Application Form

Important Information:

This product is insured by PT Asuransi Dayin Mitra Tbk. The terms and conditions of this policy shall be governed by and construed in accordance with the laws of Indonesia.

Please complete all answers in BLOCK letters. Please use a separate sheet of paper to provide full details if necessary.

Checklist:

❒ Have you completed all sections in full and accurately?
❒ Have you read, signed, and dated the declaration in section 11?
❒ Have you included a copy of the passport or national identification card for all applicants indicated in this application form?

1. Commencement of Cover

The date you would like your policy to start (dd/mm/yyyy):

Important note: For a new application for an Individual policy, cover cannot start until we have accepted the application in writing and received payment of your first annual, half yearly or quarterly premium.

2. Applicant's Details

Please provide the policyholder's information below. The policyholder must be between the ages of 18 and 69 at the time of application. If a child is being enrolled on their own and is between the ages of 6 and 17, they must be enrolled with a parent or guardian as the policyholder until they reach the age of 18. In this case, the policyholder (the parent or guardian) will not be eligible for benefits. Please provide the child's information in Section 3.
Garnet Plan applicants must be between 19 and 29 years of age at the time of application.

For child-only cover (not available for Garnet Plan), please tick here: ❒

❒ Mr. ❒ Mrs. ❒ Ms. ❒ Miss. ❒ Dr. ❒ Other:

Given Name: Surname:

Date of Birth (dd/mm/yyyy): Gender: ❒ Male ❒ Female

Nationality: ID/Passport Number:

Occupation: Marital Status:

Residential Address:

City: Postal Code: Country:

Mailing Address (if different from Residential Address):

City: Postal Code: Country:

Telephone Number (+ country code): Mobile Number (+ country code):

Email Address:

This product is insured by PT Asuransi Dayin Mitra Tbk and developed by PT Astro Pertama Indonesia

PT Asuransi Dayin Mitra Tbk
Wisma Hayam Wuruk
Jl. Hayam Wuruk No. 8
Jakarta Pusat, 10120
Indonesia

PT Astro Pertama Indonesia
B1 Nakula Plaza
Jalan Nakula Legian
Denpasar Barat 80361
Indonesia

3. Dependants to be covered under the same policy

Dependants may include your spouse/partner, any unmarried children who are under 18 years of age, or unmarried children under the age of 26 if they are enrolled as full-time students at a recognized education institute and who are dependent upon you for financial support. For child dependants between 18 and 25 years of age, please attach a letter from the college/university or a copy of the student's ID confirming their full-time student status. Your spouse/partner may be up to 69 years of age at the date of policy commencement. If there is insufficient space for all dependants, please use another Application Form. Garnet Plan dependants must be between 19 and 29 years of age at the time of application.

	Dependant 1	Dependant 2	Dependant 3	Dependant 4
Relationship to Applicant	☐ Spouse ☐ Child	☐ Child	☐ Child	☐ Child
Given Name				
Surname				
Date of Birth (dd/mm/yyyy)				
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Nationality				
ID/Passport Number				
Marital Status				
Occupation				
Country of Residence				

4. Choose Your Cover

This section need not be completed if you are applying as part of a Group scheme.

Main Plan Overall Annual Plan Limit	☐ Garnet USD 200,000	☐ Sapphire USD 1,750,000	☐ Emerald USD 2,500,000	☐ Diamond USD 3,000,000
Area of Cover	Southeast Asia, Australia and New Zealand	☐ Worldwide excluding USA ☐ Asia Pacific		
Network Access	Network B only	☐ Go Anywhere ☐ Network A ☐ Network B		
Deductible* (Applicable to all eligible entitlements per Policy Year)	☐ Nil ☐ USD 1,500 ☐ USD 3,500	☐ Nil ☐ USD 850 ☐ USD 1,500 ☐ USD 3,500 ☐ USD 8,500 ☐ USD 15,000		
Hospital Room Type	Semi-Private Room, up to USD 240 per day	☐ Standard Single Room, up to USD 460 per day ☐ Semi-Private Room, up to USD 240 per day		
Coinsurance** (Applicable to all Outpatient & Wellness Claims)	Not Available	☐ Nil ☐ 10% coinsurance ☐ 20% coinsurance		

*Deductible: is the amount of benefits usually payable, that you agree to forego each year, in return for a reduced premium.
**Coinsurance: is a percentage of benefits usually payable, that you are agree to forego in respect of each Outpatient and Wellness Claim. Coinsurance options are not offered with the Sapphire Plan.

Areas of Cover: Please ensure your Country of Residence is included in your selected Area of Cover

Asia Pacific: Australia, Bangladesh, Bhutan, Brunei, Cambodia, China, East Timor, Hong Kong, India, Indonesia, Japan, Laos, Macau, Malaysia, Maldives, Mongolia, Myanmar, Nepal, New Zealand, Pakistan, Papua New Guinea, Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Thailand, The Pacific Islands, and Vietnam, but not including any U.S. territories.

Southeast Asia: Brunei, Cambodia, East Timor, Indonesia, Laos, Malaysia, Myanmar, Papua New Guinea, Philippines, Thailand, and Vietnam.

5. Insurance Details

Are you, or your dependants, currently insured with another health insurance company? ☐ Yes ☐ No
If 'Yes', please provide the name of insurer/product:

Have you, or your dependants, ever been rejected, or had a policy cancelled, by another health insurer? ☐ Yes ☐ No
If 'Yes', please provide the reason for rejection/cancellation:

Have you, or your dependants, ever been accepted on special terms or conditions by another health insurer? ☐ Yes ☐ No
If 'Yes', please provide the terms or conditions applied:

6. Medical Declaration

Please answer all the following questions on you, and your dependants' complete medical history. We rely on this information to determine whether or not to accept your application. Failure to fully declare medical conditions, or symptoms, may invalidate the policy without refund of paid premium, and we may seek return of any reimbursement that may have been paid to you. If you are in any doubt as to whether a fact is material, it should be declared to avoid possible delays or issues.

If, between completing the Medical History Declaration and the start date of the policy, any changes occur in the facts you declared in this Medical History Declaration, such as a change in your state of health or the state of health of any of your dependants, you must tell us in writing about the change immediately. We reserve the right to decline, or accept your application with special terms and conditions.

	Applicant	Dependant 1	Dependant 2	Dependant 3	Dependant 4
Height (cm/ft)					
Weight (kg/lbs)					
Are you a smoker?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

1. Has any person named in this application ever experienced symptoms of, been diagnosed with, been in hospital, suffered, received treatment, tests or investigations for:

(a)	Any heart or circulatory condition or disorder, arrhythmia (abnormal heartbeat or valve function), aneurysms, stroke, murmur, chest pain, hemorrhage, abnormal or high blood pressure or high cholesterol?	☐ Yes ☐ No
(b)	Any blood or immune condition or disorder, abnormal blood tests, blood clotting problems, hemophilia, thalassemia, anemia, Lupus (SLE), tested positive for HIV/AIDS, Hepatitis B or C, or any auto-immune disorder?	☐ Yes ☐ No
(c)	Asthma, bronchitis or any other respiratory condition or disorder such as but not limited to rhinitis, sinusitis, sleep apnea, chronic obstructive pulmonary disease (COPD), shortness of breath, chest infections, pneumonia, tuberculosis (TB), or allergies?	☐ Yes ☐ No
(d)	Rheumatism, gout, arthritis, paralysis, muscular or skeletal/bone disorder or injury, or any form of neck, back, spine or joint disorder or injury?	☐ Yes ☐ No
(e)	Any other neurological, brain or nervous system condition or disorder such as but not limited to epilepsy, migraine, multiple sclerosis, dementia, meningitis, or nerve pain?	☐ Yes ☐ No
(f)	Anxiety, depression, compulsive or eating disorder, myalgic encephalomyelitis (ME), psychological, psychiatric or any other mental condition or disorder?	☐ Yes ☐ No
(g)	Any digestive condition or disorder, such as esophageal, stomach, ulcer, gastritis, or bowel/colon problems?	☐ Yes ☐ No
(h)	Any condition or disorder of the kidneys, liver, gall bladder, spleen, pancreas, bladder, prostate, renal, or recurrent urinary conditions?	☐ Yes ☐ No
(i)	Any reproductive system, gynecological, genital, or breast condition or disorder?	☐ Yes ☐ No
(j)	Any cancer, tumors, lumps, cysts or abnormal growth whether cancerous or benign?	☐ Yes ☐ No
(k)	Any eye, ear, nose, throat or skin disorder such as acne, eczema, or dermatitis?	☐ Yes ☐ No

(l)	Diabetes, thyroid, weight management problem, or any other glandular/endocrine disorder?	☐ Yes ☐ No
(m)	Drug and/or alcohol addiction or abuse?	☐ Yes ☐ No
(n)	Any other medical condition, hereditary or congenital disorder, symptom, sudden weight loss, fatigue, illness or injury relating to your health that has not been mentioned above?	☐ Yes ☐ No

2. Is/has any person named in this application:

(a)	Currently taking any medication (including over the counter medication such as paracetamol, antacid and antihistamine) on a regular basis, prescribed or otherwise?	☐ Yes ☐ No
(b)	Currently pregnant, undergoing any treatment or testing for any fertility or assisted conception, or had any childbirth other than full-term, natural delivery?	☐ Yes ☐ No
(c)	Undergone cancer screening or medical check-up with anything other than a normal result within the last 7 years?	☐ Yes ☐ No
(d)	Been told by a healthcare professional they will likely need treatment or surgery in the future?	☐ Yes ☐ No

3. Supplementary Information

If you answered 'Yes' to any question under Part 1 or 2 in the Medical Declaration section, please provide full details in the table below and continue on a separate sheet of paper if necessary. If possible, please enclose supporting medical reports or doctor's letter if available.

Question number	Name of Person affected by the condition	Please provide as accurately as possible the: • Nature of Diagnosis • Date(s) & duration on which the illness or injury began/ended? • Frequency and severity of condition or symptoms • Past, current, or known future treatment, details of medications, tests performed and results • Outcome of treatment (ongoing, completely recovered, recurrent, or likely to recur) • Name & Address of Doctor, Clinic, or Hospital

4. Your regular/family doctor's contact details

Please provide details of the Medical Practitioner who is most familiar, with the medical history of each person named in this application. If there is more than one doctor, please provide details on a separate sheet of paper.

Doctor's Name:

Address:

City: Postal Code: Country:

Telephone Number (+ country code):

Email Address:

Length of time you have been known to this doctor:

Date and reason for last visit:

Upon review of the information needed to consider your application, we will:

- agree to accept all of these declared medical conditions and/or may charge an increased premium;
- agree to accept some of these declared medical conditions and/or may charge an increased premium (the declared conditions we do not accept will be excluded and specified on your Insurance Certificate);
- exclude all declared medical conditions (these will be specified on your Insurance Certificate); or
- decline the application entirely.

All other terms and conditions of the Membership Guide still apply.

7. Payment Options

This section need not be completed if you are applying as part of a Group scheme.

Please tick your preferred payment frequency and method:

	Annually	Semi-annually (2% loading)	Quarterly (4% loading)
Credit Card	☐	☐	☐
Bank Transfer	☐	☐	N/A

Payment Details

Credit Card: Please complete Section 8 of this application form.

Bank Transfer: Please ensure the Policy Number is indicated in the transfer details when making payment to the corresponding account indicated below. Please also ensure that the remitted sum, to be received by our bank account, will amount to the invoiced premium.

USD account

Account Name	SAFE MERIDIAN PTE. LTD. - IGH		
Account Number	2000521723	BIC/Swift Code	CIBBSGSG
Bank Name	CIMB Bank Berhad	Bank Code	7986
Branch Name	Raffles Place Branch	Branch Code	001
Branch Address	50 Raffles Place #09-01, Singapore Land Tower, Singapore 048623		

8. Credit Card Payment & Authorization

This section has to be completed if you have indicated Credit Card as your preferred payment method under Section 7, or if you have chosen a Deductible, or a Coinsurance.

I, the undersigned, hereby authorize PT Asuransi Dayin Mitra Tbk or its Administrators to charge to my credit card account in respect of my health insurance premium (upon the acceptance of cover, renewal of cover, or a request made by me which impacts my premium, such as adding a dependant), and/or for any uncovered medical expenses incurred including, but not limited to, deductibles or coinsurances within the Direct Billing Network. This will continue until the instruction is cancelled by me giving written notice to PT Asuransi Dayin Mitra Tbk and its administrators. I understand I will be given one month's notice of any annual premium rate increase.

Declaration:

1. Where a third-party's Credit Card is used, I declare that the Cardholder has authorized and consented to such use, and that I am authorized to agree to the payment method, frequency, and terms on the Cardholder's behalf. I agree a scan or photocopy of this authorization shall be effective and valid as the original.
2. If the Cardholder is not the Policyholder, I recognize that he/she will have no right under the applicable local regulation, to enforce any of the terms and conditions of the International Global Health Policy I am applying for.
3. Upon approval of this application, I accept the premium amount will be charged to the Cardholder's Credit Card, and his/her Credit Card statement will show the amount deducted.
4. Should payment not be successfully effected pursuant to this authorization for any reason, I acknowledge that PT Asuransi Dayin Mitra Tbk and its Administrators shall under no circumstances be held responsible or liable in any manner whatsoever, including for any subsequent expiry of this policy due to late or non-payment of premiums.
5. I acknowledge that any refundable premium on my policy will be credited to the Cardholder's Credit Card account, and I will not contest the refund of the premium.

Card Type: ☐ MasterCard ☐ Visa

Cardholder's Name (as appears on card):

Card Number: Card Expiry Date (mm/yyyy):

Relationship to Policyholder (e.g. self, spouse, parent):

Cardholder's signature	Date (dd/mm/yyyy)

9. Bank Details for Claim Reimbursement

Please provide the bank account details to which you would like to receive claim reimbursement payments. You may specify a different bank account for payment of any given claim, by completing the Bank Account Details section of the relevant Claim Form.

Account Name:

Account Number: Currency of account:

IBAN Number: BIC/Swift Code:

Bank Name: Bank Code:

Branch Name: Branch Code:

Branch Address:

*IBAN is required if your bank is within the EU, or if your country requires an IBAN (e.g. Qatar, Saudi Arabia, Turkey).

10. Data Protection Notice

To process, administer, and/or manage your relationship, account and policy with us, we will need to collect, use, process, and/or disclose your personal data or personal information about you. Such personal data includes (i) information set out in this form and any other personal information provided by you or possessed by us; and (ii) your claims.

Such personal data will be collected, used, processed, and/or disclosed by us for the purpose(s) of:

a) considering whether to provide you with the insurance for which you applied;
b) processing your application for underwriting and insurance;
c) administering and/or managing your relationship, account and/or policy with us;
d) processing and/or dealing with any claims, including the settlement of claims and any necessary investigations relating to the claims, under your policy;
e) carrying out due diligence or other screening activities (including background checks) in accordance with legal or regulatory obligations or risk management procedures that are required by law or that have been put in place by us;
f) carrying out your instructions or responding to any enquiries by you;
g) dealing in any matters relating to the products and services which you are entitled to under this policy for which you are applying or have applied (including the mailing of correspondence, statements, invoices, reports or notices to you, which could involve disclosure of certain personal data about you to bring about delivery of the same, as well as on the external cover of envelopes/mail packages);
h) investigating fraud, misconduct, any unlawful action or omission, whether relating to your application, your claims or any other matter relating to your policy, and whether or not there is any suspicion of the aforementioned;
i) complying with applicable law in administering and managing your relationship with us; and/or
j) sending you marketing, advertising, promotional information about our products and services that we may be selling or marketing (unless you have specifically opted out or have written to us to stop sending you such information), through such modes of communication as: post/mail, telephone calls, text messages (SMS or WhatsApp), e-mails, and facsimiles.

(collectively the "Purposes")

We may collect personal data from sources other than yourself, personal data about you, for one or more of the above Purposes, and thereafter using, processing, and/or disclosing such personal data for one or more of the above Purposes.

Your personal data may be disclosed by us to the participating Insurers, Administrators, Assistance Company, third-party service providers or vendors, and our professional advisors, wherever they are sited, for one or more of the above Purposes, as such parties, if engaged by us, would be processing your personal data for us for one or more of the above Purposes.

We may share, if necessary, your medical information with your treating doctor or hospital to ensure appropriate care is provided to you and to ensure any claims from you can be properly assessed for benefits. We may also share your information with your Intermediary, if you have requested and authorized us to do so.

If you have declared any personal data relating to other individuals, you agree to inform the individual(s) about the content of our Data Privacy Policy, and obtain prior consent to act on their behalf to allow for the collection, use, disclosure, and transfer of their personal data in accordance with our Data Privacy Policy.

You have the right to request a copy of any information we hold on you, and to seek correction of any incorrect information held. Where reasonably possible, we will correct the information held in our files or on our systems within a reasonable time from such a request being made.

By signing this form, you confirm you have read, understood, and agreed to the above provisions, and consent to PT Asuransi Dayin Mitra Tbk and its Administrators:

- collecting, using, processing and/or disclosing your personal data for one or more of the Purposes as described above;
- collecting personal data about you from sources other than yourself and using, processing and/or disclosing the same, for one or more of the Purposes as described above; and
- disclosing and/or transferring your personal data to the participating Insurers, Administrators, Assistance Company, third-party service providers or vendors, and our professional advisors, wherever they are sited, for one or more of the Purposes as described above.

11. Declaration & Authorization

Please read the following declarations carefully and only sign below if you understand and accept them.

1. I understand that I am applying for an International Global Health policy, underwritten by PT Asuransi Dayin Mitra Tbk (the Insurer), on behalf of all the person(s) named in this application, and that this application is subject to the Insurer's written acceptance.
2. I acknowledge that I have received, read and understood the brochure and Membership Guide which explains the terms and conditions, Table of Benefits, definitions and exclusions of the policy. I understand that this Application Form, Membership Guide, and Insurance Certificate are contractual documents of the Individual policy which I am applying, and the terms stipulated will be binding on me and the person(s) named in this application. I accept that cover shall be provided in accordance with these documents.
3. I declare that I have the authority to act on behalf of the person(s) named in this application and have obtained their authorization to release the sensitive personal information provided herein, and that all information supplied herein is true and complete, including answers that are not in my own handwriting.
4. I understand that if the information provided in this application is false, incomplete or misleading, or that a submitted claim is false, fraudulent or intentionally exaggerated, it may result in the claims being rejected or not fully paid, and I will become responsible for any costs which were incurred in respect of the said claims, and/or render this policy being terminated without refund of the premiums already paid.
5. For the purpose of this application, I hereby consent and authorize any doctor who has ever treated or advised any of the person(s) named in this application to provide the Insurer or its Administrators with any and all information they may require in connection with the underwriting of the application and/or in respect of any claims or use of direct billing services under this policy. I understand that should further medical information be required in connection with the underwriting of the application and/or in respect of any claims under this policy for the person(s) named in this application, the Insurer reserves the right to request for a copy of the latest medical report from me at my own expense.
6. I understand that, as the legal policyholder of this policy, all correspondences, including claims correspondences for any person(s) named in this application will be sent to me. If any person aged 18 or over does not wish for processes to be done this way, it is agreed that they must take out a policy in their own right.
7. I agree that where medical treatment is received within the Direct Billing Provider Network by any of the person(s) named in this application for an excluded condition, or for a pre-existing condition, except where previously agreed by the Insurer or its Administrators, where it is determined that the medical treatment or condition is not eligible for cover due to waiting period not being fulfilled, I am liable to repay all claims reimbursed for such medical claims. Consequently, I understand and confirm that should I have not repaid the Insurer in respect of the non-eligible medical claims within the deadline provided, my policy may be suspended until such amount has been repay in full and/or the Administrators is allowed to offset the amount from future eligible claims submitted.

8. If I have indicated that I wish to pay by credit card, I authorize the Insurer or its Administrators to debit my account based on the premiums invoiced on or before their due dates, and all subsequent renewal premiums due as invoiced by the Insurer or its administrators until I provide advance written notice that I wish to terminate this policy.
9. I understand that the Insurer, Administrators and Assistance Company are not liable and will not pay any claims or provide any service if my policy is lapsed should the Insurer be unable to collect the full premiums for whatever reason or that I do not pay in full within the stipulated deadline from the Insurer's notification to make payment via other payment methods.
10. I understand that if I am able to claim any cost for eligible medical treatment covered by another insurer or government program, the Insurer will only be liable to pay for a proportional share of the total costs.
11. I undertake to inform the Insurer immediately in writing of any changes in the facts declared in this application, such as a change in the state of health of any person(s) named in it, that occurs before the start date of the policy.
12. I understand that this application form is valid for two (2) months from the date of completion and signing.
13. I understand that my policy will be automatically cancelled for any person(s) named in this application that becomes a resident of a country that is not covered by this policy (e.g. USA).
14. I acknowledge that it is my responsibility to check whether any person(s) named in this application is/are subject to any local compulsory health insurance requirements and to ensure that my healthcare cover is legally appropriate in my country of residence. I acknowledge that I am satisfied that the International Global Health policy I applied is legally appropriate.
15. I agree to the above declaration and authorization required to process this application, and understand that future cover will be provided in accordance with the terms and conditions of the International Global Health policy upon acceptance.

Applicant's printed name:	Applicant's Signature:	Date (dd/mm/yyyy):

Please return your completed form to:

PT Astro Pertama Indonesia
B1 Nakula Plaza
Jalan Nakula Legian
Denpasar Barat 80361
Indonesia

T: +62 361 737316 / +62 361 737317
F: +62 361 737314

E: admin@internationalglobalhealth.com
www.internationalglobalhealth.com

This product is insured by PT Asuransi Dayin Mitra Tbk and developed by PT Astro Pertama Indonesia

PT Asuransi Dayin Mitra Tbk
Wisma Hayam Wuruk
Jl. Hayam Wuruk No. 8
Jakarta Pusat, 10120
Indonesia

PT Astro Pertama Indonesia
B1 Nakula Plaza
Jalan Nakula Legian
Denpasar Barat 80361
Indonesia