Application Form

Full Medical Underwriting

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PARAMOUNT LIFE & GENERAL INSURANCE

april International

INSURANCE MADE EASY

YOUR APPLICATION, STEP BY STEP.

This is your application form. Complete it, sign it, send it.

WANT TO SAVE TIME?

The submit button at the end of this form allows you
to send a soft copy for us to start the process.
We will arrange for the signing of the form at a later stage.

An underwriting offer will be provided in **2 working days or less**.

Once our offer has been accepted and payment is received, in 5 working days, you will receive:

- Your full member's pack (by email)
  This includes relevant documentation such as claim forms, instructions, terms and conditions, and benefit schedules.
- You will be able to download your member card containing emergency contact numbers for requesting assistance services or before admission to hospital on our Easy Claim app.

1. YOUR DETAILS

IMPORTANT NOTICE

The answers you give to the questions contained in this Application will form the basis of any insurance policy issued, and will be incorporated into the contract. It is essential that you give accurate, truthful, and complete information for all persons to be insured, as inaccuracies may jeopardise coverage or invalidate a claim.

APPLICANT'S DETAILS

Family Name : _____

First Name(s) : _____

Date of Birth : DD / MM / YYYY _____ Gender : Male ◯ Female ◯

Height (cm) : _____ Weight (kg) : _____

Occupation : _____

(Specify nature of duties) _____

Smoker : Yes ◯ No ◯ Marital Status : _____

Nationality : _____ ID/Passport No. : _____

Residential Address* : _____

This policy is only available to applicants whose usual country of residence is the Philippines.

Postal Code : _____ Country : _____

Usual Country of Residence : _____

If you wish to use a different mailing address please advise us

Tel. : _____ Mobile : _____

Email : _____

Important : this email will be used for sending your policy documents and claims-related communication which may include sensitive medical information.

FAMILY MEMBERS TO BE INSURED

	FAMILY MEMBER 1	FAMILY MEMBER 2	FAMILY MEMBER 3	FAMILY MEMBER 4
Family Name				
First Name(s)				
Date of Birth	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
Gender	Male ◯ Female ◯	Male ◯ Female ◯	Male ◯ Female ◯	Male ◯ Female ◯
Marital Status				
Relationship to Applicant				
Nationality				
Smoker	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
ID/Passport No.				
Occupation (Specify nature of duties)				
Height & Weight	cm kg	cm kg	cm kg	cm kg

Please use separate sheet if necessary. Please advise us if any Family Members to be insured do not live at the Applicant's Residential Address.

2. YOUR COVER

STEP 1	SELECT YOUR COVER The following modules form the base of your policy. Each member has the flexibility to select the cover they want. If dependants will have the same cover as the Applicant, please tick here ○ and complete cover options for the Applicant only.				
MODULES	**APPLICANT**	**FAMILY MEMBER 1**	**FAMILY MEMBER 2**	**FAMILY MEMBER 3**	**FAMILY MEMBER 4**
Hospital & Surgery	○ Essential $100,000 ○ Essential $500,000 ○ Extensive ○ Elite	○ Essential $100,000 ○ Essential $500,000 ○ Extensive ○ Elite	○ Essential $100,000 ○ Essential $500,000 ○ Extensive ○ Elite	○ Essential $100,000 ○ Essential $500,000 ○ Extensive ○ Elite	○ Essential $100,000 ○ Essential $500,000 ○ Extensive ○ Elite
Annual Deductible	○ Nil ○ USD 500 ○ USD 1,000 ○ USD 2,500 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 500 ○ USD 1,000 ○ USD 2,500 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 500 ○ USD 1,000 ○ USD 2,500 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 500 ○ USD 1,000 ○ USD 2,500 ○ USD 5,000 ○ USD 10,000	○ Nil ○ USD 500 ○ USD 1,000 ○ USD 2,500 ○ USD 5,000 ○ USD 10,000
	• Your selected deductible applies to the Hospital and Surgery module only.				
Area of Cover	○ Worldwide ○ Worldwide excluding USA ○ ASEAN Excluding Singapore	○ Worldwide ○ Worldwide excluding USA ○ ASEAN Excluding Singapore	○ Worldwide ○ Worldwide excluding USA ○ ASEAN Excluding Singapore	○ Worldwide ○ Worldwide excluding USA ○ ASEAN Excluding Singapore	○ Worldwide ○ Worldwide excluding USA ○ ASEAN Excluding Singapore
	• The area of cover chosen will apply to all modules selected. • Services rendered outside of the area of cover are covered up to US$50,000 per period of insurance, only if they are directly caused by sudden illness or injury occurring during the first 30 travel days of any trip outside of your area of cover. • Please refer to clause 4 of the Policy Terms and Conditions.				

STEP 2	SELECT ANY OPTIONAL MODULES THAT YOU WISH The following modules are optional. Each member has the flexibility to select the cover they want. If dependants will have the same cover as the Applicant, please tick here ○ and complete cover options for the Applicant only.				
MODULES	**APPLICANT**	**FAMILY MEMBER 1**	**FAMILY MEMBER 2**	**FAMILY MEMBER 3**	**FAMILY MEMBER 4**
Outpatient	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite
Dental and/or Optical Optical included with Elite plan only	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite
Maternity	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite
	• **Important:** Available to women between 19 to 45 years of age who have selected at minimum an Extensive or Elite Hospital and Surgery on a NIL deductible basis, plus an optional Outpatient module.				

3. UNDERWRITING QUESTIONNAIRE

INSURANCE DETAILS		
Have you or any person to be insured ever applied for, been covered under, or held a policy administered by APRIL? If Yes, please give details.	Yes	No
Do you or any person to be insured currently have health insurance with another company? If Yes, please give details and indicate if it will be continued (and if not, as of what date).	Yes	No
Have you or any person to be insured ever had a policy or application for life, sickness, accident disability, critical illness or medical insurance refused or cancelled, or had any special terms imposed? If Yes, please give details.	Yes	No

MEDICAL DETAILS AND HISTORY	Please indicate if you or any person to be insured have or have ever had any of the **signs, symptoms, illnesses or disorders** below by ticking the appropriate box.		
1	Cancer, leukemia, tumor or neoplasm, cysts, fibrocystic breast disorder, polyp or growths of any kind	Yes	No
2	Respiratory system: Asthma, bronchitis, allergies, rhinitis or sinusitis, tuberculosis, or other disorder of the respiratory system	Yes	No
3	Circulatory system and blood disorder: Chest pain, raised blood pressure, raised cholesterol, heart condition, or other disorder of the circulatory system or blood	Yes	No
4	Gastrointestinal system: Indigestion, gastric reflux, gastric ulcer, hemorrhoids, hernia, or other disorder of the gastrointestinal system	Yes	No
5	Musculoskeletal: Bone fracture, joint injury, arthritis, back, neck or muscle pain, or other disorder of the spine	Yes	No
6	Tropical illness: Malaria, dengue fever	Yes	No
7	HIV/AIDS	Yes	No
8	Urinary system: Kidney stones or other disorder of the urinary system or prostate	Yes	No
9	Liver: Diabetes, hepatitis, fatty liver, or other disorder of the liver	Yes	No
10	Thyroid: Hypothyroidism, Hashimoto's disease, or other disorder of the thyroid	Yes	No
11	Brain and nervous system: Stroke, aneurysm, seizures, chronic headache, migraine, or other disorder of the brain or nervous system	Yes	No
12	Anxiety, depression, stress, addiction, or other mental, behavioral, developmental disorder	Yes	No
13	Gynecological system: Pregnancy (including any complication), fibroid, endometriosis, irregular periods or bleeding, menstrual pain, HPV infection, or an abnormal smear test result, or other disorder of the gynecological system	Yes	No
14	Skin: Eczema, dermatitis, psoriasis, wart, or other disorder of skin	Yes	No
15	Eyes and ears: Cataract, glaucoma, otitis, hearing loss, or other disorder of eyes or ears	Yes	No
16	Congenital, hereditary conditions, birth defects, deformities, or conditions affecting mobility	Yes	No
17	Any COVID-19 or Coronavirus infection	Yes	No
18	Any other disorder/ injury	Yes	No

3. UNDERWRITING QUESTIONNAIRE - CONTINUED

If you answered "Yes" to any of the above, please provide details in the table below. You may be required to provide a further medical questionnaire or medical reports, depending on the severity and nature of the condition declared.

Person to be insured			
Question No.			
Disease/ Medical Condition/ Sign & Symptom			
Date of first occurrence of sign & symptom	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
Frequency of sign & symptom			
Treatment Details (including name, date, duration of medication, surgery etc.)			
Date of last follow-up medical consultation/ treatment	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
Any on-going, regular, planned or preventive treatment required?			
Any on-going sign or symptom?			

MEDICAL DETAILS AND HISTORY - CONTINUED

19 **Except as disclosed elsewhere in this form, have you or any person to be insured ever been admitted to hospital as an inpatient, or undergone any procedures including endoscopy, biopsy whether as an inpatient or outpatient?**
If Yes, please give details.

Yes ○ No ○

20 **In the last five years, have you or any person to be insured been notified of any abnormal test results or awaiting results for any scans or tests performed (e.g. blood or urine test, ECG, endoscopy, X-ray, ultrasound, CT scan, MRI, PET scan etc.)?** Please also answer "yes" if there are any inconclusive or uncertain results (retesting or follow up test required) and abnormal findings that may not require treatment at present (e.g. cyst, joint degeneration, calcification, etc.)

Yes ○ No ○

21 **In the last five years, have you or any person to be insured currently taking or been prescribed any medications for a continuous period of more than one month?** If Yes, please state the medicine name, dosage and the approximate cost.

Yes ○ No ○

22 **Please enter the following details about the usual/family doctor for each person to be insured. If you do not have a usual/family doctor, please provide the names, addresses and contact information of medical providers you and your family members to be insured have seen in the last 3 years. Use a separate sheet if necessary.** If you have never seen a doctor in the past 3 years, please indicate that below.

Name			
Address			
Telephone		Fax	
Email			

Please provide more details on a separate sheet if required.

3. UNDERWRITING QUESTIONNAIRE - CONTINUED

ADDITIONAL SPACE FOR FURTHER REMARKS	You may use this space for any further comments about any medical conditions you have or have suffered from. Please remember to enclose any supporting documents with your application.

COMMENCEMENT DATE

○ On Acceptance ○ Another Date : DD / MM / YYYY
(We cannot backdate cover to a date earlier than the offer acceptance and payment date)

INTERMEDIARY ACCESS

Would you like your insurance intermediary to have access to your policy details and claims transactions through their online account?			○ Yes ○ No
Do you authorise us to discuss and/or share claims and medical information with your insurance intermediary?			○ Yes ○ No
Intermediary Name		Intermediary Code	
Company Name		Telephone	
Email			

CLAIM REIMBURSEMENT	Please provide your banking details for claim reimbursement.		
Bank Name			
Bank Address			
A/C Name		A/C No.	
Currency	○ PHP ○ USD	For all other currencies, please check with APRIL International. For international transfers to a foreign bank, note that your bank may charge you fees for each transaction which will be your responsibility to bear.	

4. PAYMENT METHODS

Cheque or Bank Draft (USD)

Cheques should be drawn on a Philippines clearing bank and made payable to "**Paramount Life & General Insurance Corporation**"
Kindly provide the (1) Name of Application or policyholder; (2) Contact No.; (3) Name of Product; (4) Producer Code; and (5) Policy Number on a separate sheet.

Bank Transfer (USD)

Account Name:	Paramount Life & General Insurance Corporation
Bank Name:	Security Bank
Bank Address:	G/F Exchange cor. Bldg. #107 V.A. Rufino cor. Bolanos & Esteban Sts. Legaspi Village, Makati City, 1229
Account Number:	515-014870-200 (USD)
Swift Code:	SETCPHMM
Notes:	1. All bank charges (outbound and inbound) will be borne by the remitter. 2. Please indicate your Policy Number as payment details to your bank. 3. Please email the bank remittance advice or instructions slip with your Policy Number to ops.ph@april.com for our accounting records and to issue an Official Receipt.

Credit Card (Point of Sale)

Paramount Life & General Insurance Corporation
Through: Cashier Department
12th Floor, Sage House,
110 V.A. Rufino St. Legaspi Village,
Makati City, 1229 Philippines

Online Payment Facility (Peso Currency Only)

- Credit Card (VISA / MC)
- Bancnet
- BDO
- BPI
- PNB
- Security Bank

Note: If you wish to pay through any of the facility above, please email myhealth@paramount.com.ph for the payment details.

DECLARATION BY APPLICANT

I/We hereby declare that the statements made by me/us in this questionnaire are to the best of my/our knowledge and belief, complete and true, and I/We hereby agree that this questionnaire forms as part of the policy issued in connection with the insurance being secured. I/We will advice the Insurer of any changes or any information prior to the policy being issued. I/We hereby agree that my/our insurance shall become effective upon approval of the Company provided that I/we have met all eligibility conditions and that myself/ourselves and my/our dependents are in good health and with no physical and mental disabilities on such date and that the full premium corresponding to my/our insurance has been paid. The insurance will not become effective if there is fraud, concealment or misrepresentation on said statements.

During the effectivity of the contract/policy, I/We agree to the following:

1. In case the company 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 the fault of the client, the company may apply the following:
   a. Measures to restrict the services available or prohibit any further transactions on the contract/policy until full and proper CDD measures have been successfully conducted; and
   b. In case the foregoing is unsuccessful, terminate business relationship. The exercise of the company of this measure shall only entitle the client/customer to receive the unused portions of premium or withdrawal value, if any, whichever is applicable.
2. 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.

Furthermore, I/we authorize any licensed physician or hospital or any organization that has my/our medical records or health information to furnish PARAMOUNT LIFE & GENERAL INSURANCE CORPORATION with information concerning my/our medical history and physical condition.

Printed Name/Title :		**Signature**
Date:	DD / MM / YYYY **Important** : The application form must be sent to us within 30 days from this date for your application to be valid.	
Contact Person:		Company Stamp
Contact Telephone Number:		

5. PERSONAL DATA PROTECTION

I/We give consent to Paramount Life & General Insurance Corporation ("Paramount") and its employees, related companies, agents and service providers to collect, use and disclose all personal data for one or more of the purposes described in Paramount 's Data Protection Policy, including but not limited to premium payment, collection, accounting, audit, compliance, regulatory, research, analysis, verification, and dispute resolution. I/We have read and agreed to the terms of the full Policy at https://www.paramount.com.ph/privacy-policy.If any personal data furnished is not about me/us, I/we warrant that I / we have obtained consent from the data subiect (or if lacking in legal capacity, his/her legal representatives, guardians or parents as the case may be) for Paramount to collect, use and disclose his/ her personal data for the above purposes and on the terms in this document, and as if the said data are about me/us.

I/We warrant that all personal data I/we have provided are accurate and complete, and I/we will inform Paramount of any changes to the data as soon as practicable.

SIGNATURE OF CARDHOLDER

Notes:
The liability of the Company (Paramount Life & General Insurance Corporation) commences only when the proposal renewal has been accepted by the Company and premium successfully deducted. Acceptance of premium does not constitute acceptance of liability.

DATA PRIVACY ACT AND CONSENT STATEMENTS: I/We hereby consent to the processing of the personal data stated above whether manually or via electronic channels, including but not limited to the collection, use, storage, customer/client profiling, and disclosure to third parties, by Paramount Life & General Insurance Corporation (hereafter, “PLGIC”), its subsidiaries, affiliates, directors, officers, employees and agents, (a) to verify and/or confirm any or all the information provided or representation made, (b) to provide, facilitate, monitor, improve the quality of, or otherwise service my/our account and such products, services, and facilities and/or channels availed by me or may be offered by PLGIC, (c) for direct marketing, and (d) to comply with legal, regulatory, or other obligations of PLGIC under applicable local or foreign laws, rules and regulations.

I/We likewise consent to the processing of the personal data stated above whether manually or via electronic channels, including but not limited to the collection, usage, storage and customer/client profiling, by authorized third parties for the foregoing purposes. Such processing may be conducted for the duration of my/our availment of PLGIC’s products, services, facilities and/or channels. I/We further consent that the personal data stated above shall be retained by PLGIC for an additional period of at least five (5) years, or for a longer period if the personal data is related to or required to be preserved for litigation or to comply with legal or regulatory requirement. I/We likewise consent to the correction, amendment, deletion and/or disposal by PLGIC, its subsidiaries, affiliates, officers, employees, agents, and authorized third parties of my/our personal data which may be inaccurate or incorrect.

I/We attest that I/we have been made aware of and understood my/our rights as a data subject and how these can be exercised, and that I/we was/were informed of the nature, extent and processing of the personal data I/We provided. I/We understand and agree that the consent hereby given may be revoked or withdrawn through formal written notice to PLGIC.

I/We authorize PLGIC, its subsidiaries, affiliates, directors, officers, employees, agents, and authorized third parties to obtain such other information they may deem necessary to verify or confirm the personal data declared or the documents furnished in relation to this application, and that I/we agree that such documents may remain in the possession of PLGIC whether or not this application is granted, for the purposes abovementioned.

Finally, I/we hereby authorize and request you, any person, organization or entity that has any record or knowledge of my/our health and physical condition to give to PARAMOUNT LIFE & GENERAL INSURANCE CORPORATION any and all information that they may desire and which is relative to any consultation, treatment or any other medical advice or examination I/we had. A photocopy (or similar copy) of this authorization shall be as valid as the original. The request for information is in connection with my/our application for insurance.

NOTE: Under Republic Act 9160 (Anti-Money Laundering Act) as amended by Republic Act 9194 and pertinent regularions, all insurance companies are required to satisfactorily establish the identities of all its customers. Hence, Paramount Life & General Insurance Corporation reserves right to not accept and process any application for insurance if the customer fails to provide sufficient evidence to establish his identity.

Underwritten by:

Paramount Life & General Insurance Corporation
15th Floor, Sage House,
110 V.A. Rufino St. Legaspi Village,
Makati City, 1229 Philippines
Phone +(632) 8 772 9200 | Fax +(632) 8 772 9291
Email: myhealth@paramount.com.ph

Arranged by:

APRIL Singapore Pte Ltd
Co. Reg. No. 200613924G
2A McCallum Street
Singapore 069043
Tel: (+65) 6736 0057 | Fax: (+65) 6222 4473
Email: contact.ph@april.com

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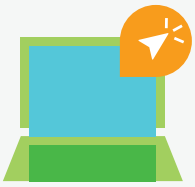
SUBMIT YOUR APPLICATION

SUBMIT ELECTRONICALLY

SUBMIT



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Paramount Life & General Insurance Corporation
15th Floor Sage House
110 V.A. Rufino St., Legaspi Village
Makati City, 1229 Philippines