Application Form for policies with full medical underwriting

Before you start

Please read this before completing your application.

How to fill in this form

- If completing a printed form, please use BLOCK CAPITALS.
- Please complete all sections of this form. **All fields marked with an asterisk (*) must be completed.** Missing information may delay your application.

What happens next

- Once you submit your application, our Medical Underwriting Team will review it.
- If you've told us about any medical conditions, we may contact you for more information.
- We'll assess your application and get back to you as quickly as possible with our decision.

If you already have a policy with us

If you already have one of our healthcare plans and you are applying for a cover upgrade or for a new plan, please tell us about any medical conditions you have claimed for since joining us.

Important signatures and consent

You'll find the Approvals section on page 13.

- The applicant and all dependants aged 18 or over must sign.
- We need your consent to process your application (see Sections 10 and 11).
- We cannot process your application without these signatures, in line with the Data Protection Regulations.
- For applicants under 18, a parent or guardian must sign on their behalf.
- If you want to appoint a broker as your main point of contact, all adults must give consent (see Section 9).

Joining an existing company policy

Please complete this section if you are joining through your employer:

Group name

Group number

If you are already on a company policy and would like to add a dependant, please provide your policy number:

Policy number

ACA ASURANSI

Just for clarity...

You will see that we often refer to the following phrases in this form. This is what we mean:

Home country: A country for which you (or your dependants, if applicable) hold a current passport or which is your principal country of residence.

Principal country of residence: The country where you and your dependants (if applicable) live for more than six months of the Insurance year.

1. Applicant's details (The applicant will be the policyholder)

Your contact details will also be used to communicate with you on important things regarding your policy. Please let us know if your details change so we can keep your information up to date and make sure you receive all communication.

We will consider applicants for cover up to the day before their 76th birthday.

Applicant's details

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other ☐

First name *

Surname *

Date of birth * (DD/MM/YYYY) / / Gender at birth * Male ☐ Female ☐

Home country * Nationality *

Principal country of residence *

Address in principal country of residence *

City/town *

Country *

Primary phone number * Country code Area code

Secondary phone number Country code Area code

Email address * (please print)

Occupation * (if you are a student, please state it)

Details of any current domestic or international health insurance:

Name of insurer

Policy number Start date (DD/MM/YYYY) / /

2. Your dependants' details

You can add dependants to your policy by completing all the fields for each person below. Dependants are your spouse/partner and any children financially dependent on you. Children can be covered:

- up to the day before their 18th birthday, or
- up to the day before their 26th birthday if they are in full-time education.

If a dependant is aged 18 to 25 and in full-time education, please provide proof of student status (such as a letter from their college or university or a copy of their student ID). **We will consider adult dependants for cover up to the day before their 76th birthday**.

If there is insufficient space for all dependants, please use another Application Form and ensure that all relevant Declaration(s) and Consent(s) are signed and dated.

	Dependant 1	**Dependant 2**	**Dependant 3**
Relationship to applicant	Spouse/Partner ☐ Child ☐	Spouse/Partner ☐ Child ☐	Spouse/Partner ☐ Child ☐
First name			
Surname			
Date of birth (DD/MM/YYYY)	/ /	/ /	/ /
Gender at birth	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Occupation (mandatory, please state if student)			
Email address (mandatory for dependants over 18)			
Home country			
Principal country of residence			
Nationality			
Details of any current domestic or international health insurance			
Name of current insurer (if applicable)			
Current policy number (if applicable)			

3. Start date of your cover

Please tell us the date you would like your cover to start * **(DD/MM/YYYY)**

/ /

If your application is accepted, we will confirm it by sending you an Insurance Certificate. Your cover will begin on the start date shown in this certificate.

4. Plan details (This section does not need to be completed if you are applying as part of a group scheme)

Select your area of cover

The area of cover is subject to full terms and conditions as stated in the Benefit Guide.

Worldwide ☐ Worldwide excluding USA ☐ Southeast Asia Select ☐

Please select the Core Plan and any optional plans you would like. Optional plans can only be purchased with a Core Plan; they can't be purchased on their own. You can find all details of the plans listed below in the Table of Benefits and Benefit Guide.

Select your Core Plan

Indonesia Care Base ☐ Indonesia Care Enhanced ☐ Indonesia Care Signature ☐

Select your optional plans

Out-patient Plans

You can select an Out-patient Plan together with the corresponding Core Plan. For example, if you chose the Care Signature Core Plan, you can only select the Care Signature Out-patient Plan. **You can't buy an Out-patient Plan separately.**

Indonesia Care Base ☐ Indonesia Care Enhanced ☐ Indonesia Care Signature ☐

Dental Plans

You can select a Dental Plan together with the corresponding Core Plan. For example, if you chose the Care Signature Core Plan, you can only select the Care Signature Dental Plan. **You can't buy a Dental Plan separately.**

Indonesia Care Base ☐	Indonesia Care Enhanced ☐	Indonesia Care Signature ☐

Select your Core Plan deductible

To reduce your Core Plan premium, simply select an optional deductible from the list below and check the corresponding discount. You can choose a deductible for your Core Plan and/or a co-payment for your Out-patient Plan (if selected). Where a deductible is chosen, it is payable per person, per Insurance Year.

Our premiums are shown in whole numbers (without cents or pence), so the actual percentage discount may vary slightly from those shown.

Optional Core Plan deductibles * Please select one of the following options.	**Premium discount**
☐ No deductible	0%
☐ US$ 1,000	10%
☐ US$ 4,000	20%
☐ US$ 8,000	30%
☐ US$ 15,000	40%

Select your Out-patient Plan co-payment

To reduce your Out-patient Plan premium, simply select an optional co-payment from the list below and check the corresponding discount. You can choose a co-payment for your Out-patient Plan and/or a deductible for your Core Plan. Where a co-payment is selected, it is payable per person, per Insurance Year.

Our premiums are shown in whole numbers (without cents or pence), so the actual percentage discount may vary slightly from those shown.

Optional Out-patient Plan co-payments	**Premium discount**
☐ No co-payment	0%
☐ 10%	12.5%
☐ 20%	25%
☐ 30%	36.5%

Select your Medical Provider Access option

- **Comprehensive**: You have access to any medical provider of your choice within your area of cover. No medical provider co-payments apply.
- **Standard**: You have access to any medical provider of your choice within your area of cover, same as per the 'Comprehensive' option. However, in this case there will be a 20% co-payment applicable to most in-patient and day-care treatments and services covered under the Core Plan, when you receive them at the medical providers listed in the Table of Benefits. The selection of the 'Standard' option will lower your premium.

5. Medical Underwriting terms

Full medical underwriting

We will assess your medical history when reviewing your application and deciding the terms of your cover. If you have a pre-existing condition (as defined below), **you must declare it accurately, honestly and completely. Please make sure you answer all questions in the 'Your Health' section for everyone included in this application**.

Pre-existing conditions

A pre-existing condition is any medical condition for which you or your dependants have had symptoms at any time in the past. This applies whether or not you or your dependants sought medical advice or treatment. We will consider any medical condition to be pre-existing if we can determine that you or your dependants would have known about it.

Any medical conditions that arise between the date you completed the Application Form and the later of the following will also be treated as pre-existing:

- the date we issued your Insurance Certificate, or
- the start date of your policy.

Please provide any additional information we may request. You must complete this application fully and accurately and disclose all relevant information.

You need to tell us about any material facts that could affect how we assess or accept your application. If you are unsure whether something is relevant, please include it.

If information is missing or incorrect, it may affect your cover or policy. Any undisclosed pre-existing medical conditions will not be covered.

6. Your health

Please answer the following questions based on your own and your dependants' full medical history. **You must disclose all material facts (i.e. facts likely to influence our assessment and acceptance of this application). If you are in any doubt about whether a fact is material, then you should disclose it to us. Failure to disclose all material facts may invalidate the policy. If this application includes one or more dependants, the following fields are mandatory and must be completed for each dependant.**

This health declaration is valid for two months from the date you complete and sign the form.

	Applicant	Dependant 1	Dependant 2	Dependant 3
Height *	cm	cm	cm	cm
Weight *	kg	kg	kg	kg
Have you used any form of tobacco in the past year? *	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If Yes, how much per day on average? 1 cigarette = 1 unit, 1 medium cigar = 2 units, 1 gram roll-your-own tobacco = 2 units, 1 pipe bowl tobacco = 2.5 units, 10mg e-cigarette nicotine = 1 unit. If none, state NO.	/day	/day	/day	/day
Do you drink alcohol? *	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If Yes, how many units of alcohol do you drink per week? 1 short = 1 unit, 250ml beer = 1 unit, 1 glass wine = 1 unit. If none, state NO.	/week	/week	/week	/week

Has any person included in this application ever suffered from, been in hospital with, or had tests, investigations or treatment of any kind, for the following conditions? *

a) **Any heart or circulatory disease or disorder,** such as, but not limited to, heart attack, coronary artery disease, vascular disease, irregular heartbeat, murmur, chest pain, clots, blood disorder, abnormal blood pressure or high cholesterol. Yes ☐ No ☐

b) **Any dermatological disease or disorder,** such as, but not limited to, psoriasis, dermatitis, eczema, allergy or acne. Yes ☐ No ☐

c) **Any endocrine disease or disorder,** such as, but not limited to, diabetes, pancreatitis, weight problems, gout or thyroid problems or other hormonal imbalances. Yes ☐ No ☐

d) **Any eye, ear, nose and throat disease or disorder,** such as, but not limited to, cataract, glaucoma, detached retina, hearing loss, ear infections, sinus problems, tonsillitis, adenoiditis or myopia with levels greater than -6. Yes ☐ No ☐

e) **Any gastrointestinal disease or disorder,** such as, but not limited to stomach problems, hernia, haemorrhoids, gall stones, colon polyps, Crohn's disease, colitis or liver problems. Yes ☐ No ☐

f) **Any infectious or viral disease or disorder,** such as, but not limited to, hepatitis A/B/C, herpes, malaria, meningitis, blood infection or sexually transmitted disease. Yes ☐ No ☐

g) **Any muscular or skeletal disease or disorder,** such as, but not limited to back, neck or joint pain, arthritis, fibromyalgia, joint replacement, any cartilage and/or ligament problem or carpal tunnel syndrome. Yes ☐ No ☐

h) **Any neurological disease or disorder,** such as, but not limited to stroke, multiple sclerosis, epilepsy, neurodegenerative disorder, paralysis, seizures, migraine, Alzheimer's or other form of dementia. Yes ☐ No ☐

i) **Any oncological disease or disorder,** such as, but not limited to any cancer, leukaemia, lymphoma, tumour, skin lesion, growth, lump, cyst, mole, polyp or naevus. Yes ☐ No ☐

j) **Any psychiatric or psychological disorder,** such as, but not limited to attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, depression, anxiety, chronic fatigue syndrome, eating disorder, obsessive-compulsive disorders, phobic disorders or alcohol/drug problems. Yes ☐ No ☐

k) **Any respiratory or lung disease or disorder,** such as, but not limited to chronic obstructive pulmonary disorder, sarcoidosis, asthma, bronchitis, sinusitis, shortness of breath or allergy. Yes ☐ No ☐

l) **Any urological or reproductive organs disease or disorder,** such as, but not limited to kidney or urinary tract problems, menstrual impairment, fertility problems, fibroids, endometriosis, testicular or prostate problems. Yes ☐ No ☐

m) **Any congenital disease or disorder present at or before birth,** such as but not limited to, adrenal hyperplasia, cystic fibrosis, Down syndrome, haemophilia, heart defects, Huntington's disease, Klinefelter's syndrome, Marfan syndrome, malformations and spina bifida.

Please do NOT disclose results of any genetic (DNA or RNA) tests as these are not required for the underwriting process. Yes ☐ No ☐

n) **Any other accident, injury, disease or disorder** not already disclosed. Yes ☐ No ☐

Please tell us whether you or your dependants: *

o) Are currently taking any prescribed or over-the-counter drugs, medication, tablets or other treatment. Yes ☐ No ☐

p) Are expecting to have a medical review, have been referred for further tests/ investigations, or are awaiting results or any treatment due to accident, injury, disease or disorder. Yes ☐ No ☐

q) Have undergone any tests or investigations within the last 10 years which resulted in referral for further medical advice or treatment, such as, but not limited to biopsy, colonoscopy, colposcopy, computed tomography (CT), mammogram, magnetic resonance imaging (MRI), Papanicolaou test (PAP) or prostate-specific antigen test (PSA), echocardiogram (Echo) or ultrasound (US). Yes ☐ No ☐

Please do NOT disclose results of any genetic (DNA or RNA) tests, as these are not required for medical underwriting.

r) Have experienced, within the past two years, any recurrent or ongoing symptoms or medical complaints NOT related to a condition already disclosed such as, but not limited to: Yes ☐ No ☐

- Fever (103°F/39.4°C or above) and/or continuous cough
- Shortness of breath
- Hoarseness
- Severe/ongoing headache
- Mole or skin marking that has bled, changed or become painful
- Tingling
- Blurred or double vision
- Unexpected weight loss
- Bleeding per rectum, change in bowel habit or urine frequency
- Loss of sensation, seizures, loss of consciousness
- Abnormal bleeding
- Joint pain/stiffness

Please complete the following question only if you are purchasing dental cover.

s) Is any person included in this application currently undergoing or have they been advised to undergo any dental treatment, dental surgery, dental prosthesis, orthodontics or periodontics? Yes ☐ No ☐

Additional information for 'Yes' answers

If you answered **Yes** to any part of the questions from a) to s) above, please provide details in the table below.

Please tell us if a full recovery has been made or if you or your dependants have any medical condition or disease related to or arising from the original diagnosis. Please enclose supporting up-to-date medical reports/test results if possible.

Name of person affected	Question	Diagnosis – where applicable state the area of the body (e.g. left arm, right foot or tooth affected)	Exact date of onset of the condition	Date of last symptoms and frequency (Daily, Weekly, Monthly, Irregular)	Past and current treatment, investigations, blood tests or readings (please include name, dosage and frequency of usage of medication and provide dates of when treatment started, frequency of treatment and if it is ongoing)	Current status (e.g. any complications, complete recovery, recurrent or ongoing). Please also indicate if you continue to see a dentist for an ongoing issue, or have stopped attending recommended routine dental checkups

Name of person affected	Question	Diagnosis – where applicable state the area of the body (e.g. left arm, right foot or tooth affected)	Exact date of onset of the condition	Date of last symptoms and frequency (Daily, Weekly, Monthly, Irregular)	Past and current treatment, investigations, blood tests or readings (please include name, dosage and frequency of usage of medication and provide dates of when treatment started, frequency of treatment and if it is ongoing)	Current status (e.g. any complications, complete recovery, recurrent or ongoing). Please also indicate if you continue to see a dentist for an ongoing issue, or have stopped attending recommended routine dental checkups

If there is insufficient space in the table above, please use another Application Form.

Please provide the name, address and telephone number of the regular/family doctor (and dentist, where applicable) for everyone included in this application. Please use a separate sheet if the space provided is not sufficient. *

7. Declaration

Please read the following declarations carefully. You will need to sign below in the '**Approvals**' section to confirm you understand and accept them.

- I declare that all information supplied above is true and complete, including those answers that are not in my own handwriting. I also declare that I have not suppressed, misrepresented or misstated any material fact. I understand that this application will be the basis of the contract between PT Asuransi Central Asia and myself, and that **any false, incorrect or misleading statement or non-disclosure of material information may make this insurance null and void, in accordance with the applicable legislation**.
- I undertake to inform PT Asuransi Central Asia immediately in writing of any changes in my or my dependants' state of health occurring between completing the Application Form and the start date of the policy.
- I agree to waive any rights that I may have to medical secrecy/confidentiality in respect of my medical information in the context of this application for insurance. I consent to allow PT Asuransi Central Asia, if it considers it appropriate, to check statements concerning my health condition and to check with other healthcare insurers all statements concerning previous or existing contracts I may have applied for.
- Subject to legal restrictions, PT Asuransi Central Asia (or its medical advisers, appointed representatives or third-party experts in case of disputes) may request medical information about me from medical professionals. In these circumstances I authorise all such practitioners, physicians, dentists, members of medical professions, and employees of hospitals, health authorities and medical facilities to provide relevant medical information as requested. I also make this statement for my dependants under the age of 18 and for dependants who cannot assess the meaning of this statement.
- **I confirm that:**
  - I have read and understood the full definitions, benefits, exclusions and conditions of this policy, including the details relating to pre-existing conditions.
  - I have received, read and understood the Benefit Guide and Table of Benefits and I accept the terms and conditions as summarised there.
  - Based on the information provided within these documents and the plan selections that I have made, I believe the product I selected is most suited to my specific insurance needs.
- **I understand that:**
  - This Application Form is valid for two months from the date of completing and signing it.
  - I can withdraw my application in writing by letter or email within 30 days from the date I receive the full terms and conditions of my policy. Provided that I have not submitted a claim, I am then entitled to a full refund of the premium.
- **I accept that:**
  - It is my responsibility to check the accuracy of the information contained within the Insurance Certificate, once issued.
  - Cover will be subject to the standard terms and conditions that apply at the start or renewal date of the policy and are set out in the Benefit Guide.
  - The cover provided by PT Asuransi Central Asia may not be suitable if my dependants and I are or become resident in countries where local compulsory health insurance restrictions are in place.
  - It is my responsibility to check if I am subject to any local compulsory health insurance requirements in my country of residence and I can confirm that my healthcare cover is legally appropriate.

8. Policyholder appointment

This section must be completed by all dependants who wish to appoint the policyholder as the main point of contact.

To help us administer the policy, you can nominate the policyholder as the main contact for the insurance. To do this, simply consent to this in the '**Approvals**' section below.

The policyholder will be authorised to act on behalf of all dependants in the administration of this policy. This may include the disclosure of sensitive medical information. This authorisation will remain in place until I or any dependant on cover request from PT Asuransi Central Asia in writing to revoke it.

9. Broker appointment (if applicable)

By consenting below in the '**Approvals**' section, I authorise the named broker to act on my behalf in relation to the administration of this policy. This may include the disclosure of sensitive medical information. This authorisation will remain in place until I ask PT Asuransi Central Asia in writing to revoke it.

10. Your personal data

Allianz's Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice, visit: **www.allianzcare.com/en/privacy.html**. Alternatively, you can contact us on 0018 0306 5171 (toll-free when calling from Indonesia) or + 60 3 92127820 (international number to call from outside Indonesia) to request a paper copy of our full Data Protection Notice. If you have any queries about how we use your personal data, please email us at: **AP.EU1DataPrivacyOfficer@allianz.com**

11. Data consent

We need your consent to collect and process your health and other personal data . **If you do not give explicit consent, we may not be able to provide you with your policy or process any claims you may be entitled to make**. If you agree, we will process your data for the following reasons and activities. **A parent or guardian should complete the consent for any member under the age of 18.**

I (the applicant), and the dependants named below agree with the following: *

Name of applicant	Name of dependant 1
Name of dependant 2	Name of dependant 3

- **Permission to collect, store and use my health data.** PT Asuransi Central Asia may collect, store and use my health data to administer the policy, for example to provide me with a quote for insurance cover, underwrite the risks to be insured or process any claims. Allianz Assistance may store my health data in accordance with the Consumer Code of the law applying to this insurance policy or with any other applicable law requiring the retention of the data.
- **Permission to obtain my data from third parties.** To provide me with insurance cover, underwrite the risks to be insured or process any claims, PT Asuransi Central Asia may obtain my health and other data from physicians, nursing and hospital staff, other medical institutions, care homes, statutory health insurance funds, my plan sponsor, professional associations and public authorities. I agree to release all individuals at these institutions and PT Asuransi Central Asia from their respective confidentiality obligations relating to my health data or other data that they have to share and use for the purposes stated above.
- **Sharing my data outside of PT Asuransi Central Asia.** PT Asuransi Central Asia may share my health and other data with the experts or institutions set out below. They will only use the data to the same extent and for the same purposes as PT Asuransi Central Asia.
  I understand that PT Asuransi Central Asia has put in place arrangements with these institutions to protect my data. I agree to release all individuals at these institutions and PT Asuransi Central Asia from their respective confidentiality obligations relating to my health data and other data that they have to share and use for the purposes set out below:

- With independent medical experts to enable them to assess insurance risks and any benefits to be paid to me or to the third party providing treatment or service to me under my insurance policy.
- With third-party service providers outside of PT Asuransi Central Asia, such as risk assessments and claims handling, where:
  - these services involve the collection and use of my health and other data, and
  - PT Asuransi Central Asia would not be able to administer my policy or pay any claims due to me without such data.
- With co-insurers to distribute the cover of the insurance risk jointly with other companies to which PT Asuransi Central Asia issues the policy, and to handle claims jointly.
- With other insurers/reinsurers that may be covering the same insurance risk at the same time (multiple insurance) to:
  - distribute the payment of any compensation that may be owed to me, or
  - collaborate in the detection or prevention of fraud and financial crime.

If I change my mind about my preferences above, including withdrawing my consent to any of these items, I can let PT Asuransi Central Asia know by emailing AP.EU1DataPrivacyOfficer@allianz.com.

12. Marketing preferences

I (the applicant) and my dependants agree that PT Asuransi Central Asia may collect, use and disclose my personal data to provide me with marketing information. I understand that my personal data will only be used for the following reasons and activities, which I have expressly agreed to by ticking the boxes below.

	Applicant	Dependant 1	Dependant 2	Dependant 3
Name				
Information that PT Asuransi Central Asia sends about their products and services, including updates on their latest promotions and new products and services.	☐	☐	☐	☐
Information sent directly by the business partners of PT Asuransi Central Asia on their products and services. I understand that you will disclose my relevant contact information to them for that purpose.	☐	☐	☐	☐
Such communications should be sent to me by the following methods:				
Email	☐	☐	☐	☐
In-app notifications	☐	☐	☐	☐
Phone	☐	☐	☐	☐
Post	☐	☐	☐	☐

13. Approvals

Please indicate the section you're providing consent for *

7	Declaration**	☐	
8	Policyholder appointment	☐	
9	Broker appointment (if applicable)	☐	Broker name
10	Your personal data**	☐	
11	Data consent**	☐	
12	Marketing preferences	☐	

** Please note that we won't be able to process your application if you have not provided consent for the marked sections in the Approvals' box above.

Signatures *

The applicant and each named dependant above 18 need to sign this Application here. By signing, you are consenting to the relevant sections ticked above.

Applicant's signature	Dependant 1's signature	Dependant 2's signature	Dependant 3's signature
Date (DD/MM/YYYY)			
/ /	/ /	/ /	/ /

14. Payment details

You don't need to complete this section if you are applying as part of a group scheme and your employer is paying the premium.
Please don't make any payments until you receive your policy number.

Your premium will need to be paid in US Dollars by bank transfer.

Payment frequency

Payments are subject to the following administration surcharges: 0% for annual payments, 3% for half-yearly payments and 4% for quarterly payments.

Please tick ☑ to indicate your preferred payment frequency:

	Annual	Half-yearly	Quarterly
Bank transfer	☐	☐	☐

Please return your fully completed form by:

Downloading and completing using Adobe Acrobat Reader and clicking the button below*

* If prompted, allow Adobe access to your email account to send the completed form.
Return the form to individual.joining@e.allianz.com or your individual broker (if appropriate).

Submit form

Or email: If you are unable to use the button above, save the form and return it via email to: individual.joining@e.allianz.com

Or post: PT Asuransi Central Asia. Registered address: Mal Ambassador Ruko 2-3, Jl. Prof. Dr. Satrio, Jakarta 12940, Indonesia

If you have any questions regarding this Application Form or the application process, please contact our Helpline on: 0018 0306 5171 (toll-free for calls from Indonesia) or + 60 3 92127820 (international number to call from outside Indonesia).

The policies are issued and covered by PT Asuransi Central Asia. Registered address: Mal Ambasador Ruko 2-3, Jl. Prof. Dr. Satrio, Jakarta 12940, Indonesia.

This insurance product belongs to PT Asuransi Central Asia. PT Asuransi Central Asia is responsible for the issuance of the policy and has the right to reject claims made not in accordance with the terms and conditions written in the policy.