redefining / insurance

Customer Care Centre
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Proposal Form

Smart*Care Executive (Individual)*

Proposer Data (*) Must be filled according to PMK No.30/PMK.010/2010 on Know Your Customer Principle

Insured Name*

ID Number
(copy must be attached)

Nationality ☐ Indonesia ☐ Foreigner Country of Origin

Place / Date of Birth / - -

Marital Status ☐ Married ☐ Single

Address (in ID Card)*

City Post Code

Current Address* (if available)

City Post Code

Phone Number (Mobile Phone)

Phone Number (Home)

Email

Occupation* ☐ Government Officials ☐ Military/Police ☐ Professional ☐ Entrepreneur
☐ Others, Please Mentioned

Corporate/Institution's Name

Type of Businesses ☐ Trade ☐ Government ☐ Transportation
☐ Manufaktur ☐ Construction ☐ Natural Resources
☐ Financial Institution ☐ Others _____

Do you have one or more types of businesses that are included in the following types of businesses

Money Changer, Money Remittance, Car Dealer, Gas Station, Parking Management, Jewelers, Gemstone and Precious Metals Store , Minimarket, Electronik Store, Export/Import, Restaurant, Recharge Voucher Trader, Property Agent, Travel Agent , Lawyer, Accounting, Financial Consultan, Antique/Art Collector, Offshore companies, including Financial Service Provider located in the tax and / or secrecy havens and jurisdictions that do not adequately implement the FATF recommendations

☐ Yes ☐ No

For the selected answer, please state Your business type (can be more than one)

(X100cb 01/16)

Position *

Source of premium? * Salary ☐ Profit ☐

Others

Total Income / Year (in IDR) * ☐ < 100 million ☐ 100 - 300 million ☐ > 300 million

Beneficiary

Relation with the Insured

(must be filled if the Beneficiary is not the Insured)

Account Number for claim payment*

Bank

Insurance purpose? *

☐ Protection

☐ Credit Requirements

☐ Others

Do you have any other policy in our Company? ☐ Yes ☐ No

If 'Yes', Please mentioned (filled in other paper if the column is not enough)

	Policy Number	Type of Insurance
1		
2		
3		
4		
5		

Insured details

Your Height & Weight ____ cm ____ kg

Plan chosen ☐ IDR Plan _____

Family member details *(Only to be completed if you applying for family plan)*

Full Name		Date of Birth	M/F	Height	Weight
Spouse		/ /		cm	kg
Child 1		/ /		cm	kg
Child 2		/ /		cm	kg
Child 3		/ /		cm	kg
Child 4		/ /		cm	kg
Child 5		/ /		cm	kg

Spouse's occupation

Individual Take Over

(Applicable only if the applicants are currently insured under an individual/family health insurance plan with other insurance company)

Give mark ☒ for the chosen benefits

Please provide a copy of your renewal invitation and previous policy documents including terms and conditions of the policy contract.

	You	Family Member
1. Have you or family member who will be insured had treatment in hospital or consulted a specialist in the last 12 months?	☐ YES ☐ NO	☐ YES ☐ NO
2. Do you or family member who will be insured have any consultation, treatment, investigation or test planned or pending (this applies whether it is to be provided by a Specialist or General Practitioner)?	☐ YES ☐ NO	☐ YES ☐ NO
3. Have you or family member who will be insured suffered from any form of heart disease, renal failure, cancer, diabetes, any alcohol or drug problems or mental illness including depression?	☐ YES ☐ NO	☐ YES ☐ NO

General Questions and Medical Declarations

For question no. 1 - 3, if the answer is YES please give explanation.

	You	Family Member
1. Do you or family member who will be insured currently participate or intend to participate in any high risk activities such as, but not limited to, motor sports, diving, aviation other than as a fare-paying passenger or war?	☐ YES ☐ NO	☐ YES ☐ NO
2. Do you or family member who will be insured currently have any health insurance in force with other insurance companies? If YES, please state the name of the insurance company and the type of coverage	☐ YES ☐ NO	☐ YES ☐ NO
3. Do you or family member who will be insured currently ever had an application for life, health or disability insurance declined, postponed, withdrawn, or accepted on special terms? If YES, please provide details .	☐ YES ☐ NO	☐ YES ☐ NO

For Question No. 4 - 9 if your answer is "YES" please explain the complete condition, diagnosis, date, Hospital/Doctor's name and address which is currently taking care of your or your dependent's health

	You	Family Member
4. Has your closest family member or any of your dependents ever suffered from tuberculosis (TBC), kidney disease, heart diseases, stroke, high blood pressure, blood vessel disease, mental disorder or cancer?	☐ YES ☐ NO	☐ YES ☐ NO
5. a) Have you or family member who will be insured smoked within the last 12 months? if YES, how many cigarettes do/did you smoke per day?	☐ YES ☐ NO	☐ YES ☐ NO
b) Do you or family member who will be insured consume alcohol? If YES, how many glasses of alcohol per week do/did you consume?	☐ YES ☐ NO	☐ YES ☐ NO
c) Have you or family member who will be insured ever used any substance or narcotics that resulted in an addiction problem? If YES, please state the type of substance/narcotics and details of usage?	☐ YES ☐ NO	☐ YES ☐ NO

	You	Family Member
6. Have you or family member who will be insured ever submitted a claim for accident, health, disability insurance or any other kind of compensation?	☐ YES ☐ NO	☐ YES ☐ NO
7. Have you or family member who will be insured ever suffered or had any treatment for: If YES, please provide details. a) epilepsy, mental disorder, depression or nervous disorder?	☐ YES ☐ NO	☐ YES ☐ NO
b) eye, ear, nose, throat disorder or illness, or other hearing or sight impairment?	☐ YES ☐ NO	☐ YES ☐ NO
c) Tuberculosis (TBC), or respiratory/ lung illness or disorder?	☐ YES ☐ NO	☐ YES ☐ NO
d) rheumatic fever, high blood pressure, chest pain, heart disease, blood circulation system, or blood vessel, or other blood disorder?	☐ YES ☐ NO	☐ YES ☐ NO
e) stomach disorder, ulcer, liver, gall bladder, or intestine disorder?	☐ YES ☐ NO	☐ YES ☐ NO
f) kidney stones, or other genital urinary system, disorder or sexual transmitted diseases?	☐ YES ☐ NO	☐ YES ☐ NO
g) cancer, tumor, cyst, or other abnormal growth?	☐ YES ☐ NO	☐ YES ☐ NO
h) diabetes mellitus, thyroid disease or disorder?	☐ YES ☐ NO	☐ YES ☐ NO
i) rheumatic, bone or join or muscle disorder?	☐ YES ☐ NO	☐ YES ☐ NO
j) AIDS or other AIDS related illness?	☐ YES ☐ NO	☐ YES ☐ NO
k) any other health problems, physical disablement, any other physical abnormalities, or wounds that have been mentioned above?	☐ YES ☐ NO	☐ YES ☐ NO
8. For the last 5 years have you or family member who will be insured: a) had or had been suggested to have the following examination: X-ray, ECG, USG, CT Scan, MRI, Blood Test such as cholesterol, AIDS, hepatitis including hepatitis B, anemia, etc.?	☐ YES ☐ NO	☐ YES ☐ NO
b) suffered from illness or had/has been hospitalized, surgery, health consultation, that has not been mentioned above (this applies whether it is to be provided by a Specialist or General Practitioner)?)	☐ YES ☐ NO	☐ YES ☐ NO
9. If you or family member that will be insured is a women a) have ever been pregnant?	☐ YES ☐ NO	☐ YES ☐ NO

	You	Family Member
b) are currently pregnant? If YES, what is current term of the pregnancy and please mention the approximate delivery date?	☐ YES ☐ NO	☐ YES ☐ NO
c) suffered from reproductive system, breast, pregnancy complication or disorder?	☐ YES ☐ NO	☐ YES ☐ NO
d) ever had or been asked by a doctor to have a pap smear examination?	☐ YES ☐ NO	☐ YES ☐ NO
e) ever had any hormonal disorder or imbalance such as non-menstrual bleeding severe period pain or other condition?	☐ YES ☐ NO	☐ YES ☐ NO

Raised Blood Pressure / Hyperlipidemia (high cholesterol)

(Applicable only if the applicants have ever had or been told to have, or currently undergoing any medical treatment for, ever been treated for, under observation for, Raised Blood Pressure/ Hyperlipidemia (high cholesterol)

1. Please provide the latest blood pressure and cholesterol reading and date.
   (If more space is required, please write on a separate sheet of paper and attach herewith.)

A. Raised Blood Pressure

Name of Person	Systolic & Diastolic Reading	Date of Reading	Is the person receiving medical treatment for Raised Blood Pressure?	Has the person's Raised Blood Pressure been managed and under the control* of a medical practitioner for at least twelve months?
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No

**) By 'control' we mean that for the last one year, you have been and is currently, under the supervision of your physician to monitor your Raised Blood Pressure.*

B. Hyperlipidemia (high cholesterol)

Name of Person	Total Cholesterol Level (Tchol)	Date of Reading	Is the person receiving medical treatment for Hyperlipidemia (high cholesterol)?	Has the person's Hyperlipidemia (high cholesterol) been managed and under the control* of a medical practitioner for at least twelve months?
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No

**) By 'control' we mean that for the last one year, you have been and is currently, under the supervision of your physician to monitor your Hyperlipidemia (high cholesterol).*

2. Please provide name and address of the treating doctor and clinic.

Name of Doctor	
Hospital/Clinic Address	Phone no : Fax no:

Family Doctor (The doctor that used to be visited and consulted with by you and family member who will be insured)

Name			
Address			
Phone no. / HP		he/she has been our family doctor for	year

Non-Disclosure

PT ASURANSI AXA INDONESIA (Insurer) is entitled not to pay the claim under this insurance contract or may cancel the contract if the proposer is not dis-close any relevant information that related to this contract. The insurer also has the right to void the contract if the non-disclosure is a fraudulent act.

Others

Do you wish to receive any interesting information or promotion from PT Asuransi AXA Indonesia or its partner?

Yes ☐ No ☐

Declaration

1. I hereby declare that I have answered all the questions provided in this form in good faith and complete. I am aware and understand if the answer or information that I have provided are incorrect, PT Asuransi AXA Indonesia reserves the right to cancel the policy without having the obligation to pay any benefit
2. I understand that the insurance coverage will be valid after its approved by PT Asuransi AXA Indonesia.
3. I hereby authorize PT Asuransi AXA Indonesia to use my personal data and information (such as name, address, phone number, etc) as stated in this form or in other means, including other parties which have an agreement relationship with PT Asuransi AXA Indonesia and/or its affiliates, in relation to any activities related to the policy issued under this form
4. Copy of this form or statement has the same legal force as the original.

_____ Place _____ / / Date	_____ Place _____ / / Date	COMPLETED BY AXA AUTHORISED PERSON
Proposer's Signature	Intermediary's Signature	Checked by: Date:

Please do not sign this form in blank condition and please make sure your answer according to the circumstances