Maxicare Healthcare Corporation

(This portion is to be accomplished by Maxicare Underwriter)	
DATE RECEIVED	
EFFECTIVE DATE	
ID NUMBER	
EMPLOYEE NO	
CORPORATE CODE	
CORPORATE NAME	

MAXICARE APPLICATION FORM

I hereby apply for Maxicare Healthcare Program membership and agree that I shall abide by the provisions of the Membership Agreement and Maxicare regulations to which I commit, agree and undertake to be bound by the conditions thereof. I understand that there shall be no coverage in effect unless my application is approved by Maxicare and Membership card is issued and hence, that Maxicare will not be liable for any Medical bills between the time that I sign this application form and the effective date of my application coverage is approved and membership card/s issued and delivered to me.

The receipt of the corresponding membership fees by Maxicare does not constitute acceptance of my application or of my dependents as a Maxicare Healthcare Program member until the corresponding application has been approved and the membership card/s has been issued to me or my dependents. In the event that my application is denied or disapproved for any reason, the membership fees I may have paid or remitted will be refunded to me by Maxicare.

I hereby agree and undertake as my obligation to obtain from Maxicare the latest copy of Membership Agreement and to know and understand all the terms, conditions and provisions enumerated in the said Membership Agreement. Failure to do shall be construed as a waiver of notice on my part and complete agreement to the new or amended terms and conditions of the Program.

I hereby agree and undertake as my responsibility, to keep my healthcare program membership on Active status by paying the corresponding membership fee on or before the due date. Furthermore, I recognize Maxicare's right to disapprove / deny my application with no obligation to disclose the reason for such disapproval or denial.

PART 1 APPLICANT INFORMATION

NOTE: TO FACILITATE PROCESSING OF THIS APPLICATION, PLEASE ACCOMPLISH THIS FORM IN FULL. KINDLY WRITE IN BLOCK LETTERS AND CHECK THE APPROPRIATE BOX WHERE APPLICABLE

☐ NEW APPLICANT ☐ ADDITIONAL APPLICANT ☐ REAPPLICATION ☐ TRANSFEREE

TYPE OF COVERAGE	☐ INDIVIDUAL ☐ FAMILY ☐ GROUP/CORPORATE SPECIFY NAME: ____________
PLAN TYPE	☐ PLATINUM PLUS ☐ PLATINUM ☐ GOLD ☐ SILVER ☐ BRONZE (Not applicable for Individual, Family & Group)
MODE OF PAYMENT	☐ ANNUAL ☐ SEMI-ANNUAL ☐ QUARTERLY ☐ MONTHLY (Not applicable for Individual, Family & Group)
DENTAL COVERAGE	☐ YES ☐ NO

PRINCIPAL/PAYOR

LASTNAME	FIRSTNAME	MIDDLE INITIAL	DATE OF BIRTH (M-D-Y)	AGE	BLOOD PRESSURE
CIVIL STATUS	NATIONALITY	HEIGHT (FT. IN.)	WEIGHT (LBS)	SEX	TIN NO.
NO. OF CHILDREN	JOB TITLE	NAME OF OFFICE /BUSINESS		NATURE OF BUSINESS	
RESIDENCE ADDRESS (NUMBER, STREET, VILLAGE, BRGY, CITY, ZIP CODE)			MOBILE NO: RES. PHONE NO:	FAX NO: E-MAIL ADDRESS:	
CONTACT PERSON & MAILING ADDRESS (NUMBER, STREET, VILLAGE, BRGY, CITY, ZIP CODE) (IF UNDER AN AGENT/BROKER PLEASE INDICATE AGENTS/BROKERS ADDRESS)			OFFICE PHONE NO:	FAX NO:	

YOUR SPOUSE

LASTNAME	FIRSTNAME	MIDDLE NAME	DATE OF BIRTH (M-D-Y)	AGE
NATIONALITY	JOB TITLE	NAME OF OFFICE BUSINESS	NATURE OF BUSINESS	

PROPOSED MEMBERS

FULL NAMES OF APPLICANTS (Arrange Name Chronologically Based on Age)	IF APPLYING		RELATION	BIRTHDAY (M-D-Y)	AGE	SEX	HEIGHT (FT. IN.)	WEIGHT (LBS)	CIVIL STATUS	DENTAL COVERAGE		OCCUPATION
	YES	NO								YES	NO	
	YES	NO								YES	NO	
	YES	NO								YES	NO	
	YES	NO								YES	NO	
	YES	NO								YES	NO	
	YES	NO								YES	NO	

FOR FAMILY AND GROUP ACCOUNTS: 2 UP TO 21 YEARS OLD ARE ACCEPTABLE AGES FOR MINOR DEPENDENTS. CHILDREN WHO ARE 22 YEARS OLD AND ABOVE WILL BE CONSIDERED AS INDIVIDUAL APPLICANTS.

DEPENDENTS PLAN TYPE	☐ PLATINUM PLUS ☐ PLATINUM ☐ GOLD ☐ SILVER ☐ BRONZE (Not applicable for Individual, Family & Group)

PART 2.A STATEMENT OF HEALTH

I/We hereby clearly understand and agree that failure to declare illnesses in the following questions (referring to any proposed member) will invalidate future claims and that the corresponding details of which will be indicated in PART 2.B.

MEDICAL QUESTIONNAIRE	YES	NO
1. **Has any proposed member/s complained of any untoward symptoms pertaining to diseases or conditions of:**		
1a. The brain or nervous system – such as loss of consciousness, dizziness, headaches, seizure disorder, paralysis, mental retardation, stroke?	☐	☐
1b. The cardiovascular system – such as heart disease, rheumatic fever, palpitation, shortness of breath, chest pain, high or abnormal blood pressure, heart murmur, etc.?	☐	☐
1c. The peripheral vascular diseases – such as varicose veins, phlebitis, aneurysm, arthritis, embolism, etc.?	☐	☐
1d. The digestive system – such as ulcer, gall bladder disorder, liver disease, colitis, chronic diarrhea, fistula, hemorrhoids, colon or intestinal disorder, hernia, malabsorption and pancreatitis?	☐	☐

1e. The genito-urinary system – such as renal colic, stone, bladder or kidney disorder, stricture, prostate disorder, syphilis, or venereal disease, etc.?	☐	☐
1f. The metabolic system – such as diabetes, gout, thyroid or adrenal disorder etc. and immune system disorders including acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC) etc.?	☐	☐
1g. The musculo-skeletal system – such as back sprain, neck or back disorder arthritis, fractures, slipped disc, dislocation, joint problems, physically handicapped, etc.?	☐	☐
1h. The respiratory tract – such as asthma, tuberculosis, spitting or coughing blood, allergies, emphysema, lung/chest disease of any kind, etc.?	☐	☐
2. **Has any proposed member/s ever received a medical advice or treatment for, or ever had any known indications of any breast condition, infertility or other female problems?**	☐	☐
3. **So far as you know, is a proposed member/s now pregnant?** **Expected delivery date: (M-D-Y) ________________________**	☐	☐
3a. If YES, is caesarean section anticipated?	☐	☐
4. **Has any proposed member/s ever received medical advice or treatment for:** 4a. Disease of eyes, ears, nose or throat?	☐	☐
4b. Any skin disorders, cancer, psoriasis, keratosis, herpes, etc.?	☐	☐
4c. Cancer?	☐	☐
4d. Tumor?	☐	☐
4e. Alcoholism or drug dependency?	☐	☐
4f. If YES to 4e, is he a member of a support group?	☐	☐
5. **Has any proposed member/s ever had any:** 5a. Hospitalization/Surgery? If YES, please give details ________________________	☐	☐
6. **Any congenital disorders?**	☐	☐

PART 2.B STATEMENT OF HEALTH DETAILS

For "YES" answers in PART 2.A, please complete the following information. You may use a separate sheet for more details or attached pertinent documents related to the declarations.

QUESTION NO.	FIRSTNAME	DIAGNOSIS/MEDICATION	INCLUSIVE DATES	NAME OF HOSPITAL & DOCTOR

PART 2.C HEALTH COVERAGE

	YES	NO
1. Were you a previous member of any Health Maintenance Organization (HMO)? If "YES", which HMO: ________________________ When did your former membership begin ________________________and end ________________________	☐	☐
2. Have you ever been treated or examined or hospitalized while you were a member of this HMO? If "YES", please list the date of last exam or treatment and the place of confinement ________________________	☐	☐
3. Have you filed any claims for reimbursement of medical services with your previous HMO? If "YES", what is the status? ________________________	☐	☐
4. Have you ever been rejected for medical insurance including an HMO plan, or have been offered insurance at higher (rated up) premiums? If "YES" please explain briefly ________________________	☐	☐

PART 3 CONDITIONS OF ENROLLMENT & AUTHORIZATION

- Unless my application is approved by the Underwriting Department of Maxicare Healthcare Corporation (MHC), I will not be eligible for coverage. I will only be eligible for coverage once the Underwriting Department of Maxicare Healthcare Corporation (MHC) approves my application.
- Maxicare Healthcare Corporation will not provide benefits for conditions or ailments manifested or in existence on or before the effective date of coverage, except if specified in the Service Agreement.
- Agents and Brokers offering the plans do not have the authority to accept me or my family as MHC subscribers, and have no authority to alter the agreement, waive any requirements approve my application.
- Should this application be approved, Maxicare card/s will be issued to me and/or my enrolled dependents.
- The Statement of Health provides MHC with the basic information needed to determine the scope of my healthcare coverage. This also constitutes part of the contract between MHC and myself / my family.
- I voluntarily acknowledged that MHC Account Representative has satisfactorily explained the details on the provisions on pre-existing conditions, exclusions and out-patient executive check-up surrounding my desired healthcare plan.
- I understand that neither my family nor I will be eligible for benefits should there be false or withheld data, and that my coverage may be revoked based on extent of misrepresentations or non-disclosure.

AUTHORIZATION FOR DISCLOSURE OF PERSONAL INFORMATION

I hereby authorize any healthcare facility, physician but not limited to Maxicare physician and surgeon, or other healthcare professional to provide Maxicare Healthcare Corporation, its agents or employees, all informations pertaining to my application, or any examination or treatment furnished me or my dependents, who are also applying for coverage, or to any illness, injury or condition that I or these dependents have had at any time in the past or in the future until the expiration of this authorization. I understand that this information is collected with the evaluation and processing of an application for coverage or a change in benefits, or to determine eligibility for benefits. This authorization is valid for the entire period of my membership. A photocopy of this authorization is as valid as the original.

I hereby certify that the foregoing answers are true and complete and to the best of my knowledge and that my or my enrolled dependent's health status are accurately represented in the above statements. I understand that MHC may require me or any of my enrolled dependents to have a physical examination or to submit medical requirements and I authorize the release to MHC of any information relative to such examination for use in considering my application. I hereby apply for MHC Healthcare Coverage and agree that I shall abide by the provisions of the contract and MHC regulations. I understand that there is no coverage in effect unless Maxicare Underwriting approves my application and that MHC will not be liable for any medical bills incurred prior to its approval by the MHC Underwriting Department.

In the event the applicant is applying alone or as a minor, the applicants name should be entered on the "Signature of Applicant" portion, and the applicant payer or parent of minors should sign where indicated.

I HAVE READ THE MAXICARE APPLICATION FORM, CONDITIONS OF ENROLLMENT AND AUTHORIZATION STATED ABOVE AND FULLY UNDERSTAND AND AGREE TO THEM.

SIGNATURE OF APPLICANT (Or legal guardian)
Signature over printed name

____
DATE

SIGNATURE OF APPLICANT'S SPOUSE
(if applying)

____
DATE

-This portion is to be accomplished by Agents/Brokers-

AGENT/BROKER'S NAME	ADDRESS	CONTACT NOS.