INDIVIDUAL MEDICAL APPLICATION FORM

1. Plan Type

☐ Single Plan ☐ Couple Plan ☐ Family Plan

2. Policyholder Information

First Name: ______________________________ Last Name: ______________________________

Occupation: ______________________________ Company: ______________________________

ID Type & No.: ______________________________ Date of Birth: ______________________________

☐Male ☐Female ☐Single ☐Married ☐Divorced

Email Address: ______________________________ Telephone No.: ______________________________

Address: ____

3. Spouse Information (please complete for Couple or Family Plan)

First Name: ______________________________ Last Name: ______________________________

ID Type & No.: ______________________________ Date of Birth: ______________________________

☐Male ☐Female

Email Address: ______________________________ Telephone No.: ______________________________

4. Dependent Children Information (please complete for Family Plan)

4.1. Child 1

First Name: ______________________________ Last Name: ______________________________

ID Type & No.: ______________________________ Date of Birth: ______________________________

☐Male ☐Female ☐Natural Child ☐Legally Adopted Child

Is the child a full-time student? ☐Yes ☐No

4.2. Child 2

First Name: ________________________________ Last Name: ________________________________

ID Type & No.: ____________________________ Date of Birth: ____________________________

☐Male ☐Female ☐Natural Child ☐Legally Adopted Child

Is the child a full-time student? ☐Yes ☐No

4.3. Child 3

First Name: ________________________________ Last Name: ________________________________

ID Type & No.: ____________________________ Date of Birth: ____________________________

☐Male ☐Female ☐Natural Child ☐Legally Adopted Child

Is the child a full-time student? ☐Yes ☐No

4.4. Child 4

First Name: ________________________________ Last Name: ________________________________

ID Type & No.: ____________________________ Date of Birth: ____________________________

☐Male ☐Female ☐Natural Child ☐Legally Adopted Child

Is the child a full-time student? ☐Yes ☐No

4.5. Child 5

First Name: ________________________________ Last Name: ________________________________

ID Type & No.: ____________________________ Date of Birth: ____________________________

☐Male ☐Female ☐Natural Child ☐Legally Adopted Child

Is the child a full-time student? ☐Yes ☐No

5. Medical History

Do you, your Spouse (if any) or your Dependent Children (if any) have or previously had any illnesses/diseases?

☐Yes ☐No If yes, please provide details: ______________________________________

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6. Policyholder Banking Details for Reimbursement

Bank Name: ______________________________ Branch: ______________________________

Account No.: ______________________________ BSB No.: ______________________________

Account Holder Name: ____

7. Beneficiary for Funeral Benefit, Death Benefit and/or Accidental Death (in case of Death of Policyholder)

First Name: ______________________________ Last Name: ______________________________

ID Type & No.: ______________________________ Date of Birth: ______________________________

Relationship to Policyholder: ☐Spouse ☐Child ☐ Parent

8. Policyholder Declaration

All personal information obtained herein is collected for the purpose of assessing the application for insurance for myself/my Spouse/my Dependent Children.

I hereby declare that the information given on this form is true and complete to the best of my knowledge.

I understand that failure to disclose any material fact known to me may invalidate the insurance policy and hereby authorize PHA to obtain information and/or records from any organisation, institute or individual that has any record or knowledge of my/my Spouse's/my Children's sick records, medical history, or medical treatment.

Date: ________________ Signature of Policyholder: ____