



ASIANET APPLICATION FORM BRONZE & SILVER PLANS

ADMINISTERED BY THIRD MILLENNIA HEALTH

PLEASE COMPLETE AND RETURN TO: admin@thirdmilleniahealth.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	BRONZE	SILVER		
AsiaNet Plan	<input type="checkbox"/>	<input type="checkbox"/>		
AREA OF COVER	<input type="checkbox"/> South East Asia, Australia & New Zealand ONLY			
EXCESS?	<input type="checkbox"/> No thanks!	<input type="checkbox"/> US\$850 (15% Discount)	<input type="checkbox"/> US\$1,500 (20% Discount)	<input type="checkbox"/> US\$3,500 (35% Discount)

SECTION 5 - 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 6 - 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.

a) Have you, or anyone named on this application form, been admitted to a hospital or other similar establishment in the last 5 years? YES NO

b) Have you, or anyone named on this application form, been prescribed with a course of any drugs or medication, or treatments for a period in excess of 7 days in the last 5 years? YES NO

c) Have you, or anyone named on this application form, any known or foreseeable need to consult with a medical practitioner or any other healthcare professional and/or to be required to be prescribed any drugs or medication and/or to be admitted to a hospital or other similar establishment? YES NO

d) Have you, or anyone named on this application form, ever been diagnosed with anything serious, concerning or which could impact on you in later years? YES NO

e) Are you, or anyone named on this application form, suffering from any disability, abnormality, recurrent illness, major illness or injury, not already noted above? YES NO

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: _____

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 7 - 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 8 - 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 Millennium 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:

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