PAHAMI & MILIKI ASURANSI

Terdaftar dan diawasi oleh OJK OTORITAS JASA KEUANGAN

Application Form

## Continuous Personal Medical Exclusions

# MyHEALTH Individual Medical Plans

Download our Easy Claim mobile app for quicker claims reimbursement!

Please print only if necessary

ASURANSI ARTARINDO

# YOUR APPLICATION, STEP BY STEP.

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

An underwriting offer will be provided in **3 working days or less**.

## ONCE OUR OFFER HAS BEEN ACCEPTED, 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 cover-age or invalidate a claim. You are applying for Continuous Personal Medical Exclusions 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. You are applying for **Continuous Personal Medical Exclusions (CPME)**, which means that any special terms, exclusions or loadings on your current/expiring health insurance policy will be carried over and applied to your new MyHEALTH policy. We may apply additional loading or exclusions based on the information declared below.

**PROPOSER'S DETAILS** Contact information of the person who will own the policy

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 : ______

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**

| | SPOUSE/PARTNER | CHILD 1 | CHILD 2 | CHILD 3 |
|---|---|---|---|---|
| | | Unmarried children proposed for insurance must be aged 18 or under. Unmarried children over 18 in full-time education can be covered up to 23 years old. | | |
| 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 | | | | |
| 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 proposer'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 proposer, please tick here ○ and complete cover options for the proposer only.

| MODULES | PROPOSER | SPOUSE/PARTNER | CHILD 1 | CHILD 2 | CHILD 3 |
|---|---|---|---|---|---|
| Hospital & Surgery | ○ Core<br>○ Essential<br>○ Extensive<br>○ Elite | ○ Core<br>○ Essential<br>○ Extensive<br>○ Elite | ○ Core<br>○ Essential<br>○ Extensive<br>○ Elite | ○ Core<br>○ Essential<br>○ Extensive<br>○ Elite | ○ Core<br>○ Essential<br>○ Extensive<br>○ Elite |
| Annual Deductible | ○ Nil<br>○ USD 500<br>○ USD 1,000<br>○ USD 2,500<br>○ USD 5,000<br>○ USD 10,000 | ○ Nil<br>○ USD 500<br>○ USD 1,000<br>○ USD 2,500<br>○ USD 5,000<br>○ USD 10,000 | ○ Nil<br>○ USD 500<br>○ USD 1,000<br>○ USD 2,500<br>○ USD 5,000<br>○ USD 10,000 | ○ Nil<br>○ USD 500<br>○ USD 1,000<br>○ USD 2,500<br>○ USD 5,000<br>○ USD 10,000 | ○ Nil<br>○ USD 500<br>○ USD 1,000<br>○ USD 2,500<br>○ USD 5,000<br>○ USD 10,000 |
| | • Your selected deductible applies to the Hospital and Surgery module only. | | | | |
| Area of Cover | ○ Worldwide<br>○ Worldwide excluding USA<br>○ ASEAN excluding Singapore | ○ Worldwide<br>○ Worldwide excluding USA<br>○ ASEAN excluding Singapore | ○ Worldwide<br>○ Worldwide excluding USA<br>○ ASEAN excluding Singapore | ○ Worldwide<br>○ Worldwide excluding USA<br>○ ASEAN excluding Singapore | ○ Worldwide<br>○ Worldwide excluding USA<br>○ ASEAN excluding Singapore |

- The area of cover chosen will apply to all modules selected.
- If you selected Core, your area of cover will be ASEAN excluding Singapore by default.
- Services rendered outside of the area of cover are covered up to US$100,000 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 in the USA. If you selected Core, you will be covered up to US$100,000 for accidents only.
- Please refer to clause 4 of the Policy Terms and Conditions.

## STEP 2 — SELECT YOUR OPTIONAL MODULES

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 proposer, please tick here ○ and complete cover options for the proposer only.

| MODULES | PROPOSER | SPOUSE/PARTNER | CHILD 1 | CHILD 2 | CHILD 3 |
|---|---|---|---|---|---|
| Outpatient | Core with<br>○ nil coinsurance<br>○ 20% coinsurance | Core with<br>○ nil coinsurance<br>○ 20% coinsurance | Core with<br>○ nil coinsurance<br>○ 20% coinsurance | Core with<br>○ nil coinsurance<br>○ 20% coinsurance | Core with<br>○ nil coinsurance<br>○ 20% coinsurance |
| | Essential with<br>○ nil coinsurance<br>○ 20% coinsurance | Essential with<br>○ nil coinsurance<br>○ 20% coinsurance | Essential with<br>○ nil coinsurance<br>○ 20% coinsurance | Essential with<br>○ nil coinsurance<br>○ 20% coinsurance | Essential with<br>○ nil coinsurance<br>○ 20% coinsurance |
| | Extensive with<br>○ nil coinsurance<br>○ 20% coinsurance | Extensive with<br>○ nil coinsurance<br>○ 20% coinsurance | Extensive with<br>○ nil coinsurance<br>○ 20% coinsurance | Extensive with<br>○ nil coinsurance<br>○ 20% coinsurance | Extensive with<br>○ nil coinsurance<br>○ 20% coinsurance |
| | Elite with<br>○ nil coinsurance<br>○ 20% coinsurance | Elite with<br>○ nil coinsurance<br>○ 20% coinsurance | Elite with<br>○ nil coinsurance<br>○ 20% coinsurance | Elite with<br>○ nil coinsurance<br>○ 20% coinsurance | Elite with<br>○ nil coinsurance<br>○ 20% coinsurance |
| Dental and/or Optical<br>Optical included with Elite plan only | ○ Core<br>○ Essential<br>○ Extensive<br>○ Elite | ○ Core<br>○ Essential<br>○ Extensive<br>○ Elite | ○ Core<br>○ Essential<br>○ Extensive<br>○ Elite | ○ Core<br>○ Essential<br>○ Extensive<br>○ Elite | ○ Core<br>○ Essential<br>○ Extensive<br>○ Elite |
| Maternity | ○ USD 5,000<br>○ USD 8,000<br>○ USD 15,000 | ○ USD 5,000<br>○ USD 8,000<br>○ USD 15,000 | ○ USD 5,000<br>○ USD 8,000<br>○ USD 15,000 | ○ USD 5,000<br>○ USD 8,000<br>○ USD 15,000 | ○ USD 5,000<br>○ USD 8,000<br>○ USD 15,000 |

- **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 AND MEDICAL DETAILS | If the answer is Yes to any of the following questions, please provide full details. |
|---|---|

**Do you or any person to be insured currently have health insurance with another company?**
If Yes, please provide details and attach all existing insurance certificates, schedules and endorsement relating to all persons to be insured. CPME is only available to persons currently covered by an equivalent international medical insurance policy.

Yes ◯ No ◯

**Do you and any person to be insured have or have ever had any signs, symptoms, treatments, consultations, investigations, diagnostic tests for cancer?**

Yes ◯ No ◯

**Have you or any person to be insured been suffering from chronic conditions such as but not limited to polyps, cysts, asthma, heart conditions, cerebral infarction/stroke, brain multiple sclerosis, renal failure, liver cirrhosis, autoimmune disease, joint replacement, severe mental illness/Alzheimer's, Parkinson, Epilepsy, Down syndrome? Or ever made a claim against your insurance in relation to chronic conditions?**

Chronic condition : A disease, illness or injury that has one or more of the following characteristics:
a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests; or
b. it needs ongoing or long-term control or relief of symptoms; or
c. you need to be rehabilitated or specially trained to cope with it; or
d. it continues indefinitely; or
e. it has no known cure; or
f. it comes back or is likely to come back.

Yes ◯ No ◯

**Do you or any person to be insured have any recent (12 months) hospitalisations or plan of surgery or treatment/consultation for cancer and/or chronic conditions?**

Yes ◯ No ◯

**Is anyone to be covered on this plan currently pregnant?**

Yes ◯ No ◯

**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 | | | |

# 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 date you accept our final offer.

| INTERMEDIARY ACCESS | | | |
|---|---|---|---|
| Would you like your insurance intermediary to have access to your policy details and claims transactions through their online account at healthbyapril.com/portal? | | | 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 | ◯ USD ◯ IDR ◯ EUR | For all other currencies, please check with APRIL International Care. 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. | |
| The following information must be provided for bank accounts outside Indonesia: | | | |
| Sort Code | | BIC (Swift) Code | |
| Corresponding Bank Details (if applicable) | | | |

# 4. PAYMENT METHODS

**Bank Transfer - ANNUAL PAYMENT IN USD**

Please send full payment (inclusive of all bank charges and surcharges) to:
**Beneficiary Bank**

| | |
|---|---|
| **Bank Name :** | Bank UOB Indonesia |
| **Bank Account :** | 3279-0393-17 |
| **Account Name :** | PT. Asuransi Artarindo |
| **Account Address :** | Jalan MH. Thamrin No.10 Jakarta 10230 |
| **SWIFT Code:** | BBIJIDJA |
| **Bank Address:** | Jalan MH. Thamrin No.10 Jakarta 10230 |

1. All bank charges will be borne by the remitter.
2. Please indicate your Policy Number as a payment detail to your bank.
3. Please fax (+62) 21 3971 1001 or email fa@artarindo.co.id the bank remittance advice or instruction slip with your Policy Number to PT. Asuransi Artarindo email accounting records and to issue an Official Receipt.

**Credit Card - ANNUAL PAYMENT IN USD**

# 5. DECLARATION BY PROPOSER

| PRODUCER DETAILS (FOR OFFICIAL USE ONLY) | | |
|---|---|---|
| Producer Name | | Or Stamp Above |
| Producer Code | | |
| Company Name | | |
| Telephone | | |
| Email | | |

I/We declare that the statements contained in this application form are correctly recorded, and that they are full, complete and true. I/We further declare that I have not withheld any material fact and that except as declared herein, all persons to be insured are currently in good health. I/We will notify PT. Asuransi Artarindo/APRIL immediately if after signing this application and before a policy is issued I/We become aware of material facts not disclosed in this form, or if the health of any person to be insured changes such that any answer on this form is not full complete, and true. If a policy is issued to me, this proposal and the statements made herein shall form the basis of the policy between me/us and PT. Asuransi Artarindo. I understand that no insurance shall be in force until and unless the application has been accepted and the appropriate premium paid.

I/We agree that any information collected or held by PT. Asuransi Artarindo /APRIL (whether contained in the Application or otherwise obtained) may be used and disclosed by PT. Asuransi Artarindo /APRIL Asia to its associated individuals/companies or any independent third parties (within or outside Indonesia) for any matters relating to this application, any policy issued and to provide advice or information concerning products and services which PT. Asuransi Artarindo /APRIL believes may be of interest to me/us and to communicate with me/us for any purpose.

I/We hereby declare that I/We have received, read and understood, or have been advised of and understand, the contents of the brochure and any information material relating to this insurance product.

I/We am/are aware that I/We can seek advice from a qualified advisor before I/We sign this enrolment form. Should I/We choose not to, I/We take sole responsibility to ensure that this product is appropriate to my financial needs and insurance objectives.

I/We authorise PT. Asuransi Artarindo /APRIL to release the names, dates of birth, sex, passport and/or identification number, any information provided on the application and any records PT. Asuransi Artarindo /APRIL may have regarding the Insured person(s) shown on the Namelist to hospitals, clinics, laboratories, physicians, specialists, dentists, chiropractors, acupuncturists, physiotherapists, or other medical practitioners for the purpose of providing direct bill paying services for the insured person(s). By signing this Authority and Release Form, I/We also acknowledge the specific Policy term listed below:

Right of Recovery: In the event of authorisation of payment and/or payment is made by PT. Asuransi Artarindo /APRIL for a claim which is not covered under this Policy or when the limit of liability for this insurance is exceeded, PT. Asuransi Artarindo /APRIL reserves the right to recover the said sum or excess from you. This recovery includes but is not limited to deducting the payments owed from other claims made by you during the policy period. If the amount owed remains outstanding for more than 90 days, then PT. Asuransi Artarindo /APRIL reserves the right to suspend the direct billing service to you without further notice.

| SIGNATURE |
|---|
| |

Name : ______________________

Title : ______________________

Date : ______________________

## 5. DECLARATION BY PROPOSER - CONTINUED

| CLAIM PAYMENT DECLARATION | | | |
|---|---|---|---|
| I, the undersigned: | | | |
| Policyholder | | | |
| Policy Number | | | |
| I hereby certify that my claim payments are to be transferred to the account below and that the details are correct: | | | |
| Account Name | | Bank Name | |
| Account Number | | Branch | |
| Swift Code | | Country | |
| Bank Address | | | |
| Relationship with Policy Holder | | | |

I will be fully responsible for any errors in the details supplied above

Signed this day DD/MM / YY in Jakarta

Best Regards,

STAMP DUTY & WET SIGNING

Policy Holder Name : ____________________

Underwritten by:

**PT. Asuransi Artarindo**
Gedung Hermina Tower Lt. 12,
Jl. HBR Motik Blok B-10 Kav. 4
Gunung Sahari Selatan, Kemayoran,
Jakarta Pusat 10610
Tel: (+62) 21 3971 0999

Arranged and administered by:

**APRIL Singapore Pte Ltd**
Co. Reg. No. 200613924G
2A McCallum Street
Singapore 069043

INDO MH PDF ED 05/2024

# SUBMIT YOUR APPLICATION

## SUBMIT ELECTRONICALLY

SUBMIT

Save this file and
send it to
asia.app@april.com

OR

## PRINT, SIGN, EMAIL

PRINT

Send the scanned copy to
asia.app@april.com

Mail to **PT. Asuransi Artarindo**
**Gedung Hermina Tower Lt. 12,**
**Jl. HBR Motik Blok B-10 Kav. 4**
**Gunung Sahari Selatan, Kemayoran,**
**Jakarta Pusat 10610**