MediCard Philippines, Inc.

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Rev. 02
1 JANUARY 2020

APPLICATION FOR MEMBERSHIP

INSTRUCTIONS:
PLEASE PRINT OR TYPE YOUR ANSWER TO THE QUESTIONS AND CHECK THE APPROPRIATE BOX WHERE APPLICABLE.
USE INK. DO NOT FILL-OUT SHADED BOX, THIS IS FOR EDP USE ONLY.

FAMILY NAME	FIRST NAME	MI	BIRTHDATE (YYYY MM DD)	PLACE OF BIRTH

SEX	CIVIL STATUS	HEIGHT (FT. / IN.)	WEIGHT	NATIONALITY	CONTACT No(s).	EMAIL ADDRESS
☐ MALE ☐ FEMALE	☐ SINGLE ☐ WIDOW / WIDOWER ☐ MARRIED ☐ SEPARATED		LBS.			

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

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

TYPE OF PLAN	OCCUPATION	GROUP/CORPORATE NAME	NATURE OF WORK
☐ (**I**)NDIVIDUAL ☐ (**G**)ROUP ☐ (**F**)AMILY ☐ (**C**)ORPORATE			

PRINCIPAL/PAYOR (FOR APPLICANT UNDER PLAN TYPES F, G, OR C)			RELATIONSHIP TO PRINCIPAL/PAYOR
LAST NAME	FIRST NAME	MI	

ROOM PLAN	MODE OF PAYMENT	SOURCE OF INCOME	INSURANCE BENEFICIARY (NOT MINOR, FOR SME OR CORPORATE ACCOUNTS ONLY)
	☐ ANNUAL ☐ QUARTERLY ☐ SEMI-ANNUAL ☐ MONTHLY	☐ EMPLOYED ☐ PENSION ☐ SELF EMPLOYED ☐ OTHERS _____	

AGENT: LAST NAME	FIRST NAME	MI	CODE
INVESTOPINOY FINANCIAL & INSURANCE CONSULTANTS			B275

	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)

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.

CONSENT: In compliance with Republic Act 10173 also known as the Data Privacy Act of 2012, we need your Consent to allow us to collect and process your information. We will only disclose and share your information with our accredited healthcare providers who may also be responsible in rendering our services to you

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 you may visit www.medicardphilscom/privacy or email privacy@medicardphils.com for more information

By signing below, we will consider that you agree to give your Consent to us. If in case, applicant/patient/claimant is unable to sign, his/her authorized representative may warrant that he/she has full authority to sign on behalf of the applicant/patient/claimant.

SIGNATURE OVER PRINTED NAME / RELATIONSHIP TO APPLICANT | **DATE**

WITNESSED BY:

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

NAME OF AGENCY	**SIGNATURE OF APPLICANT'S PAYOR, PARENT OR GUARDIAN OR FAMILY MEMBER**	**DATE**

MEDICAL ACTION / DATE

☐ (**A**)PPROVED
☐ (**D**)ISAPPROVED
☐ D(**E**)FERRED

YYYY MM DD

MEDICAL DEPARTMENT REMARKS