iCare
SAY YES TO BETTER HEALTH

iCare Persona

APPLICATION FOR INDIVIDUAL PLAN

PLEASE WRITE LEGIBLY IN BLOCK LETTERS. FILL OUT ALL BLANKS / BOXES OF THIS APPLICATION AND ITS ATTACHMENT, WHEN APPLICABLE, AND SUBMIT THEM TO ICARE AS SOON AS POSSIBLE. ONLY COMPLETELY FILLED-OUT APPLICATIONS WITH OTHER DOCUMENTARY REQUIREMENTS, IF ANY, INCLUDING VALID IDENTIFICATION DOCUMENT (ID), WILL BE PROCESSED.

PART I – PRINCIPAL / PRIMARY APPLICANT'S INFORMATION

LAST NAME**			FIRST NAME**				MIDDLE NAME		SEX (M/F)**
AGE**	BIRTHDATE (mm/dd/yyyy)**	PLACE OF BIRTH	HEIGHT**	WEIGHT**	CIVIL STATUS	CITIZENSHIP	RESIDENCE TEL. NO.	MOBILE NUMBER**	
PRESENT ADDRESS** →I	NO. & STREET		TOWN/BARANGAY			CITY/MUNICIPALITY			ZIP CODE
COMPANY NAME			OCCUPATION / POSITION			☐ SSS No. _____ or ☐ GSIS No. _____ or ☐ National ID No. for Non-Filipinos _____ ☐ Not applicable		TAX IDENTIFICATION NUMBER** _____ _ Not Applicable. Reason: ☐ Nonresident Alien*** ☐ Student with no TIN	
COMPLETE BUSINESS ADDRESS →I			E-MAIL ADDRESS**						
			OFFICE TEL. NO.						

* Scanned of photocopy of one (1) official Identification Document of the Applicant must be submitted (e.g. Passport, Driver's License, PRC ID. Please refer to 'Valid Identification Cards for Financial Transactions' under BSP Circular No. 792, s. 2013). **Required field ***Must not derive any income in/from the Philippines. If deriving income, please secure TIN as required by Philippine laws. Whether or not deriving income in the Philippines, please provide scanned or photocopy of passport, stamp of last arrival and Philippine visa/ work permit (if applicable).

PART II – INFORMATION ON THE AGREEMENT

PROGRAM TYPE →I	❑NATIONWIDE ACCESS – Open Access to all Accredited Hospitals and Clinics, including *top 6 Hospitals	❑NATIONWIDE ACCESS – Open Access to all Accredited Hospitals and Clinics, excluding *top 6 Hospitals	❑LUZON ACCESS – Open Access to all Accredited Hospitals and Clinics in Luzon (except NCR)	❑VISMIN ACCESS – Open Access to all Accredited Hospitals and Clinics in Visayas and Mindanao

** Asian Hospital and Medical Center, Cardinal Santos Medical Center, Makati Medical Center, St. Luke's Medical Center (QC and BGC) and The Medical City*

ROOM ACCOMMODATION	❑SUITE ☐ 250K ☐ 500K	❑PRIVATE	❑SEMI-PRIVATE	❑WARD	DENTAL COVERAGE: (Optional Benefit) ❑YES ❑NO
MODE OF PAYMENT	❑ANNUAL				

PART III – INFORMATION ON THE PAYOR / LEGAL GUARDIAN [To be filled-out only if the applicant is not the payor or the applicant is a minor][1]

LAST NAME**		FIRST NAME**		MIDDLE NAME	SEX (M/F)
COMPANY NAME (if Company paid[2]) / BUSINESS NAME		CONTACT PERSON & POSITION TITLE		TIN (Company/Payor/Legal Guardian)**	
PAYOR / LEGAL GUARDIAN COMPANY ADDRESS →I	NO. & STREET	TOWN/BARANGAY		CITY/MUNICIPALITY	ZIP CODE
RELATIONSHIP TO APPLICANT	RESIDENCE TEL.NO.	MOBILE NUMBER**	OFFICE TEL. NO.**	E-MAIL ADDRESS **	

[1] The following documents must be submitted: Photocopy of 'Valid Identification Card for Financial Transactions' of Payor, For Guardians, also submit Judicial Declaration of Guardianship or Affidavit of Guardianship as the case may be, and other proof of Actual Care and Custody of the minor. [2] **If company paid, please provide documents (i.e. letter providing that the Company is the Payor with ID of the signatory). **Required field**

PART IV – SOURCE OF FUNDS (Check all that apply)

PRINCIPAL / PAYOR / LEGAL GUARDIAN					Name of Employer/Business
❑SALARY	❑PENSION	❑REMITTANCES	❑COMMISSIONS	❑OTHERS _____	❑ BUSINESS _____

PART V – BILLING ADDRESS

Deliver Billing Notices to my:	❑RESIDENCE	❑OFFICE	❑EMPLOYER/PAYOR	❑ LEGAL GUARDIAN
❑I PREFER PAPERLESS BILLING	Paperless Billing is the smart and ecological choice, and we encourage you to use it. But if you ever need a paper copy of your bill, you can make that request easily.			

PART VI – LIFE (GROUP TERM) INSURANCE

DESIGNATION OF BENEFICIARIES:

- The **PRIMARY (P)** beneficiary shall receive the death benefit should the insured individual die ahead of him/her. A PRIMARY beneficiary may be designated as REVOCABLE or IRREVOCABLE beneficiary.
- If the beneficiary designation is **IRREVOCABLE (I)**, the insured individual cannot change the beneficiary nor exercise any right under the policy without the consent of the irrevocably designated beneficiary.
- If the primary beneficiary is designated as **REVOCABLE (R),** the insured individual may exercise all his rights under the policy without the consent of the designated revocable beneficiary.
- The **CONTINGENT (C)** beneficiary shall receive the death benefit should all the Primary beneficiaries die before the insured individual. A Contingent beneficiary designation is considered as revocable.
- If the insured individual fails to indicate the designation of his/her beneficiaries, default designation will be "Primary" and "Revocable".
- Unless otherwise stated, the primary beneficiaries shall share equally in the insurance proceeds.
- For minor beneficiaries, the representative of the minor beneficiary must secure and submit a court-approved Affidavit of Legal Guardianship.

NAME OF BENEFICIARIES[3] (Surname, First Name, Middle Initial)	Sex	Designation (Please read the notes above before ticking off the boxes below)	Relationship with Applicant	Birthdate (mm/dd/yyyy)	Age	Exact Amount / Percentage of Sharing (Optional)
		☐P ☐R ☐I ☐C				
		☐P ☐R ☐I ☐C				

[3] The following are recommended beneficiaries: spouse, son/daughter, parent, brother/sister

AUTHORIZATION. I hereby authorize any person, organization or entity that has any record or knowledge of my health to give to iCare, Inc. ("Insular Health Care") any or all of such records or information in his/her/its possession. These include, but is not limited to, records or information relating to any medical examination, consultation, diagnosis, hospitalization, treatment or availment of other healthcare services. I also authorize iCare to process my personal and sensitive personal information in accordance with its Data Privacy Policy, including its subsequent amendments, as published in its website: https://www.insularhealthcare.com.ph/privacy-policy/. I am aware that should I have any privacy concern regarding my personal data, I may consult iCare's Data Protection Officer at dataprivacy@insularhealthcare.com.ph or Tel: 813-0131 loc 8505, or the National Privacy Commission at https://privacy.gov.ph

I understand that the consent I am giving through this form is in addition to any other consent that I may have already given iCare and its affiliates regarding the processing of my personal data. I further understand that the consent I have given shall remain in full force until revoked in writing except to the extent that action has already been taken based therein. I hereby release iCare, its affiliates and partners from any liability arising from any disclosure and/or

processing made in accordance with the consent I have given. A photographic copy of this authorization shall be as valid as the original.

[Maaaring humingi ng tulong kung hindi nakakaunawa ng Ingles. Huwag pumirma kung mayroong hindi naiintindihan.]

Printed Name & Signature of Applicant	Date Signed	Printed Name & Signature of Employer/ Payor/ Legal Guardian	Date Signed

PART VII – QUESTIONNAIRE

		YES	NO
1.	Are you now actively at work on a regular full-time basis or actively performing daily normal activities of life?	☐	☐
2.	Do you engage in any hazardous sport or avocation?	☐	☐
3.	Are you presently covered under any hospitalization or medical plan?	☐	☐
4.	Have you ever been rejected for insurance, including healthcare plans, or been offered insurance at a higher or rated premium?	☐	☐
5.	Have you had any deferment, rejection, or discharge from any outfit because of any physical or mental condition?	☐	☐
6.	Do you have any physical abnormality such as lumps or growths on any part of your body, impairment of sight or hearing, loss of any part of your body, or other physical defects?	☐	☐
7.	During the past years, have you:		
	a. Consulted, been treated or operated on by a physician or medical practitioner?	☐	☐
	b. Had any medical examination or check-up?	☐	☐
8.	Have you ever been confined in any hospital or clinic for medical treatment or surgical operation?	☐	☐
9.	Have you ever consulted or been treated for high blood pressure, heart trouble, diabetes, cancer, liver disease, asthma or peptic ulcer?	☐	☐
10.	Are you now taking any regular medication or undergoing medical treatment or observation?	☐	☐
11.	For women only:		
	a. Date of last menstrual period: _____		
	b. Date of last delivery: _____		
	c. Are you pregnant? If yes, state number of months: _____	☐	☐
	d. Have you ever delivered by caesarian section or experienced any abnormality in your pregnancies?	☐	☐

Please explain fully a "NO" answer to Question 1 and any "YES" answer to Questions 2-11 above. You may use an extra sheet if needed.

Please indicate details of all known illnesses/injuries. Only health conditions declared in the application shall be covered; provided that, these conditions are not part of the permanent exclusions to the program or these are not otherwise illnesses/injuries excluded in the underwriting process of your application. Genuinely unknown (and therefore undeclared) health conditions will be evaluated for possible consideration; provided that, these are not concealment cases. Any information contained herein shall be considered final.

Q1-Q6

(Q7-Q11) Chief Complaints and Diagnosis	Date, Duration, Treatment and Results	Name and Address of Physician and Hospital

Home Office Endorsement

Do you have any existing HMO carrier, group hospital plan or self-insured policy? ❑ Yes ❑ No
If yes, please specify: _____ Duration of Membership. _____
Submitted Identification Data (ID) Type: _____ Number: _____
Issuing Authority: _____ Place of Issue: _____ Date of Expiration/Validity: _____

DECLARATION. I hereby declare and agree that all statements and answers contained herein and in any accompanying document (including the Summary of Benefits) are full, complete and true, and bind all parties in interest under the agreement herein applied for. I understand that payment and receipt of any amount does not constitute acceptance of application and that there shall be no contract of health care coverage unless and until an agreement is issued on this application and a deposit for the full membership fee according to the mode of payment applied for is actually paid while I am in good health and during my lifetime. I understand that any concealment or misrepresentation relating to any material fact shall render the health care coverage and life (group term) insurance null and void.

I also declare that I had been briefed on the salient features as well as the benefits and limitations of the iCare Program. I accept the iCare Program as contained herein and in other accompanying documents (including the Summary of Benefits), and I agree to its terms and conditions. I am aware that no information acquired by any representative of iCare shall be binding upon said company unless set out in writing in this application; that any physician is hereby expressly authorized to disclose or give testimony at any time relative to any information acquired by him/her in his/her professional capacity, upon any question affecting my eligibility for health care coverage; provided that, in case of failure by such physician or any entity to furnish said information despite my authorization, I hereby undertake to personally facilitate acquisition of the same to expedite the evaluation of my application. I further declare that my acceptance of any agreement issued on this application shall be a ratification of any correction, in addition to this application, as stated in the space for Home Office Endorsement.

TERMS AND CONDITIONS. 1. The proposed member must be in good health and medically acceptable to iCare, Inc. (under the company's underwriting rules) on the date of the coverage applied for is issued. 2. As a pre-requisite to processing this application, it is important that the proposed member should make a deposit equal to at least a full modal membership fee for the basic health care coverage and any other benefit(s) applied for. Any excess deposit shall be held for the proposed member subject to his/her instructions. The deposit may be in cash. If made through a check or a bank draft, it shall be considered valid only if honored on first presentation of payment. All payments are treated as deposits only until the Agreement is issued to the proposed member. Should any of these terms and conditions not be met, no health care coverage shall be in force and the proposed member's deposit shall be returned.

IMPORTANT NOTICE. Payment of the proposed member's deposit should be made at the Head Office, at any of the iCare branch offices nationwide or to a bona fide agent (whose provisional receipt will be replaced with an official receipt upon remittance to the Head/Branch Office of iCare). If within ten (10) days after payment has been made and the proposed member does not receive his/her official receipt, the proposed member should notify the company immediately. Payment can also be made through bank deposit or fund transfer into the bank account of iCare2. As stated above, a 'Summary of Benefits' forms part of this agreement wherein the proposed member should certify his/her acceptance of the product features and terms and conditions of the iCare Program, and submitted to iCare together with this application.

[Maaaring humingi ng tulong kung hindi nakakaunawa ng Ingles. Huwag pumirma kung mayroong hindi naiintindihan.]

Printed Name & Signature of Applicant	Date Signed	Printed Name & Signature of Employer/ Payor/ Legal Guardian	Date Signed

AGENT'S CONFIDENTIAL REPORT

1. I am ☐ aware/ ☐ not aware of any information on the health, habits or reputation of the applicant, which is not disclosed in this application and which may have a bearing on the risk to be undertaken by the Company. (If aware, please state information: _____).
2. I ☐ personally saw the applicant/ ☐ did not personally see the applicant.
3. I ☐ personally asked each question from the applicant exactly as set forth in this application and personally recorded the answers exactly as how they were given to me/ ☐ did not personally ask the question from the applicant/ ☐ did not ask each question exactly as set forth in this application/ ☐ did not personally record the answers ☐ did not record the answers exactly as how they were given to me. (In case of any answer in the negative, please explain why: _____).

4. I personally briefed the applicant on the salient features as well as the benefits and limitations of the iCare Program.
5. I understand that any misdeclaration or falsity in my declarations may result in the termination of my Agency Agreement and/or the forfeiture of any commission or payment due me. I hereby consent to be solidarily liable with iCare for any damage, liability, expense, claim or judgment arising out of or in connection with such misdeclaration or falsity.

ARLEN O. MACASPAC			
Printed Name & Signature of Agent/ Date	Agent's Code	Printed Name & Signature of Agency Leader/ Date	Agency Leader's Code

FOR HOME USE ONLY		
FOR CASHIER	FOR MEDICAL UNDERWRITING	FOR MEMBERS' RELATIONS/ CUSTOMER RELATIONS

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