PT Asuransi Artarindo berizin dan diawasi
oleh Otoritas Jasa Keuangan (OJK)

PAHAMI & MILIKI ASURANSI

Application Form

Full Medical Underwriting

MyHEALTH Individual Medical Plans

Download our Easy Claim mobile app
for quicker claims reimbursement!

april-international.com

ASURANSI ARTARINDO

april International
INSURANCE MADE EASY

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 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.

Are you or any intended member of this policy, or any family member or close associate a politically exposed person?
If Yes, please give details.

Yes ○ No ○

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

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.				
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, sexually transmitted disease	Yes ◯	No ◯
8.	Urinary system: Kidney stones or other disorder of the urinary system or prostate	Yes ◯	No ◯
9.	Liver, gallbladder and pancreas: Hepatitis, fatty liver, gallstone, or other disorder of the liver, gallbladder or pancreas	Yes ◯	No ◯
10.	Endocrine, nutritional and metabolic diseases: Diabetes, Hypothyroidism, Hashimoto's disease, or other disorder of the thyroid or endocrine glands	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 ◯

MEDICAL DETAILS AND HISTORY – 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?			

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	
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
This Individual and Family Application Form is valid for 28 days from date of receipt by PT. Asuransi Artarindo. We cannot backdate cover to a date earlier than the date you accept our final offer.

○ On Acceptance ○ Another Date : DD / MM / YYYY

INTERMEDIARY ACCESS
By choosing to give any access to your intermediary, you declare that you have obtained consent from all the members.

I/We would like our insurance intermediary to have access to my/our policy details and claims transactions through their online account at **https://members.april-international.com**.	Yes ○	No ○
I/We authorise APRIL to discuss and/or share claims and medical information with my/our 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. 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 of Indonesia:			
Sort Code		BIC (Swift) Code	
Corresponding Bank Details (if applicable)			

4. PAYMENT METHODS

PREMIUM PAYMENT FREQUENCY
Please select the frequency with which you wish to pay your premiums.

	CREDIT CARD	BANK TRANSFER
Annual Payment (No Surcharge)	◯	◯
Semi-Annually (4% Surcharge)	◯	◯
Quarterly (5% Surcharge)	◯	◯

Important Notice for Semi-Annual & Quarterly Payments: This policy is issued on an annual basis. By opting to pay in instalments, you acknowledge liability for the full annual premium. The payment frequency cannot be changed during the policy year, only at renewal provided you notify us in writing. The credit card you authorize below must remain valid for the entire duration of the policy and be active at the time instalment premiums are due, as it will be used to automatically collect these payments. If your credit card is lost or stolen, please notify us immediately to update your payment method and avoid disruption to your policy.

◯ **BANK TRANSFER | ANNUAL PAYMENT IN IDR & USD**

Name Penerima / Beneficiary (Account Name):	**PT. ASURANSI ARTARINDO**
Alamat / Address:	**Hermina Tower 12th Floor, JL. HBR Motik Blok 8-10 Kav. 4, Gunung Sahari Selatan, Kemayoran, Jakarta Pu sat 1610**

Bank Name	Currency	Bank Account	Address
BANK BUMI ARTA CBG KOPI JAKARTA	IDR	101-12-21274	Jl. Kopi No. 3,5,7; Jakarta 11230
BANK MANDIRI CBG JAKARTA KOTA	IDR	115-00-8900145-9	Jl. Lapangan Stasiun No. 2, Jakarta
BANK CENTRAL ASIA CBG MANGGA BESAR	IDR	161-302-229-9	Jl. Raya Mangga Besar 15, Jakarta 11180
BANK NEGARA INDONESIA CBG KRAMAT	IDR	149-0631-880	Jl. Kramat Raya No. 154-156
BANK NEGARA INDONESIA CBG KRAMAT	USD	149-1608-023 Swift Code: BNINIDJA	Jl. Kramat Raya No. 154-156
BANK UOB - KC UOB PLAZA	USD	3279-0393-17 Swift Code: BBIJIDJA	Jl. MH. Thamrin No. 10, Jakarta 10230
BANK DANAMON CBG GRIYA UTAMA SUNTER	USD	770-009-8309 Swift Code: BDINIDJA	Jl. Griya Utama Blok A Kav No. 43, Jakarta 14350

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 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.
4. *For IDR payments, we will use Bank Danamon's selling rate on the transaction date, which can be accessed here: https://www.danamon.co.id/en/Kurs-Details*

◯ **CREDIT CARD | ANNUAL PAYMENT IN USD**

If you choose to pay your premiums by credit card, you will receive a payment link by email sent to the address you provided on this form.

5. DECLARATION BY PROPOSER

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

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 / YYYY	in Jakarta	
Best Regards,			
Policy Holder Name		Stamp duty & Wet Signing (if applicable)	

5. DECLARATION BY PROPOSER - CONTINUED

PERSONAL DATA PROTECTION STATEMENT

I, as a policyholder acting on behalf of my employees or other individuals who will be insured ("members"), give consent to PT. Asuransi Artarindo/APRIL and its third parties whether individuals or entities including related entities, employees, agents, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data relating to myself or other individuals that I have furnished via any means in the past, present & in the future, for one or more purposes described in **PT. Asuransi Artarindo Privacy Notice** and **APRIL Singapore Pte Ltd Privacy Notice**, including but not limited to considering whether to provide insurance, carrying out due diligence, pricing, administering and servicing policies, communications, renewals, reinsurance, collections, claims, accounting, audit, legal, compliance, research, analysis, information-sharing, surveys, data storage & backups. If there is any personal data relating not to myself but to the members or other individuals that I have furnished via any means in the past, present & in the future, I warrant that I have obtained prior consent from these data subjects (or if they are lacking in legal capacity, from their legal representatives, guardians or parents as the case may be) for PT. Asuransi Artarindo/APRIL and its Appointees to collect, use and disclose their personal data for the abovementioned purposes and on the same terms herewith. I warrant that all personal data I have provided are accurate and complete, and I shall inform PT. Asuransi Artarindo/APRIL of any changes to the personal data to my knowledge as soon as practicable.

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).

☐ Please tick this box if you do not wish to receive any marketing communications from APRIL.

☐ Please tick this box if you do not wish to receive any marketing communications from Artarindo or companies with whom it maintains marketing arrangements.

DECLARATION BY APPLICANT

1. I, as a policyholder acting on behalf of the members, hereby confirm this declaration is correct and consent to disclose personal data to APRIL and PT. Asuransi Artarindo.
2. I acknowledge that I have made my own independent decision in applying for the product selected with the premium information and key product features informed by APRIL or my intermediary (or else had a chance to seek for advice from a qualified intermediary). I confirm that the relevant insurance product features are suitable for my needs as well as the member's needs, and the premiums are affordable.
3. I (and the members) have read, understand, and consent to **PT. Asuransi Artarindo Personal Information Collection Statement** and **APRIL Singapore Pte Ltd Privacy Notice**.
4. I (and the members) have read, understand, and agree to the **Brochure**, **Policy Terms and Conditions**, **Benefits Schedule**.

I declare that the statements contained in this application form are correctly recorded, and that they are full, complete and true. I further declare that I have not withheld any material fact and that except as declared herein. I will notify PT. Asuransi Artarindo/APRIL immediately if after signing this application and before a policy is issued I 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 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.

APPLICANT SIGNATURE

Name : _____

Title : _____

Date : _____

Important : The application form must be sent to us within **30 days** from this date for your application to be valid.

MH INDO 2025/04

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
Tel: (+62) 31 9920 6851
Email: contact.indo@april.com

ASURANSI ARTARINDO

PT Asuransi Artarindo berizin dan diawasi oleh Otoritas Jasa Keuangan (OJK)

PAHAMI & MILIKI ASURANSI

april International

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