MediCard
INDIVIDUAL & FAMILY PLAN

The **MediCard Individual & Family Plan** takes your worries away when you or your family needs medical attention.

BENEFITS INCLUDE:

- Hospital confinement
- Outpatient care
- Preventive healthcare
- Emergency care
- Dental care

MEMBERSHIP ELIGIBILITY

PRINCIPAL MEMBER
Company or self-employed individual 18 years old up to 60

DEPENDENTS
For Married Principal Member

1. The legal spouse at least 18 years old up to age 60
2. Legitimate and/or legally adopted children above 30 days up to 21 years of age unmarried and unemployed and living under the same roof as the principal member

For Single Principal Member

1. Parents up to age 60, unemployed and dependent upon the principal member
2. Brothers and sisters above 30 days up to 21 years of age who are not gainfully employed, unmarried and are living under the same roof as the principal member

For Single Parent Principal Member
Children 30 days old and up to 21 years of age

Enrollees age 41 above are required to undergo medical evaluation and pay a minimal fee of P650 at any MediCard Free-Standing Clinics (FSCs).*

The choice of enrolling dependents must follow a hierarchy. This means that the spouse first must be enrolled followed by the eldest child, second child and so on for married personnel. For single personnel, the parents must be enrolled first followed by the eldest brother/sister and so on.

Subject to change
Please visit www.medicardphils.com for further information.

RATES:
Without AHMC, MMC, SLMC-QC, SLMC-Global City, TMC & CSMC

	WARD	SEMI-PRIVATE
Limit for Dreaded Disease	₱50,000.00	₱60,000.00
	ANNUAL	ANNUAL
Principal Member only	₱10,739	₱12,049
Principal + 1 dependent	19,468	21,828
Principal + 2 dependents	28,696	31,490
Principal + 3 dependents	37,930	41,153
Principal + 4 or MORE deps	47,161	50,820
In excess of 4 dependents (per dependent)	9,231	11,080

With AHMC, MMC, SLMC-QC, TMC & CSMC without SLMC-Global City

	SEMI-PRIVATE w/o AHMC	SMALL PRIVATE
Limit for Dreaded Disease	₱100,000.00	₱120,000.00
	ANNUAL	ANNUAL
Principal Member only	₱18,850	₱21,908
Principal + 1 dependent	34,133	39,625
Principal + 2 dependents	50,315	57,428
Principal + 3 dependents	66,491	75,230
Principal + 4 or MORE deps	82,663	93,031
In excess of 4 dependents (per dependent)	16,172	17,801

NOTE:

- Non-Philhealth members (e.g. parents below 60 and unemployed, etc.) shall pay the Philhealth portion of their total hospital bills during confinement.
- Services availed by a MEMBER in excess of the coverage or allowable limit shall be settled by the MEMBER directly with the hospital. Failure of the MEMBER to settle the excess charges shall necessitate MediCard to bill the MEMBER, all excess charges with corresponding twenty percent (20%)service fee, payable within fifteen (15) calendar days from the receipt of billing. Otherwise, a corresponding penalty of 1% per month will be incurred. If the bills remain unpaid after thirty (30) calendar days, the concerned MEMBER shall cease to be entitled for coverage until after bills have been settled in full.
- Above rates are inclusive of VAT. Prices may change without prior notice.

AHMC – Asian Hospital and Medical Center
SLMC-QC – St. Luke's Medical Center – Quezon City
CSMC – Cardinal Santos Medical Center
MMC – Makati Medical Center
TMC – The Medical City
SLMC GC – St. Luke's Medical Center Global City

Pre-Existing Conditions (PEC):
Any illness, injury or any adverse medical condition shall be considered pre-existing if prior to the effectivity date of membership, the pathogenesis or onset of such illness, injury or adverse medical condition has started as determined by MediCard's Medical Director or accredited physicians. The determination of the pre-existing condition shall not be limited to one (1) year from the effectivity date of membership.

Provisions on PEC:

1st year of membership	NO PEC Coverage
2nd year of continuous membership and onwards	Up to ₱5,000 per illness, per member, per year provided that the pathogenesis or onset of such illness, injury or adverse medical condition started prior to or during the 1st year of membership

INSTRUCTIONS: PLEASE PRINT YOUR ANSWER TO THE QUESTIONS AND CHECK THE APPROPRIATE BOX WHERE APPLICABLE.

AGENT CODE:_____

FOR APPLICANT	FAMILY NAME	FIRST NAME	MI

BIRTHDATE (YYYY / MM / DD)

SEX: ☐ MALE ☐ FEMALE

NATIONALITY

CIVIL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOW / WIDOWER ☐ SEPARATED

HEIGHT: FT. IN.

WEIGHT: LBS.

EMAIL ADDRESS

CONTACT No(s).

PLACE OF BIRTH

PRESENT ADDRESS: UNIT/BLDG., NUMBER, STREET, SUBDIVISION, BARANGAY, CITY, PROVINCE

PERMANENT ADDRESS: UNIT/BLDG., NUMBER, STREET, SUBDIVISION, BARANGAY, CITY, PROVINCE

TYPE OF PLAN

☐ (I)NDIVIDUAL ☐ (G)ROUP ☐ (F)AMILY ☐ (C)ORPORATE

PRINCIPAL/PAYOR (FOR APPLICANT UNDER PLAN TYPES F, G, OR C)

LAST NAME	FIRST NAME	MI

RELATIONSHIP TO APPLICANT

TIN

SSS NUMBER

SOURCE OF INCOME: ☐ EMPLOYED ☐ SELF EMPLOYED ☐ PENSION ☐ OTHERS _____

OCCUPATION

GROUP/CORPORATE NAME

NATURE OF WORK

ROOM PLAN

PREFERRED PLAN TYPE

☐ PRINCIPAL MEMBER ONLY
☐ PRINCIPAL + 1 DEPENDENT
☐ PRINCIPAL + 2 DEPENDENTS
☐ PRINCIPAL + 3 DEPENDENTS
☐ PRINCIPAL + 4 OR MORE DEPENDENTS

	YES	NO
1. Have you ever been treated for or ever had any known indication of:		
a. Disorder of eyes, ears, nose, or throat?	☐	☐
b. Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke, mental or nervous disorder?	☐	☐
c. Shortness of breath, persistent hoarseness or cough, blood-spitting bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	☐	☐
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack, or other disorders of the heart or blood vessels?	☐	☐
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, diverticulitis colitis, hemorrhoids, recurrent indigestion, or other disorders of the stomach, intestines, liver or gallbladder?	☐	☐
f. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorders of kidney, bladder, prostate or reproductive organs?	☐	☐
g. Diabetes, thyroid or other endocrine disorders?	☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, such as spine, back or joints?	☐	☐
i. Deformity, lameness or amputation?	☐	☐
j. Disorder of skin, lymph glands, cysts, tumor, or cancer?	☐	☐
k. Allergies, anemia or other disorders of the blood?	☐	☐
l. Excessive use of alcohol, tobacco or any habit-forming drugs?	☐	☐
2. Are you now under observation or taking treatment?	☐	☐
3. Do you smoke cigarette? If so, how many sticks a day?	☐	☐
4. Other than above, have you:		
a. Had any physical disorder or any known indication thereof?	☐	☐
b. Had a medical examination, consultation, illness, injury, surgery?	☐	☐
c. Been a patient in a hospital, clinic, sanitarium, or other medical facility?	☐	☐
d. Had electrocardiogram, x-ray, other diagnostic tests?	☐	☐
e. Been advised to have any diagnostic test, hospitalization, or surgery, which was not completed?	☐	☐
5. Have you ever had military service deferment, rejection or discharge because of physical or mental condition?	☐	☐
6. Have you ever applied for or received a pension, payment, or benefit due to injury, sickness or disability?	☐	☐
7. Do you have a parent, brother, sister who died of or had high blood pressure, tuberculosis, diabetes, cancer, heart or kidney disease, or mental illness?	☐	☐
8. FOR FEMALES ONLY:		
a. Have you ever had any abnormal menstruation, pregnancy, childbirth or disorder of the female organs or breast?	☐	☐
b. Are you now pregnant? If yes, how many months?	☐	☐
c. Are you taking contraceptive pills?	☐	☐
9. Have you ever been rejected or terminated for medical insurance including MediCard program, or have been offered insurance at a higher (rated-up) premium? If Yes, please explain.	☐	☐

DETAILS OF "Yes" ANSWERS, IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: (Include diagnosis, results, dates, duration and names and addresses of all attending physicians and medical facilities)

How to enroll:

1. Fill out this form and submit to our office at the 9th floor The World Centre Building, 330 Sen. Gil Puyat Avenue, Salcedo Village, Makati City or call (02) 8884-9999, 1-800-1-888-9001 (Toll free for Smart/PLDT) or 1-800-8-944-8400 (Toll free for Globe/Touch Mobile).

2. You may also apply online. Simply visit www.medicardphils.com and pay thru credit card or deposit payment over-the-counter at specified banks.*

This medical questionnaire must be updated to include any condition or disease which occurs after the date of submission of the application and prior to MediCard's acceptance. Failure to provide this information to MediCard will constitute a misrepresentation of the presence of a pre-existing condition or disease and may void the coverage. Receipt of membership fees by MediCard does not constitute acceptance of the application as a MediCard program member. MediCard reserves the right to reject any applicant and is not obligated to disclose the reason for rejection.

We hereby certify that the foregoing answers are true and complete and to the best of our knowledge. Our health is accurately represented in the above statements. We understand that MediCard may require us to have a physical examination and we authorize the release of any information from such examination to MediCard for use in considering our application. We also understand and agree that whenever necessary in the administration of the Service Agreement, MediCard physicians may discuss with any hospital, health care facility, physician and surgeon, or other health care professionals medical information related in this application. We understand that this information is collected in connection with the evaluation and processing of any application for coverage or a change of benefits, or to determine eligibility for benefits.

We apply for MediCard program membership and agree that we shall abide by the provisions of the Contract and MediCard regulations. We understand that there is no coverage unless our application is approved by the MediCard Underwriting Group and that MediCard will not be liable for any medical bills between the time that we sign this application and the effective date of our coverage if our application is approved. Any money we may have sent will be returned if the application is rejected, except our processing fee.

Note: In the event the applicant is applying alone or is a minor, the applicant's name should be entered on the "Signature of Applicant" line, and the applicant's payor, parent or guardian or family member should sign where indicated.

Data Privacy Terms

In compliance with Republic Act 10173 also known as the Data Privacy Act of 2012, and its Implementing Rules and Regulations, we need your Consent to: (a) allow us to collect, process, or share your information with our accredited healthcare providers who may also be responsible in rendering appropriate medical services to you; and (b) to share utilization data with your Principal (in case of dependents);

To the extent our capacity to render our services to you is affected, the withholding or withdrawal of such Consent shall relieve us from our obligation to deliver the appropriate services to you.

You are afforded with certain rights and protection in accordance with the said Act and may visit www.medicardphils.com/privacy or email privacy@medicardphils.com for more information.

By agreeing with our terms we will consider that you agree to give your Consent to us.

SIGNATURE OVER PRINTED NAME / RELATIONSHIP TO APPLICANT | DATE

WITNESSED BY:

SIGNATURE OF SOLICITING AGENT	AGENT'S CODE NUMBER	SIGNATURE OF APPLICANT	DATE
	B275		

NAME OF AGENCY	SIGNATURE OF APPLICANT'S PAYOR, PARENT OR GUARDIAN OR FAMILY MEMBER	DATE
INVESTOPINOY FINANCIAL & INSURANCE CONSULTANTS		

MEDICAL ACTION / DATE	MEDICAL DEPARTMENT REMARKS
(A)PPROVED **(D)**ISAPPROVED D**(E)**FERRED YEAR MONTH DAY	

*Mode of payment is annual only. Payments are accepted at BDO, Unionbank, and RCBC.

MediCard

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Let us take charge of your family's health.