ASIANET APPLICATION FORM
BRONZE & SILVER 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		BRONZE		SILVER
AsiaNet Plan	Network A	☐		☐
AsiaNet Plan	Network B	☐		☐
AREA OF COVER		☐ South East Asia, Australia & New Zealand ONLY		
EXCESS?	☐ No thanks!	☐ US$850 (15% Discount)	☐ US$1,500 (20% Discount)	☐ 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 Safe Meridian, 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 Safe Meridian policy.

2. I hereby declare all information supplied on this application and medical declaration form to be complete and correct and I agree that Safe Meridian 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 Safe Meridian 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

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