MSH INTERNATIONAL
SIACI SAINT HONORE GROUP

MSH INTERNATIONAL
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Asia care

Application Form
(Individuals & Families)

2015

Checklist:

- ☐ Application form & medical questionnaire *signed and completed in detail.*
- ☐ Photocopy of your passport
- ☐ Proof of education *if you have children aged between 18 and 24 years old*
- ☐ 2 inch photo, no longer than 6 months old *(optional)*
- ☐ Document related to medical history *if any*
- ☐ Bank details for the reimbursement of your claims
- ☐ A copy of your previous insurance certificate *in order to waive waiting periods for benefits that had equal or higher levels of coverage*

Please fill this form in BLOCK CAPITALS or apply online at sea.msh-intl.com

What would you like to do?

Not yet a member of MSH INTERNATIONAL

☐ Apply for Asiacare

Already a member of MSH INTERNATIONAL

☐ Update my details Policy No: _____

☐ Add an additional dependent to my current policy.
Please fill in section C, D, E

☐ Change my personal details.
Please proceed to section B

A Your Plan

Quotation Reference Number: _____

** If the quotation has passed the validation date, please redo another quotation or contact our sales representative.*

Plan Start Date: d d / m m / y y y y

Currency for Plan: ☐ USD($) ☐ EUR(€)

Formula

Deductibles	*Vital*	*Harmony*	*Optimum*
NIL	☐	☐	☐
100 $/€	N/A	☐	☐
500 $/€	N/A	☐	☐
1,000 $/€	N/A	☐	☐
Medical Evacuation	☐ YES *(optional)*		

Geographical Areas of Coverage

Zone 1
Bangladesh, Bhutan, Brunei, Burma / Myanmar, Cambodia, East Timor, India, Indonesia, Laos, Malaysia, Maldives, Nepal, Pakistan, Philippines, Sri Lanka, Thailand, Vietnam

+ Belgium, France, Germany, Luxembourg, Netherlands only for stays of less than 90 days.

Worldwide coverage for services and supplies required as a result of an accident or medical emergency for 60 days per trip outside of the Area of Coverage

B Planholder Details

First Name:

Surname:

Country(ies) of Residence:

Where will you be living for the period of your cover:
(please specify countries & date, if possible)

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Other _____

Number of Children:

Number of Grandchildren:

Date of Birth: d d / m m / y y y y

Nationality:

Occupation / Industry:

Job Title:

Language:

Mobile Number:
(include country code)

Email Address:

Home Address:

Town:

City:

Postal Code:

Country:

Billing Address: ☐ Same as Home Address

Town:

City:

Postal Code:

Country:

C Eligible family members to be covered with you

	Family Member 1	*Family Member 2*	*Family Member 3*	*Family Member 4*
First name:				
Surname:				
Gender:	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Marital Status:				
Date of birth:	d d / m m / y y y y	d d / m m / y y y y	d d / m m / y y y y	d d / m m / y y y y
Nationality:				
Relationship to Planholder:				
Occupation / Industry:				
Currently in full time Education?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of Institution:				
Date of Graduation:	d d / m m / y y y y	d d / m m / y y y y	d d / m m / y y y y	d d / m m / y y y y

D Medical History

	Planholder	Family Member 1	Family Member 2	Family Member 3	Family Member 4
Height (cm/ft)					
Weight (kg/lbs)					
Blood pressure (Optional)					

*Please reply to the questions below with either **yes** or **no**. If the response given is **yes**, please provide full details in the relevant sections below, clearly stating the person to which the information relates. Any extra information regarding the state of your health may be added on additional sheets of paper and attached to this form.*

1 Does your present state of health prevent you from performing your full time profession?

	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Therapeutic Part Time Leave					
Total leave of absence					
Reason(s)					

2 Have you undergone or been advised to undergo surgery, other than for the extraction of the appendix, tonsils or andenoids?

	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Details of surgery					
Date(s)					

3 During the past five years, have you been prescribed sick leave or a medical treatment exceeding three weeks?

	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Please give reason					
Nature of treatment					
Which circumstances apply					

4 Have you received care or undergone tests during the past five years which have led to a stay in a medical establishment (hospital, clinic, convalescent home, physiotherapy, dietary needs or treatment center, sanatorium...)?

	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Date(s) *(Please attach photocopies of post-operative and cell reports)*					

5 During the past ten years, have you experienced any of the following: neurological or psychological illness (including depression), rheumatism, (affecting the vertebrae), cancer, leukaemia or other blood related illness?

	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Please indicate which illness and state clearly all relevant details (date, duration, treatment, recovery date, after-effects, comments)					

D Medical History

	Planholder	Family Member 1	Family Member 2	Family Member 3	Family Member 4
6 Have you had a screening for AIDS, hepatitis virus or for one of the human immuno-deficiency viruses?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Date					
Nature of the test					
Result					
7 Have you had any after-effects resulting from an accident or illness?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Description					
Date of event					
Nature of effect					
Recovery date					
After-effects					
8 Do you suffer from a disability or are you entitled to a disablement pension (civilian or military) or old age pension?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Nature of disability					
Nature of pension or annuity					
Rate *(Please attach notification)*					
9 Have you ever been accepted on special conditions or refused life insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Reason for and date of rejection					
10 Are you currently suffering from any symptoms: (pain, lumps, bleeding etc) for which you have not yet consulted a doctor?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, please describe					
11 Are you currently undergoing any investigations or taking any medications or receiving any form of treatment recommended or prescribed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
List with dosage					

I hereby declare that the above statements are full, complete and true, and that I have not declared or omitted to declare any particular that may mislead the Insurer. I am aware that any false declaration or omission may result in denial of coverage from the Insurer. Under these circumstances, medical expenses involved - if any - shall be my own responsibility, regardless of the amount.
I also certify having been informed of the cover granted by the Insurance Company policy.

In: _____

Signature of the Applicant preceded by "read and approved"

Date: d d / m m / y y y y

E Doctor's / Medical Practitioner's Details

Please give details of your current doctor or the one who is most familiar with your family's medical history.

Name:	Name:
Hospital/Clinic/Practice:	Hospital/Clinic/Practice:
Telephone:	Telephone:
Fax:	Fax:
Email:	Email:
Address: Postcode:	Address: Postcode:

F Method and frequency of premium payment

Please note, the total cost of your plan is based on an indicative quote and may be changed after we have reviewed your application. Surcharges apply if you wish to pay semi-annually (2% surcharge), quarterly (4% surcharge).

	Annually	*Semi-annually*	*Quarterly*
Credit card	☐	☐	☐
Bank Transfer	☐	☐	☐

***Credit card**: We accept Visa, MasterCard and American Express. Please complete the Credit Card Authorization section at the end of this application form*

G Bank Details for Claim Reimbursement

Account holder's name:	
Bank name:	Country:
Bank address:	
IBAN or account no:	Routing code (e.g. Swift or sort code):

H How would you like to receive your document?

☐ Printed copy ☐ Online ☐ Printed copy and online

I Your current insurance policy

Please tell us about your current insurance policy if you would like have a continuous transfer of your benefits. Waiting periods apply for certain medical conditions – meaning that you will have no coverage for these conditions until the end of the waiting periods. However, waiting periods may be waived if you hold an insurance policy with a similar cover to Asia Care, with no break of cover. Benefits in your current insurance policy must be equal or higher than those of Asia Care in order for waiting periods to be waived.

☐ *I am currently insured by an insurance policy*

Name of current insurer:	Policy No:
Name of the current plan:	End Date:

** Please attach a copy of your Insurance Certificate and Table of Benefits*

J Credit Card Authorization

☐ *Visa* ☐ *MasterCard* ☐ *American Express*

Card number as it appears on **Your** card:

Cardholder's name:

Expiry date: | Start date: | CCV code:

Bank address:

Once Your payment details have been processed, Your credit card details will be destroyed by Us. Please charge the above card.

☐ Annually ☐ Semi-annually ☐ Quarterly

I hereby authorize MSH INTERNATIONAL to debit my credit card for the amount of my insurance premium and all subsequent renewal premiums until I write to MSH INTERNATIONAL through registered post to terminate this agreement. I understand that the premiums are reviewed annually and will change each year. I understand that MSH INTERNATIONAL will not be liable should my credit card be declined and I do not make payment through alternative methods.

Signature (Insured/main applicant):

Date: d d / m m / y y y y

Name:

K Declaration and Authorization

I hereby apply for coverage on behalf of all the family members named in this application form.

- I declare that I have read and accepted the Member's Handbook which contains the Table of Benefits, Terms and Conditions, Definitions, Waiting Periods and Exclusions of this Plan. I am fully aware that all Terms and Conditions of this Plan, which are included in the Member's Handbook, are parts of the agreement of the Plan and establish the contract between myself and MSH INTERNATIONAL. I therefore understand that coverage shall be provided according to this agreement.
- I declare that the information presented in this application, including the information concerning any persons named in this application, is accurate and complete, although certain disclosures may not be provided in my own handwriting. I understand that it is against the law for me and my eligible family members to intentionally provide inaccurate, incomplete or misleading information in order to defraud MSH INTERNATIONAL, and that any fraudulent disclosures will result in various forms of penalties
- I understand that, should there be any changes regarding the information in this application form, such as a family member's state of health, I must inform MSH INTERNATIONAL.
- I authorize any doctor who has ever provided treatment or given advice to any persons named in this application to disclose information regarding the treatment that are related to any claim under this Plan. I have obtained the consent of all persons to be enrolled to disclose their healthcare information in accordance with this authorization.
- I declare that I have read and understood the Cancellation and Termination rights, Complaints procedures and Legal notices.
- MSH INTERNATIONAL is acting on behalf of Hauteville Insurance Company Limited for the purposes of issuing and administering Plans, receiving premiums and paying claims.
- If I have agreed to make payment via credit card, I authorize MSH INTERNATIONAL to debit my account with the appropriate premiums prior to or on their due dates. I also authorize subsequent renewal premiums to be invoiced by MSH INTERNATIONAL until I provide a written notice for the termination of this Agreement.
- I understand that if I do not pay for my premium in due time and do not provide an alternative method of payment upon request, MSH INTERNATIONAL cannot be liable for coverage and therefore will not pay for any claims.
- I agree that I am liable to all claims MSH INTERNATIONAL has paid for my plan which have resulted from any medical treatment deemed as non-covered claims.
- I understand that if I do not repay for funds expended in good faith by MSH INTERNATIONAL for any medical treatment that is not covered under the plan, subsequent valid claims may be compromised to compensate for the outstanding funds and/or my plan may be suspended until the outstanding amounts have been paid in full.
- I acknowledge that, if MSH INTERNATIONAL discovers any of my claims to be fraudulent, my plan may be immediately terminated.
- I understand that the medical information of any persons named in this application form will be exchanged between MSH INTERNATIONAL, the insurer and the medical professionals within its network.
- I authorize MSH INTERNATIONAL to send documents concerning this Plan to the home and/or billing address and email address I have provided or, upon my notification, to my intermediary's address.
- I authorize MSH INTERNATIONAL to send documents by PDF file format to my email or to the relevant intermediary.
- I understand that my phone conversations with representatives of MSH INTERNATIONAL may be recorded for the purposes of training and quality management.
- I acknowledge that I may cancel my membership and that of any additional Family Member within 30 days of receiving my first membership certificate by letting MSH INTERNATIONAL know through registered mail.
- I understand that even if I have paid for my membership, I will be reimbursed the full amount of my premium if I cancel within 7 days of my payment, given that I have submitted no claims. Passed the 7 days deadline, MSH INTERNATIONAL reserves the right to withhold the amount relating to the period of actual coverage.
- I agree to the declaration above and understand that coverage is provided in accordance with the Terms and Conditions of the Plan.

Signature (Insured/main applicant):

Date: d d / m m / y y y y

Name:

For intermediary only

Contact Person: Olaf Malecha	**Company Name:** Pro Vorsorge Broker Olaf Malecha
Phone Number: +493916218959	**Code ID:** A 1044

Identification stamp: