Member and Card Maintenance Form

All fields must be filled out. Please write in PRINT.

Member Information

Full Name (FIRST NAME, M.I., LAST NAME)**:**

Member Type (Indicate if PRINCIPAL or DEPENDENT)**:**

Maxicare Card Number (1168-XXXX-XXXX-XXXX):

Date of Birth (MM/DD/YYYY)**:**

Company or Account Name:

Mobile Number of the Principal:

Request (Indicate if UPDATE OF CONTACT DETAILS or PIN RESET)**:**

E-mail Address):

Reason of Request:

Declaration

I hereby manifest that my Maxicare reimbursement card is securely in my possession and I take full responsibility for security, custody, and possession of my Maxicare reimbursement card and my personal identification number (PIN), as well as transactions made using the said Maxicare reimbursement card and PIN. I am aware that my current PIN will be changed with a default PIN upon approval of this request, and that I can change my PIN at any Equicom Savings Bank ATM upon receipt of PIN reset notification.

I hereby manifest that all declarations, statements and information provided in this document are accurate and complete. I further agree and understand that any requests made will be subject to approval by Maxicare Healthcare Corporation. Upon approval of these requests, I allow Maxicare Healthcare Corporation to effect the necessary adjustments.

Terms and Conditions

I agree and understand that in the course of providing services to me, MAXICARE shall engage the services of, and/or interact with, other third parties, such as, but not limited to its parent company, affiliated companies, subsidiaries, financial advisors, affiliated third parties or independent/non-affiliated third parties and service providers, whether local or foreign (collectively referred to as "Representatives"). In connection with the foregoing, I hereby irrevocably authorize MAXICARE and its Representatives, being my healthcare maintenance services provider, as my attorney-in-fact to:

a. Obtain, collect, examine, process, and store my and/or my dependents personal information, including sensitive personal information and privileged information, medical records, or any other information relative to my and my dependents' hospitalization, consultation, and treatment or any medical advice in connection with the benefit/claim availed under the Service Agreement, as may be deemed necessary by MAXICARE.

b. Disclose the aforementioned information to my employer, its representatives, agents and brokers, MAXICARE and its Representatives, including the service providers which will perform the services contemplated in the agreement, for any legitimate business purpose as MAXICARE may deem appropriate, including but not limited to outsourced processing of MAXICARE transactions, profiling or historical statistical analysis, providing advice or information which MAXICARE and its Representatives believe may be of interest to me, to effectively administer or manage my account, enhance customer services, or to communicate with me for any purpose. Processing would include both manual and automated handling of personal information and storage and data transfers using physical methods as well as electronic via information and communications systems employed by MAXICARE and its Representatives. I retain the right to be informed, to object, access, complain, and rectify, to request for filtering of certain information, and to the corresponding damages in case of violation of your rights within the corresponding limitations as set forth in the pertinent laws. The authorities herein provided shall be valid and existing during the term of the agreement, including any extensions thereof, and until necessary for the establishment, exercise or defense of any claims arising from the said agreement.

For purposes hereof, I hereby warrant that I have been duly authorized by my dependent/s to sign and execute any and all documents and make representations for and in his/their behalf as if the same were personally done by him/them. I understand my rights and obligations pursuant to the Data Privacy Act and its implementing rules and regulations, as the same may be amended. I further agree to hold MAXICARE and its Representatives free and harmless from and against any and all suits or claims, actions, or proceedings, damages, costs, and expenses, including attorney's fees, which may be filed, charged, or adjudged against MAXICARE or any of its directors, stockholders, officers, employees, agents, or Representatives in connection with or arising from the use, processing and disclosure by MAXICARE or its Representatives of the aforementioned information.

Signature of the Principal Member Over Printed Name

Date Signed