MARI Berasuransi

Terdaftar dan diawasi oleh OJK OTORITAS JASA KEUANGAN

APPLICATION FORM

MyHEALTH INDIVIDUAL AND FAMILY

Download our Easy Claim mobile app for quicker claims reimbursement!

Available on the App Store

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april-international.com

Please print only if necessary

ASURANSI ARTARINDO

april international

Insurance made easy.

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.

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 ○ Essential ○ Extensive ○ Elite	○ Core ○ Essential ○ Extensive ○ Elite	○ Core ○ Essential ○ Extensive ○ Elite	○ Core ○ Essential ○ Extensive ○ Elite	○ Core ○ Essential ○ 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. • 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 ○ nil coinsurance ○ 20% coinsurance	Core with ○ nil coinsurance ○ 20% coinsurance	Core with ○ nil coinsurance ○ 20% coinsurance	Core with ○ nil coinsurance ○ 20% coinsurance	Core with ○ nil coinsurance ○ 20% coinsurance
	Essential with ○ nil coinsurance ○ 20% coinsurance	Essential with ○ nil coinsurance ○ 20% coinsurance	Essential with ○ nil coinsurance ○ 20% coinsurance	Essential with ○ nil coinsurance ○ 20% coinsurance	Essential with ○ nil coinsurance ○ 20% coinsurance
	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance
	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance
Dental and/or Optical Optical included with Elite plan only	○ Core ○ Essential ○ Extensive ○ Elite	○ Core ○ Essential ○ Extensive ○ Elite	○ Core ○ Essential ○ Extensive ○ Elite	○ Core ○ Essential ○ Extensive ○ Elite	○ Core ○ Essential ○ Extensive ○ Elite
Maternity	○ USD 5,000 ○ USD 8,000 ○ USD 15,000	○ USD 5,000 ○ USD 8,000 ○ USD 15,000	○ USD 5,000 ○ USD 8,000 ○ USD 15,000	○ USD 5,000 ○ USD 8,000 ○ USD 15,000	○ USD 5,000 ○ USD 8,000 ○ 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 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 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

18 **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 ○

19 **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 ○

20 **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 ○

21 **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.

DESIRED COMMENCEMENT DATE	DD / MM / YYYY

Important : This Individual and Family Application Form is valid for 28 days from date of receipt by PT. Asuransi Artarindo. We cannot backdate cover.

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 ○
Producer Name		Producer Code	
Company Name		Telephone	
Email			

4. PAYMENT METHODS

Bank Transfer - only for USD account

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

Bank Name :	Bank Danamon	Bank UOB Indonesia
Bank Account :	770-009-8309	3279-0393-17
Account Name :	PT. Asuransi Artarindo	PT. Asuransi Artarindo
Account Address :	Komp. Ruko Griya Utama Sunter Blok A No.43, Sunter, Jakarta 14350	Jalan MH. Thamrin No.10 Jakarta 10230
SWIFT Code:	BDINIDJA	BBIJIDJA
Bank Address:	Komp. Ruko Griya Utama Sunter Blok A No.43, Sunter, Jakarta 14350	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.

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 : _____

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 | Fax: (+62) 21 3971 1001

Arranged and administered by:

APRIL Singapore Pte Ltd
Co. Reg. No. 200613924G
31 Boon Tat Street #02-01
Singapore 069625
Tel: (+65) 6736 0057 | Fax: (+65) 6222 4473
Email: contact.sg@april.com

MH INDO 2020/08

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,

Policy Holder Name : _____

SUBMIT YOUR APPLICATION

SUBMIT ELECTRONICALLY

SUBMIT

Click **SUBMIT**
if you want your default email
program to send this document to us.

Alternatively,
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