INDIVIDUAL APPLICATION FORM
Premier & PremierNet Plans

ADMINISTERED BY THIRD MILLENNIA HEALTH

PLEASE COMPLETE AND RETURN TO: admin@thirdmillenniahealth.com

If filling form by hand, please complete using capitals and black ink. *(*Mandatory fields)*

SECTION 1 - TELL US ABOUT YOURSELF

Mr/Dr/Mrs/Ms/Miss:	Surname:
First name:	Date of birth (dd/mm/yy):
Address:	
Telephone No (for correspondence):	
Telephone No (other):	
Fax No:	
Email address:	
Nationality*:	
Country of usual residence*:	How long have you lived here:
Occupation:	
Industry:	

SECTION 2 - HAVE YOU BEEN PREVIOUSLY INSURED?

Have you previously been insured, or are you currently insured, with another health insurer?: ☐ YES ☐ NO

Name of Insurer:

Name of plan or product:

Date your last/current policy expired:

SECTION 3 - WOULD YOU LIKE TO INCLUDE FAMILY MEMBERS?

Please note that children who are included in this plan must be under 18 years of age or under 24 years of age if in full time education. Please provide a school certificate for children above 18 years of age.

Status	Gender (m/f)	First Name (s)	Surname	Date of Birth (dd/mm/yy)	Nationality	Occupation/ Full Time Education
Partner						
1st Child						
2nd Child						
3rd Child						
4th Child						

SECTION 4 - WHICH PLAN HAVE YOU CHOSEN?

PLAN	ESSENTIAL	EXECUTIVE	ULTRA
Premier Plan Blue Ribbon	☐	☐	☐
PremierNet Network A (Area 2 ONLY)	☐	☐	☐
PremierNet Network B (Area 2 ONLY)	☐	☐	☐

AREA OF COVER (Premier Plan)	☐ Area 1 (Worldwide)	☐ Area 2 (Worldwide excluding mainland China, USA & the Caribbean)

EXCESS?	☐ No thanks!	☐ US$850 (15% Discount)	☐ US$1,500 (20% Discount)	☐ US$3,500 (35% Discount)

SECTION 6 - PAYMENT & COMMENCEMENT DATE

How often do you want to pay? : ☐ Annually ☐ Half Yearly (2% loading) ☐ Quarterly (4% loading)

How do you want to pay? : ☐ Bank Transfer ☐ Credit Card

Date on which you wish your plan to commence: ☐ On acceptance ☐ Other Date: (dd/mm/yy):

This date cannot be more than 30 days from the date you sign this application form or be the 28th, 29th, 30th or 31st of the month
Unfortunately your insurance cannot start until we have accepted your application and received payment of your first annual, half yearly or quarterly premium. Cover also cannot be backdated.

SECTION 7 - MEDICAL DECLARATION

Please take care when answering these questions to ensure that the information you provide is detailed, correct and complete for yourself or any other family member you are including in this application. If, after completing your application form, any changes occur in the facts you declared, 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, and we reserve the right to decline or accept your application with special terms.

IMPORTANT NOTE - We rely on the information that you give us in this form to decide whether or not to accept your application. If you do not provide us with full details of a condition or symptom or treatment (past or current) that in our opinion later results in health costs during the life of a policy, we reserve the right on discovery to terminate your policy without refund of premium and to seek return of any benefits that may have been paid to you. If you declared it and we accepted your application form, this will never happen to you.

Have you or anybody named in this application form:

a) Seen a doctor or other healthcare professional of any kind in the last three years? ☐ YES ☐ NO
If YES, please describe why and when:

b)Sought treatment from a hospital, had an operation or procedure or had any laboratory tests or x rays (radiology) in the last five years? ☐ YES ☐ NO
If YES, please describe why and when:

c) Been told by a healthcare professional you will likely need treatment or surgery in the future? ☐ YES ☐ NO
If YES, please explain why:

Please tick YES or NO to each of the following questions.. If you tick YES to a question, please give full details on the next page, or continue on a separate sheet of paper.

1) Have any persons named in this application ever:	
1.1) Undergone a surgical operation (including any cosmetic surgery)	☐ YES ☐ NO
1.2) Been a patient in a hospital, clinic or sanatorium?	☐ YES ☐ NO
1.3) Been advised to have any medical tests or investigation?	☐ YES ☐ NO
1.4) Had any abnormal medical test results?	☐ YES ☐ NO
1.5) Been tested positive for HIV or Hep C?	☐ YES ☐ NO
1.6) Suffered from any pre or post natal complications, complications of childbirth or suffered any miscarriage?	☐ YES ☐ NO
1.7) Consulted a dentist or oral surgeon in the past 12 months?	☐ YES ☐ NO
1.8) Been on sick leave from work for more than 15 days due to illness or injury, or are currently on sick leave?	☐ YES ☐ NO
1.9) Had an application or renewal of insurance turned down or accepted with special terms (e.g. with premium loading, special conditions or exclusions?)	☐ YES ☐ NO
2. Are any of the persons named in this application aware of any symptoms or conditions or abnormal signs which may give rise to a claim?	☐ YES ☐ NO
3. Are any persons named in this application currently taking any medication or being treated by a practitioner of any kind (e.g. Doctor, physiotherapist, chiropractor, acupuncturist etc)	☐ YES ☐ NO
4. Have any persons named in this application form ever suffered from, been diagnosed with or prescribed drugs for:	
4.1) Heart or circulatory disorders e.g. high blood pressure, high cholesterol, angina/chest pains, heart attack, heart failure, abnormal heartbeat or valve function, aneurysms, deep vein thrombosis, or varicose veins.	☐ YES ☐ NO
4.2) Diabetes or any Endocrine (glandular) disorder e.g. diabetes (Type 1 or Type 2), thyroid or other glandular problems, sugar in the urine or raised blood sugar	☐ YES ☐ NO
4.3) Breathing or respiratory conditions or disorders e.g. shortness of breath, sleep apnea, asthma, COPD, pneumonia, bronchitis or tuberculosis	☐ YES ☐ NO
4.4) Allergies of any kind Where confirmed by diagnosis or suspected be it hayfever, drug allergies, skin allergies or something more sever. Please describe which person suffers from the allergy, describe its symptoms, frequency, and medications usually taken if any, on a separate page and attach to this application form.	☐ YES ☐ NO
4.5) Stomach, intestines, liver,or gall bladder problems e.g. stomach inflammation/ ulcers, irritable bowel, Crohn's disease, colitis, change in bowel habits, severe or repetitive abdominal pain, haemorrhoids/piles, pancreatitis, liver inflammation, cirrhosis, acid reflux, ulcers, gall stones or hernias	☐ YES ☐ NO
4.6) Cancer, tumors, cysts or growths e.g. Leukemia, lymphoma, polyps, benign growths, fibrous mass, undiagnosed lumps, any cancers or pre-cancerous condition, any skin blemish or mole that has changed color or increased in size recently?	☐ YES ☐ NO
4.7) Skin problems e.g. eczema, dermatitis, rashes, psoriasis, acne, cysts, or moles that itch or bleed	☐ YES ☐ NO
4.8) Neurological, brain or nervous system disorders e.g. stroke, transient ischemic attack (TIA), dementia, migraine, repeated headaches, multiple sclerosis, epilepsy/fits, nervepain (including sciatica and shingles), Parkinson's Disease, cerebral palsy, numbness, tingling or paralysis of any kind or meningitis	☐ YES ☐ NO
4.9) Muscle or skeletal problems e.g. arthritis, spinal conditions, back pain, neck/shoulder problems, cartilage and ligament problems, joint problems or replacements, fractures, osteoporosis, repetitive strain injuries (RSI), carpal tunnel syndrome, gout or inflammatory conditions.	☐ YES ☐ NO

4.10) Urinary or reproductive system problems ☐YES ☐NO
e.g. Renal conditions, kidney or bladder problems (including kidney failure or kidney stones), recurrent urinary infections, incontinence, blood or protein in the urine; pregnancy/ childbirth problems (including caesarean sections), heavy or irregular periods, fibroids, endometriosis, infertility, abnormal smears, polycystic ovaries, testicular or prostate disorders.

4.11) Blood or immune disorders ☐YES ☐NO
e.g. Abnormal blood tests, blood clotting problems, haemophilia, thalassemia, anaemia, Lupus (SLE), or any autoimmune disorder.

4.12) Infectious or contagious diseases of any kind ☐YES ☐NO
e.g. Malaria, hepatitis, HIV/AIDS, sexually transmitted diseases of any kind

4.13 Eye, ear, nose, throat and dental problems ☐YES ☐NO
e.g. cataracts, glaucoma, visual impairment; deafness, ear infections, reoccurring tonsillitis; sinusitis or reoccurring sinus problems, dental infections, wisdom teeth problems or gingivitis.

4.14) Psychiatric/ psychological or nervous disorders ☐YES ☐NO
e.g. schizophrenia, compulsive or eating disorders; depression, stress, anxiety, attention deficit disorder, post natal depression or drug/alcohol addiction.

4.15) Any other kind of condition or disorders ☐YES ☐NO
e.g. Chronic fatigue syndrome (CFS); periodic/recurring or persistent pain; Drug or chemical poisoning, gynaecological conditions, infirmity, congenital or hereditary conditions of any kind, fainting spells or blackouts, chronic fatigue syndrome,RSI, carpal tunnel syndrome, prosthesis items of any kind.

A few more details.....

	You	Partner	Child 1	Child 2+
Height (cms):				
Weight (kgs):				
Blood pressure & date taken:				

If you have answered YES to any question, please give full details below and continue on a separate sheet of paper:

Question No:	**Name of person who suffered the illness/injury:**
Date(s) on which the illness/injury occurred:	
Diagnosis:	
Treatment/tests performed and results:	
Date you last suffered symptoms or received treatment relating to this condition:	
Name and address of treating physician:	
Please give details of need for further consultation or treatment for this condition or of any on going concern or need for monitoring:	

Question No:	**Name of person who suffered the illness/injury:**
Date(s) on which the illness/injury occurred:	
Diagnosis:	
Treatment/tests performed and results:	
Date you last suffered symptoms or received treatment relating to this condition:	
Name and address of treating physician:	
Please give details of need for further consultation or treatment for this condition or of any on going concern or need for monitoring:	

SECTION 8 - DOCTORS CONTACT DETAILS:

Please give details of the doctor who is most familiar with your medical history and the medical history of your family members, if there is more than one doctor please provide details on a separate sheet:

Doctor's name:

Practice name:

Address:

Phone number:

Email address:

Length of time you have known this doctor: Date last visited:

Which family member(s) did this doctor treat?

SECTION 9 - DECLARATION AND AUTHORISATION

1. On behalf of myself and each person named on this application form, I hereby give consent for any doctor from whom I/ we have sought treatment or consultation, to provide Vivilate, or any of the companies it has employed, with any information they ask for in connection with this application form and in respect of any claims I have lodged or may later lodge under a Vivilate policy.

2. I hereby declare all information supplied on this application and medical declaration form to be complete and correct and I agree that Vivilate and any of the companies it has employed to provide services in respect of the insurance product I am applying for, can view the information I have provided and any additional information I might provide on request, including my medical history and claim data. I fully understand that if I have omitted any information intentionally or otherwise I risk my policy being cancelled without refund of premium should my application be successful.

3. I hereby authorize Vivilate to send any document or communication relating to this insurance policy or to any claim made hereunder to me by email using the email address I have stated in this application or to Third Millennia Health.

Signature: **Date:** (dd/mm/yy)

Print name:

NOTES:

Thank you for taking the time to complete this application form, but before you send to us please check and make sure that you have answered ALL the questions to avoid any unnecessary delays.

PLEASE ENCLOSE A PASSPORT SIZED PHOTOGRAPH WITH YOUR APPLICATION FORM.

THIRD MILLENNIA
Evolution of health and wellbeing in Asia

PLEASE COMPLETE AND RETURN TO:
Third Millennia Health
Represented by: PT API Pacific, Nakula Plaza Building B1,
Jalan Nakula, Legian, Bali 80361, Indonesia
t: + 62 (0) 361 737317
f: + 62 (0) 361 737314
e: admin@thirdmillenniahealth.com

VIVILATE