEASE WRITE LEGIBLY AND ACCOMPLISH ALL FIELDS IN BLOCK LETTERS.
- WRITE N/A FOR FIELDS THAT ARE NOT APPLICABLE.
- ALL FIELDS MUST BE COMPLETED OR ELSE APPLICATION WILL NOT BE PROCESSED.

GET STARTED WITH YOUR HEALTHCARE

☐ I'm a new applicant ☐ I'm applying for myself and my family ☐ I'm reapplying ☐ I'm transferring via Maxilink
☐ I am applying my dependents ☐ I am applying for additional dependent(s) on my renewal account

SELECT A PLAN TYPE

	☐ PLATINUM PLUS	☐ PLATINUM	☐ GOLD	☐ SILVER
Maximum Benefit Limit (MBL)	P 200,000	P 150,000	P 100,000	P 60,000
Room and Board (R&B)	Large Private	Regular Private	Regular Private	Semi-Private

DENTAL COVERAGE ☐ Yes ☐ No

PHILHEALTH MEMBER ☐ Yes ☐ No

ABOUT THE PLANHOLDER

☐ Principal - An individual who directly entered into an Agreement with Maxicare
☐ Payor - Refers to a non-member or non-enrollee who is the Sponsoring Entity, duly authorized representative and/or legal guardian of a minor enrollee responsible for the processing, application, submission of proofs of eligibility and fulfilling the financial obligations of the minor enrollee

LAST NAME FIRST NAME MIDDLE NAME EXTENSION NAME (Jr., Sr., I,II)

BIRTHDATE(MM/DD/YYYY) AGE GENDER CIVIL STATUS NATIONALITY NO. OF CHILDREN

PLACE OF BIRTH

PRESENT ADDRESS		BILLING ADDRESS	
HOUSE NO.		HOUSE NO.	
STREET		STREET	
VILLAGE		VILLAGE	
BARANGAY		BARANGAY	
TOWN/MUNICIPALITY		TOWN/MUNICIPALITY	
PROVINCE		PROVINCE	
ZIP CODE		ZIP CODE	

☐ Please check if same as permanent address ☐ Please check if same as permanent address

WORK INFORMATION
EMAIL ADDRESS HOME NO. MOBILE NO. OFFICE PHONE NO.

BUSINESS INFORMATION
NAME OF OFFICE/BUSINESS JOB TITLE PHILHEALTH NO.

IF WORKING FOR A COMPANY, IS IT BASED IN THE PHILIPPINES? YES ☐ NO ☐

SOURCE/S OF FUNDS (CHECK ALL THAT APPLY) ☐ SALARY ☐ BUSINESS ☐ SAVINGS ☐ SALE OF ASSET ☐ GIFT/INHERITANCE ☐ INVESTMENT ☐ REMITTANCE FROM (COUNTRY) ☐ OTHERS:

ABOUT YOUR HEALTH

BLOOD PRESSURE \ HEIGHT(FT. IN.) WEIGHT (LBS)

Have you been diagnosed with any of this condition/disease/disorder?

☐ Neurologic (brain, cord, nerves)
☐ Psychiatric (mental)
☐ Ophthalmologic (eyes)
☐ Otolaryngologic (ears, nose, throat)
☐ Cardiovascular (heart and blood vessels)
☐ Pulmonary (lungs)
☐ Gastrointestinal (esophagus, stomach, intestine, liver, etc.)
☐ Urogenital/ Renal (kidney, prostate, etc.)
☐ Reproductive/ OB GYN (uterus, fallopian tubes, ovaries, etc.)
☐ Allergy
☐ Congenital
☐ Endocrine (pituitary, thyroid, adrenals)
☐ Cancer
☐ Dermatologic (nails, skin, scalp)
☐ Orthopedic (bone)
☐ Hematologic (blood)
☐ Surgical
☐ Autoimmune/ Connective Tissue Disease Infection

Are you taking any maintenance medicines? Please specify:

ABOUT THE PLANHOLDER'S DEPENDENTS

If Applying	FULL NAME OF APPLICANT	RELATION	AGE	GENDER	DATE OF BIRTH (MM/DD/YYYY)	PLACE OF BIRTH	CIVIL STATUS	HEIGHT	WEIGHT	BLOOD PRESSURE	PHILHEALTH MEMBER Y/N	DENTAL COVERAGE? Y/N	OCCUPATION
1 ☐													
2 ☐													
3 ☐													
4 ☐													
5 ☐													

DEPENDENT'S PLAN TYPE ☐ PLATINUM PLUS ☐ PLATINUM ☐ GOLD ☐ SILVER

FOR FAMILY GROUP ACCOUNTS: 15 DAYS OLD UP AND 21 YEARS AND 5 MONTHS OLD ARE ACCEPTABLE AGES FOR MINOR DEPENDENTS. CHILDREN WHO ARE 22 YEARS OLD ABOVE WILL BE CONSIDERED AS INDIVIDUAL APPLICANTS.

Note: You are required to submit at least one (1) clear copy of any valid government ID (if a Filipino citizen), or ACR/Passport (if a foreign national) - with specimen signature. Maxicare may request for additional document(s) when deemed necessary in compliance with government regulations.

HOW WOULD YOU LIKE TO PAY

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Over-The-Counter Bank ☐ Credit Card ☐ Maxicare Office Cashier

MAXICARE ENROLLMENT TERMS AND CONDITIONS

The Terms and Conditions contained herein form the contract between me as a Member and my dependents and Maxicare Healthcare Corporation ("Maxicare") as the provider of the services. I and my dependent/s acknowledge that Maxicare reserves the right to modify the Terms and Conditions or their policies for availment from time to time. In executing this document and in affixing my signature hereto, I confirm that:

1. By enrolling, I acknowledge and agree to abide by all the terms and conditions contained herein and in the Membership Agreement.
2. All my representations, warranties and undertakings shall be deemed to be material and have been relied upon by Maxicare. Consequently, I shall be directly and solely responsible for the accuracy of any and all information that I submit during enrollment. They shall survive the execution and delivery of these Terms and Conditions, notwithstanding the consummation of the transaction contem- plated herein.
3. I and my dependents' availment of the medical services through the use of Maxicare Letter of Authorization ("LOA") issued by Maxicare's Call Center, Help Desks, Primary Care Centers, Customer Care Representatives, Affiliated Coordi- nators and Partners, Maxicare Kiosk, Member Gateway, or Maxicare electronic systems, signifies that I agree with the terms and conditions contained herein and in the Membership Agreement.
4. I agree and understand that in the course of providing service/s to me and/or my dependents, Maxicare shall engage the services of, and/or interact with, other third parties, such as, but not limited to its parent company, affiliated companies, subsidiaries, financial advisors, affiliated third parties or indepen- dent/non-affiliated third parties and service providers, whether local or foreign (collectively referred to as "Representatives").
5. I understand that Maxicare shall not be responsible for the payment of charges/ expenses resulting from:
   a. Availment of the following hospital or medical services/treatment/proce- dures (diagnostic and therapeutic):
      i. those rendered by non-affiliated physicians/specialists or a reliever physician;
      ii. those not related to this confinement as determined by the Claims Department of Maxicare;
      iii. those without prior authorization of Maxicare;
      iv. those miscellaneous items outside of your/your dependent's healthcare benefit plan;
      v. room accommodation beyond the benefit plan limits; or
      vi. co-payment and/or coinsurance defined for the service.
   b. Failure to file PhilHealth benefit claim to cover all PhilHealth costs incurred during confinement;
   c. I or my dependent's personal preference to prolong confinement beyond the attending physician's prescribed duration of hospitalization;
   d. Amount in excess of my or my dependent's allowable benefit limit in the professional fee of attending doctor/s with whom my or my dependent has prior agreement;
   e. Benefit availment found to be not covered and deemed excluded under the Membership Agreement, including concealment, even if unintentional or unrelated to the current availment, of relevant medical information, and those in excess of Benefit Limits set out in the agreement, even if condition- ally approved by Maxicare. If at the time of issuance of the LOA, the amount of my or my dependent's previous availment is not reflected yet, Maxicare reserves the right to re-adjudcate the Member's coverage based on the total remaining balance of the benefit limit; and
   f. Other expenses and charges analogous to the foregoing. Maxicare shall collect from me the expenses incurred relative to any availment, if upon post verification by Maxicare, any of the above-mentioned circumstances shall be found present. My request for LOA may likewise be denied outright in the event that the availment is not coverable by Maxicare.

1. In lieu of signing the LOA, I or my dependent/s may confirm the availment of the medical services through electronic confirmation of the transaction via personal identification number (PIN), email, or other electronic confirmation which the facility shall allow. It is my responsibility to ensure that any changes in my and my dependent/s' contact information are duly communicated to Maxicare to enable my or my dependent/s to receive the electronic notifications for the transaction accordingly.
2. I confirm that the benefits and coverage requiring the services of a physician shall only be performed by an Affiliated Physician or Specialist referred by Maxicare. I and my dependents' are aware that there are agreed standard Professional Fees for specific medical services between the Physicians and Maxicare. Should I or my dependent/s undertake a private arrangement with the Physician or Specialist for higher Professional Fee/s, I shall be personally liable to pay the incremental charges resulting from said balance billing. In no case can I demand for reimbursement from Maxicare for the balance billing charged by the Affiliated Physician or Specialist.
3. I and my dependent/s have freely, knowingly and voluntarily given my consent for Maxicare and its Representatives to:
   a. Obtain, collect, examine, process, and store copies of my and/or my depen- dents' personal information, including sensitive personal information, privileged information, medical records or any other information or material, i.e., picture, voice recording, fingerprints, and etc., relative to my (and/or my dependents') hospitalization, consultation, treatment or any medical advice in connection with the benefit/clai availed under the Agreement as may be deemed necessary by Maxicare. Except as otherwise stated hereon, any information obtained relative to the authority herein given shall be strictly confidential. The extent of the collection and processing shall be necessary and incidental to the performance of the services contemplated in the Agreement.
   b. Disclose such information to the Company, its representatives, agents and brokers, Maxicare and its Representatives, including the service providers which will perform the services contemplated in the Agreement, and relevant government agencies in compliance with the Republic Act No. 11223 otherwise known as the "Universal Health Care Act", for any legitimate business purpose as Maxicare may deem appropriate, including but not limited to outsourced proceding of Maxicare transactions, billing of co-pay arrangements or Administrative Services Only (ASO), profiling or historical statistical analysis, providing advice or information which Maxicare and its Representatives believe may be of interest to me or the Company, to effectively administer or manage my account, enhance customer services, or to communicate with me for any marketing purposes.

I retain the right to be informed, to object, access, complain, and rectify, to request for filtering of certain information, and to the corresponding damages in case of violation of my rights within the corresponding limitations as set forth in the pertinent laws.

9. I shall declare only accurate, truthful, and up-to-date information to Maxicare in the course of my application and during the effectivity of this policy, and update within 30 calendar days any change in information I have provided. I further agree to be governed by the terms of this policy and the rules and regulations of the Insurance Commission, the Anti-Money Laundering Council, the Bureau of Internal Revenue, the Securities and Exchange Commission, and other applicable Philippine laws and regulations, as they may be amended from time to time, and other applicable laws, regulations, or issuances of its regulators.
10. During the effectivity of the contract/policy:
    a. In case Maxicare is unable to comply with relevant customer due diligence (CDD) measures, as required under the Anti-Money Laundering Act, as amended and relevant issuances, due to no fault of Maxicare, it may apply the following:
       i. Measures to restrict the services available or prohibit any further transactions on the policy until full and proper CDD measures have been successfully conducted; and
       ii. In case the foregoing is unsuccessful, terminate business relationship. This measure shall only entitle me/my representative to receive the unused portions of premium, if any.
    b. Be bound by obligations set out in relevant United Nations Security Council Resolutions relating to the prevention and suppression of proliferation financing of weapons of mass destruction, including the freezing and unfreezing actions as well as prohibitions from conducting transactions with designated persons and entities.
11. I and my dependents hereby represent that, in order to provide the services contemplated in the Agreement, the authorities herein provided shall be valid and existing during the term of the Agreement, including any extensions thereof, and until necessary for the establishment, exercise or defense of any claims arising from the said Agreement.
12. I and my dependent/s hereby warrant that we understand our rights and obligations pursuant to the Data Privacy Act and its implementing rules and regulations, as the same may be amended. Consequently, I and my depen- dents hereby agree to hold Maxicare and its Representatives free and harmless from and against any and all suits or claims, actions, or proceed- ings, damages, costs, and expenses, including attorney's fees, which may be filed, charged, or adjudged against Maxicare or any of its directors, stockholders, officers, employees, agents, or Representatives in connection with or arising from the use, processing and disclosure by Maxicare or its Representatives of the aforementioned information pursuant to Maxicare's reliance on my and my dependents' consent that Maxicare and its Represen- tatives have the authority to examine, use, process, store or disclose, as the case may be, said information for the above-mentioned purposes.
13. Maxicare shall not be liable for any loss or damage of whatever nature in connection with the implementation of transactions covered by this Terms and Conditions in the following instances:
    a. Disruption, failure or delay which are due to circumstances beyond the control of Maxicare, fortuitous events such as but not limited to prolonged power outages, breakdown in computers and communica- tion facilities, typhoons, public disturbances and calamities, and other similar or related cases;
    b. Loss or damage I and my dependents' may suffer due to theft or unauthorized use of my or my dependents' MaxicareCard, passwords, personal data, or violation of other security measure with or without your participation; and
    c. Inaccurate, incomplete or delayed information you received due to disruption or failure of any communication facilities.
14. I hereby warrant that I have been duly authorized by my dependent/s to sign and execute any and all documents and make representations for and in his/their behalf as if the same were personally done by him/them.
15. The Terms and Conditions contained herein are governed by the laws of the Philippines and all suits to enforce the agreement between me and Maxicare or its Representatives shall be settled in the proper courts of Makati City.
16. Maxicare shall not be liable for any loss, liability, damage or expense arising out of or in connection with the use of the Online Enrollment System, unless such loss, liability, damage or expense shall be proven to result directly from the gross and willful misconduct of Maxicare or its Representatives. In no event will Maxicare be liable for special, indirect, punitive or consequential damages. Under no circumstances will the liability of Maxicare exceed, in the aggregate, the fees actually paid pursuant to the Service Agreement.
17. Maxicare reserves the right to amend these Terms and Conditions at any time without the need of prior notice or approval.

_____ (Printed Name & Signature)
Principal Member

_____ Date

*The Terms and Conditions are subject to change. You may access https://maxicare.ph/member-terms for the latest version of the Membership Terms and Conditions and address any queries related thereto to compliance@maxicare.com.ph.

REMINDERS ON PRE-EXISTING CONDITIONS

1. I have read and understood the contents of the MyMaxicare brochure enumerating the exclusions, limitations and other terms and conditions which will govern my membership with Maxicare.
2. I agree and understand that should my medical condition be diagnosed by a Maxicare affiliated physician as a Pre-Existing Condition, the limitations on Pre-Existing Conditions as stated in the brochure provided to me will apply.

I have read the MyMaxicare application form, conditions of enrollment and authorization stated above and fully understand and agree to them.

_____ Signature of Applicant (or legal guardian)
Signature Over Printed Name

_____ Date

I hereby authorize my Business Partner to receive a copy of my Official Receipt, billing invoice and other pertinent documents relative to this application and/or account.
Note: this is only applicable for accounts under agents or brokers.

This portion is to be accomplished by Business Partner

ARLEN O. MACASPAC	investopinoy@gmail.com	09068010471
Business Partner	Email Address	Contact