Policy Number

Application Number H_____

Application Form for Global Health Access

An insurance contract is a contract of utmost good faith and the Proposed Principal Insured/Proposed Owner and Dependent(s) is required to disclose ALL material facts to AXA Philippines ("us"). Otherwise, the insurance policy may not be valid. All answers to the questions stipulated in this Application Form are the basis of and are an inseparable part of the insurance policy. In case of doubt as to whether a fact is material or not, the fact should be disclosed.

FOR OFFICE USE ONLY
Date Received: _____
Time Received: _____
Receiving Dept./Office: _____

1. DETAILS OF THE PROPOSED PRINCIPAL INSURED*

**DETAILS OF THE PROPOSED PRINCIPAL INSURED/PROPOSED OWNER if Principal Insured is same as proposed Owner*

Full Name	*(Last name, First name, Middle name)*
Date of Birth	*(yyyy/mm/dd)*
Place of Birth	*City,Province,Country*
Sex	*Male/Female*
Height	*Height: _____m/_____ft & in*
Weight	*Weight _____kg/_____lbs*
Nationality	*Nationality*
Civil Status	*Single/Married/Widowed/Divorced or Annulled*
Principal Country of Residence This refers to the country where the Proposed Principal Insured lives or intends to stay for most of the year being one hundred eighty-five (185) days or more and which will be shown as the Proposed Principal Insured's address and place of residence in our records. It is deemed to be in the Philippines.	*Country*
Is the Proposed Principal Insured a US citizen or a US tax resident? If yes, then please provide US TIN or SSN.	*Yes/No* *US TIN/SSN*
Identity Number (TIN, SSS or GSIS)	*Identity Type* *Identity Number*
RESIDENCE/PRESENT ADDRESS	*Unit/Floor Number, Building Name, Street, Barangay, City, Province, Zip Code*
PERMANENT ADDRESS (IF DIFFERENT FROM RESIDENCE ADDRESS)	*Unit/Floor Number, Building Name, Street, Barangay, City, Province, Zip Code*
BUSINESS ADDRESS	*Unit/Floor Number, Building Name, Street, Barangay, City, Province, Zip Code*
NATURE OF BUSINESS/WORK *(Please indicate source of fund; if employed, please include name of employer and position)*	
PREFERRED MAILING ADDRESS (Select One)	◯ Residence ◯ Permanent Address ◯ Business
Contact Information	*HOME PHONE:* *Contact Number* *BUSINESS PHONE:* *Contact Number* *MOBILE (Required):* *Contact Number* *EMAIL (Required):* *Email Address*
Does the Proposed Principal Insured have a current International Health cover with any other insurer? If yes, please provide details in the declaration of existing international health insurance page.	*Yes/No*
Are the Family Members to be insured (if any) also covered under the same International Health cover as the Proposed Principal Insured? If yes, please provide details in the declaration of existing international health insurance page.	*Yes/No*
Does the Proposed Principal Insured want to transfer the current International Health cover to Global Health Access?	*Yes/No*

2. DETAILS OF PROPOSED OWNER*

**This will only appear if the Proposed Principal Insured is not the same as Proposed Owner*

Is the Proposed Principal Insured the same as Proposed Owner?*	*Yes/No*
NATURE OF BUSINESS/WORK *(Please indicate source of fund; if employed, please include name of employer and position)*	
Is the Proposed Owner an Individual or a Corporation?	*Individual/Corporation*

This will only appear if the Proposed Owner is an Individual

Full Name	*(Last name, First name, Middle name)*
Date of Birth	*(yyyy/mm/dd)*
Place of Birth	*City, Province, Country*
Sex	*Male/Female*
Height	*Height: _____m/_____ft & in*
Weight	*Weight _____kg/_____lbs*
Nationality	*Nationality*
Civil Status	*Single/Married/Widowed/Divorced or Annulled*
Principal Country of Residence	*Country*
Is the Proposed Owner a US citizen or a US tax resident? If yes, then please provide US TIN or SSN.	*Yes/No* *US TIN/SSN*
Identity Number (TIN, SSS or GSIS)	*IdentityType IdentityNumber*
RESIDENCE/PRESENT ADDRESS	*Unit/Floor Number, Building Name, Street, Barangay, City, Province, Zip Code*
PERMANENT ADDRESS (IF DIFFERENT FROM RESIDENCE ADDRESS)	*Unit/Floor Number, Building Name, Street, Barangay, City, Province, Zip Code*
BUSINESS ADDRESS	*Unit/Floor Number, Building Name, Street, Barangay, City, Province, Zip Code*
PREFERRED MAILING ADDRESS (Select One)	◯ Residence ◯ Permanent Address ◯ Business
Contact Information	*HOME PHONE: Contact Number* *BUSINESS PHONE: Contact Number* *MOBILE (Required): Contact Number* *EMAIL (Required): Email Address*
Relationship of Proposed Owner to Proposed Principal Insured	
	CONTINGENT OWNER UPON DEATH OF OWNER (not applicable for Corporate Owner): _____ *RELATIONSHIP OF CONTINGENT OWNER TO PROPOSED PRINCIPAL INSURED (not applicable for Corporate Owner):* _____

This will only appear if the Proposed Owner is a Corporation

Full Business/Corporate Name	*Business/Corporate Name*
Business Type	*Business Type*
Business Address	*Unit/Floor Number, Building Name, Street, Barangay, City, Province, ZIP code*
Full name of Authorized Signatory 1 & Position	*Full name of Authorized Signatory 1* *Position*
Contact Information of Authorized Signatory 1	*HOME PHONE: Contact Number* *BUSINESS PHONE: Contact Number* *MOBILE (Required): Contact Number* *EMAIL (Required): Email Address*
Relationship of Proposed Owner to Proposed Principal Insured	
Full name of Authorized Signatory 2 & Position	*Full name of Authorized Signatory 2* *Position*
Contact Information of Authorized Signatory 2	*HOME PHONE: Contact Number* *BUSINESS PHONE: Contact Number* *MOBILE (Required): Contact Number* *EMAIL (Required): Email Address*
Relationship of Proposed Owner to Proposed Principal Insured	

3. FAMILY MEMBERS TO BE INCLUDED IN THE PLAN *(Limited to Spouse, Children and those with insurable interest based on Section 10 of the Insurance Code of the Philippines.)*

Sec. 10. Every person has an insurable interest in the life and health:
(a) Of himself, of his spouse and of his children;
(b) Of any person on whom he depends wholly or in part for education or support, or in whom he has a pecuniary interest;
(c) Of any person under a legal obligation to him for the payment of money, or respecting property or services, of which death or illness might delay or prevent the performance; and
(d) Of any person upon whose life any estate or interest vested in him depends.

	Family Member 1	Family Member 2	Family Member 3
Full Name	*(Last name, First name, Middle name)*	*(Last name, First name, Middle name)*	*(Last name, First name, Middle name)*
Date of Birth	*(yyyy/mm/dd)*	*(yyyy/mm/dd)*	*(yyyy/mm/dd)*
Place of Birth	*City, Province, Country*	*City, Province, Country*	*City, Province, Country*
Sex	*Male/Female*	*Male/Female*	*Male/Female*
Height	*Height: _____m/_____ft & in*	*Height: _____m/_____ft & in*	*Height: _____m/_____ft & in*
Weight	*Weight _____kg/_____lbs*	*Weight _____kg/_____lbs*	*Weight _____kg/_____lbs*
Nationality	*Nationality*	*Nationality*	*Nationality*
Civil Status	*Single/Married/Widowed/Divorced or Annulled*	*Single/Married/Widowed/Divorced or Annulled*	*Single/Married/Widowed/Divorced or Annulled*
Principal Country of Residence	*Country*	*Country*	*Country*
Is the Proposed Owner a US citizen or a US tax resident? If yes, then please provide US TIN or SSN.	*Yes/No* *US TIN/SSN*	*Yes/No* *US TIN/SSN*	*Yes/No* *US TIN/SSN*
Identity Number (TIN, SSS or GSIS)	*IdentityType* *IdentityNumber*	*IdentityType* *IdentityNumber*	*IdentityType* *IdentityNumber*
RESIDENCE/PRESENT ADDRESS	*Unit/Floor Number, Building Name, Street, Barangay, City, Province, Zip Code*	*Unit/Floor Number, Building Name, Street, Barangay, City, Province, Zip Code*	*Unit/Floor Number, Building Name, Street, Barangay, City, Province, Zip Code*
PERMANENT ADDRESS (IF DIFFERENT FROM RESIDENCE ADDRESS)	*Unit/Floor Number, Building Name, Street, Barangay, City, Province, Zip Code*	*Unit/Floor Number, Building Name, Street, Barangay, City, Province, Zip Code*	*Unit/Floor Number, Building Name, Street, Barangay, City, Province, Zip Code*
BUSINESS ADDRESS	*Unit/Floor Number, Building Name, Street, Barangay, City, Province, Zip Code*	*Unit/Floor Number, Building Name, Street, Barangay, City, Province, Zip Code*	*Unit/Floor Number, Building Name, Street, Barangay, City, Province, Zip Code*
NATURE OF BUSINESS/WORK *(Please indicate source of fund; if employed, please include name of employer and position)*			
PREFERRED MAILING ADDRESS (Select One)	◯ Residence ◯ Permanent Address ◯ Business	◯ Residence ◯ Permanent Address ◯ Business	◯ Residence ◯ Permanent Address ◯ Business
Contact Information	*HOME PHONE: Contact Number* *BUSINESS PHONE: Contact Number* *MOBILE (Required): Contact Number* *EMAIL (Required): Email Address*	*HOME PHONE: Contact Number* *BUSINESS PHONE: Contact Number* *MOBILE (Required): Contact Number* *EMAIL (Required): Email Address*	*HOME PHONE: Contact Number* *BUSINESS PHONE: Contact Number* *MOBILE (Required): Contact Number* *EMAIL (Required): Email Address*

4. BASIC PLAN DETAILS

Area of Cover	*Worldwide/WorldwideExcludingUS*
Plan Selected	
Annual Deductible	*Nil/PHP100,000/PHP200,000/PHP500,000*
Mode of Payment	*Annual/Semi-annual*
Method of Payment	*ADA/PDC/CC/Cash*

5. OTHER INSURANCE DETAILS

Please answer all the questions in full and to the best of your knowledge. If you are uncertain about whether the additional information you have is necessary to be declared, please declare anyway. It can only help us determine if our product will cater to your specific requirements.

	Proposed Principal Insured	Family Member 1	Family Member 2	Family Member 3	Family Member 4	Family Member 5
Please write down in the space provided the names of the persons to be insured according to the sequence in the previous pages	Full name of proposed principal insured _____	Full name of family member _____	Full name of family member _____	Full name of family member _____	Full name of family member _____	Full name of family member _____
Has the person to be insured a) ever had a life, health or critical illness application that was declined, deferred, or accepted with higher than standard premiums or an exclusion applied on health grounds?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
b) presently receiving a disability benefit or incapable for work or have ever made an insurance claim for disability, accident, medical care or critical illness and/or other insurance benefits?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No

If you answered "Yes" in the Other Insurance Details section, please provide details of "Yes" responses in the table below.

Person to be insured	Question No.	Name of Insurer	Details (date of occurrence/claim, terms offered and reason, claim amount, benefit type/source/reason for claim)

6. UNDERWRITING QUESTIONS *(To be completed for all persons to be insured)*

Disclosure: In accordance with the Insurance Commission's Circular Letter No. 2016-54, your medical information will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to your information in order to protect your right to privacy in accordance with law. A copy of Circular Letter No. 2016-54 may be accessed at the Insurance Commission's website at www.insurance.gov.ph.

Please answer all the questions in full and to the best of your knowledge. If you are uncertain about whether the additional information you have is necessary to be declared, please declare anyway. It can only help us determine if our product will cater to your specific requirements.

	Proposed Principal Insured	Family Member 1	Family Member 2	Family Member 3	Family Member 4	Family Member 5
Please write down in the space provided the names of the persons to be insured according to the sequence in the previous pages	Full name of proposed principal insured _____	Full name of family member _____	Full name of family member _____	Full name of family member _____	Full name of family member _____	Full name of family member _____
1. Has the person to be insured ever been treated for or ever had any sign or symptom of, or undergone consultations, investigations, medication, monitoring or advice for ANY of the following: a) Brain or Nervous System Disorder/Disease such as Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Cerebral Palsy, Dementia, Hydrocephalus, Multiple Sclerosis, Myasthenia Gravis, Parkinson's Disease, Muscular Dystrophy	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No

	Proposed Principal Insured	Family Member 1	Family Member 2	Family Member 3	Family Member 4	Family Member 5
Please write down in the space provided the names of the persons to be insured according to the sequence in the previous pages	Full name of proposed principal insured _____	Full name of family member _____	Full name of family member _____	Full name of family member _____	Full name of family member _____	Full name of family member _____
b) Mental Health Disorder such as Psychosis, Schizophrenia, Depression, Attention Deficit Disorder (ADD) / Attention Deficit Hyperactivity Disorder (ADHD)	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
c) Blood and Lymphatic System Disorder such as Hodgkin's Lymphoma, Multiple Myeloma, Thalassemia, Anti-phospholipid Syndrome (APAS)	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
d) Cancer of any type, Malignant tumor, Leukemia	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
e) Chronic Respiratory Conditions such as Chronic Obstructive Pulmonary Disease, Chronic Asthma, Chronic Bronchitis, Emphysema	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
f) Eye, Ear, Nose & Throat Disorder such as Corneal Ulcer, Deafness, Glaucoma, Retinal Detachment, Meniere's Disease/Syndrome	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
g) Heart and/or Cerebrovascular disease such as Angina (Chest pain), Heart Attack, Abdominal Aortic Aneurysm (AAA), Atrial Fibrillation (AF), Cerebrovascular Accident (CVA) or stroke including Transient Ischemic Attack (TIA), Cardiomyopathy, Supraventricular Tachycardia (SVT), Murmurs, Heart Failure, Heart Valvular Disease (such as Valvular Insufficiency/ Regurgitation, Mitral Valve Prolapse), Abnormal Heart Beat, or any Heart/Blood/Vascular Diseases.	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
h) Gastrointestinal Disorder such as Liver Cirrhosis, Fatty Liver, Colitis (Ulcerative), Crohn's Disease, Hepatitis B, Hepatitis C	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
i) Kidney and Urinary Tract Disorder such as Chronic Renal Failure, Chronic Kidney Disease, Polycystic Kidney Disease	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
j) Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex or any other AIDS related condition	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
k) Hypertension (High Blood Pressure), High Cholesterol, Dyslipidemia	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
l) Diabetes, other Endocrine Disorders Impaired Glucose Tolerance, Impaired Fasting Glucose	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
m) Musculoskeletal Diseases and Autoimmune Diseases such as Systemic Lupus Erythematosus, Psoriatic Arthritis, Rheumatoid Arthritis, Dermatomyositis, Mast Cell Activation Syndrome (MCAS), Degenerative Joint Disease	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No

	Proposed Principal Insured	Family Member 1	Family Member 2	Family Member 3	Family Member 4	Family Member 5
Please write down in the space provided the names of the persons to be insured according to the sequence in the previous pages	Full name of proposed principal insured _____	Full name of family member _____	Full name of family member _____	Full name of family member _____	Full name of family member _____	Full name of family member _____
n) Congenital Disorders such as Down Syndrome	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
o) Transplantations, Prosthetic implants & appliances in the body (e.g. shunts, pace-makers, or joint replacements)	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
2. Other than those already disclosed elsewhere in this form, has the person to be insured:						
a) Ever been prescribed, advised, or undergone any medication or medical treatment;	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
b) Currently taking any medication or medical treatment whether prescribed or not?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
3. Other than those already disclosed elsewhere in this form, has the person to be insured:						
a) Ever been hospitalized for more than five (5) days; or	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
b) Undergone any surgery or Out-patient procedures of any kind, such as but not limited to, cataract extraction, excision of mass or tumor, chemotherapy, incision and drainage, colonoscopy and other endoscopic procedures, blood transfusion, ophthalmologic procedures, casting, hemodialysis, dilatation & curettage, radioactive iodine therapy, etc.	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
4. Has the person to be insured:						
a) Ever had results/investigations that are abnormal or that fall outside the reference range, for example but not limited to biopsy, endoscopy, pap smear, mammogram, breast ultrasound, Prostate-Specific Antigen (PSA) test, prostate examination, tumor marker, blood tests, cancer screening tests, health checks, or pathology;	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
b) Currently awaiting the completion or results of any medical investigation or diagnostic tests;	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No
c) Intending to seek or currently seeking any medical advice, examination, or procedure other than Annual Physical Exam or Executive Check up?	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No	◯Yes ◯No

If you answered "Yes" in the Underwriting Questions section, please provide details of "Yes" responses in the table below.

Person to be insured	Question No.	Details of medical condition (including date of first and last consultation, nature of treatment, dosage, results and where applicable, state the area of the body affected, e.g. right eye, left leg, etc.	Present state of health	Name & address of each doctor or hospital

7. CLIENT DETAILS

	Proposed Principal Insured	Family Member 1	Family Member 2	Family Member 3	Family Member 4	Family Member 5
1. Do you smoke cigarettes/ e-cigarettes/vape/smokeless tobacco? (If yes, indicate no. of sticks/packet per day, ml per day & no. of years)	*Yes/No* PI no. of: sticks/day; packets/day; months/years ml per day (for vaping)	*Yes/No* FM1 no. of: sticks/day; packets/day; months/years ml per day (for vaping)	*Yes/No* FM2 no. of: sticks/day; packets/day; months/years ml per day (for vaping)	*Yes/No* FM3 no. of: sticks/day; packets/day; months/years ml per day (for vaping)	*Yes/No* FM4 no. of: sticks/day; packets/day; months/years ml per day (for vaping)	*Yes/No* FM5 no. of: sticks/day; packets/day; months/years ml per day (for vaping)
2. Are you and/or your immediate family member entrusted with appointive or elective position in the Philippines or in a foreign state, a senior politician, judicial or military official, senior executive of government or state-owned or controlled corporations or political party official?	*Yes/No* *Position/Public Office:*	*Yes/No* *Position/Public Office:*	*Yes/No* *Position/Public Office:*	*Yes/No* *Position/Public Office:*	*Yes/No* *Position/Public Office:*	*Yes/No* *Position/Public Office:*

8. TELEPHONE UNDERWRITING AUTHORIZATION

I/We, hereby permit AXA Philippines to call me/us to clarify or obtain further information regarding any matter pertaining to the assessment and processing of my/our application for health insurance.

I / We understand that:

- I am/we are required to be truthful to the best of my/our knowledge
- The call is recorded and will take a few minutes of my /our time
- My/our answers will be binding and shall form part of the basis of my/our application for this policy. The result of the call will be documented and a copy of which, shall be attached to the policy contract.

I / We may be contacted at any of the contact numbers declared in the application form.

Preference: ◯ During Office Hours ◯ Others Specify _____

9. DECLARATIONS AND AGREEMENT BY THE PROPOSED OWNER FOR AND ON BEHALF OF ALL THE PERSONS TO BE INSURED:

1.I/We hereby apply for Global Health Access insurance policy underwritten by AXA Philippines ("AXA"). By signing this Application Form, I/We confirm that I/We agree to accept the terms, conditions, exclusions and limitations stated in the Global Health Access policy contract and that I/we confirm that I/we read this Application Form carefully and the questions were fully explained to me/us in a language/dialect which I/We understand. I/We have read and understood all declarations and agreements which are hereby given and made willingly and voluntarily and with full knowledge of my rights under the law.

2. I/We hereby declare that to the best of my/our knowledge and belief that the statements and answers given in this Application Form are true and complete and that I/we have not withheld any material facts, that is, facts likely to influence the assessment and acceptance of this Application Form. I/We understand that any mis-statement of facts, whether by commission or by omission may be grounds for AXA, in its absolute and sole discretion, to decline to pay any benefit under the policy and also, to void the policy. I/We agree that this Application Form, together with any additional statements signed by me/us which shall be deemed to be part of this declaration, shall be the basis of the contract of insurance.

3. I/We agree that if the health status of any of the above mentioned persons to be insured changes after this Application Form is signed and before AXA issues the policy, I/we shall immediately notify AXA of the changes, otherwise, AXA reserves the right to void the policy.

4. I/We understand and agree that AXA has the right to accept or decline this application. If AXA accepts my/our application, I/we agree to let AXA issue the formal policy documents.

5. I/We understand that AXA reserves the right to request for a copy of the latest medical report from me/us at my/our own expense should further medical information be required.

6. I/We also agree that in case of any claims, I/we authorize any hospital, physician or other person who has attended to us, or has examined us or who is authorized to maintain medical records to disclose, when requested to do so by AXA, any and all information with respect to any illness or injury, medical history or treatment. A photocopy of this authorization shall be considered as effective and valid as the original.

7. I/We hereby authorize any person, physician, clinic, hospital, insurance company, or other organization, insurance association, institution, that has any record or knowledge of my/our health and/or financial information to disclose or release to AXA or its authorized companies and their affiliates any medical information sharing facility of the insurance industry, or any government agency requiring such, for any legitimate purpose, including underwriting and administration of insurance coverage and claims.

8. I/We authorize AXA to request and obtain from third parties, whether government agencies or private entities, any information concerning me/us relevant to this Application Form, including medical or financial information.

9. Any of my/our personal information collected or held by AXA Philippines (whether contained in the application/s or otherwise), may be used in connection with matching for whatever purpose with such other personal information and/or may be used, stored, disclosed, transferred (whether within or outside the Philippines) to such persons as AXA Philippines may consider necessary, including without limitation but not limited to any of its affiliated or related companies, or any individuals/organizations/corporations/entities associated with AXA Philippines:

a. to process and deal with my application/policy;
b. to provide all services related to my application/policy, to promote other products/services by AXA Philippines and its affiliated

or related companies/entities, and to process my information for product development and for marketing purposes;
c. to communicate with me for any purpose and/or to comply with the laws of any applicable jurisdiction.

I/We also authorize AXA to disclose my/our personal information to affiliated entity(ies), or to persons or entities providing services on AXA's behalf, or to any medical information sharing facility of the insurance industry, or any government agency requiring such, for any legitimate purpose, including underwriting and administration of insurance coverage and claims, consistent with the purpose for which the information was obtained. I/We understand that AXA does not sell any of my/our personal information.

I/We understand that we have the right to access our personal information at any time; correct or rectify any information collected or held by AXA Philippines which are inaccurate, false, or incomplete; object in case of any unauthorized collection; erase or block information which is incomplete, outdated and false; and such other rights as may be available under the Data Privacy Act.

10. I/We have the right to request access to and correct any of my/our personal information held by AXA. I/We understand that such request may be made in writing and submitted to the Policy Services Unit of AXA.

11. I/We declare that I/we have informed AXA of all my/our citizenships, residencies and tax residencies, and provided AXA with my/our taxpayer identification number(s). I/We agree to promptly update AXA of any changes to said information. I/We authorize AXA to disclose my/our personal information to any government or tax authority (within or outside the Philippines) for the purposes of ensuring AXA's compliance with applicable laws and regulations.

I/We agree that AXA shall have the right to: (a) require the claimant(s) and/or payee(s) of the policy to provide AXA with their above-mentioned personal information and/or sign such documents as AXA may reasonably require; (b) and disclose said personal information to any government or tax authority (whether within or out of the Philippines) for the purposes of AXA's compliance with applicable laws and regulations. If I/we fail to any of the above-mentioned acts, I/we agree that AXA may provide my/our personal information to such government or taxation authority(ies) to comply with the applicable laws and regulations.

12. I/We understand that AXA PH will store my/our personal information for at least five (5) years or a period as may be allowed under the Data Privacy Act and applicable laws and regulations.

13. I/We understand that AXA PH, upon my/our request, will provide the contact details of the personal information controller or the responsible officer in charge of the custody of my/our personal information.

14. The premiums paid for the insurance have been declared to relevant tax authorities and none of it was derived, directly or indirectly, from illegal activities or sources and/or tax evasion. If required by the proper tax and/or other governmental authorities, AXA may, in its discretion, disclose certain information about me/us or about my policy.

15. I/We confirm that my/our Principal Country of residence is stated correctly in Part 1 of this Application Form. I/We understand and agree to inform AXA immediately if any of the member changes the Principal Country of Residence and AXA reserves the right to revise the premium or to decline to continue the cover.

16. I/We understand that the designated Contingent Owner (if any) will automatically become the new Owner of this policy or in the event that I/we have not designated a Contingent Owner, I/we understand that the Principal Insured shall automatically become the new Owner of the policy in the event that the Owner predeceases the Principal Insured person while the policy is in force.

17. I/We also understand that the membership card(s) issued for this policy are to be used only for admissions to hospitals for treatments within the policy terms and conditions. In the event that charges incurred are not claimable from the policy for any reason, I/we shall undertake to pay AXA within 30 days from the receipt of all expenses that are not claimable under the policy. I/We further agree to return the membership card(s) upon request from AXA or on termination of the policy or termination of coverage for any insured person.

18. I understand that notices related to my policy may be sent to me through mail, email or SMS in the mailing/email address/number I provided above.

19. There shall be no contract of insurance unless and until a policy is issued on this Application Form and the full first premium of the basic health insurance and any special benefit applied for, according to the mode of payment specified in answer to Part 4, is actually paid during the lifetime and good health of all persons to be insured.

20. I/We have read and fully understood the Health Insurance Proposal (or the illustration of benefits) for the policy applied for.

21. An electronic copy of this application shall be binding to me/us and shall be considered, for all intents and purposes, as originally signed document. I/We will inform the Company of any inaccuracy or error in my/our personal data as soon as possible, and I/we understand that absent any request for correction within a reasonable period, the Company shall rely on the electronic copy exclusively.
An electronic copy of the policy contract shall be sent to the Owner's declared email address by default. Upon request and payment of reasonable fee, a hard copy of the policy contract may be delivered to the nearest AXA Philippines Service Center for pick up by the Owner or his/her representative or directly to the Owner's mailing address, whichever is preferred.
My/Our electronic submissions shall constitute my/our intention to apply for this Policy and be bound by the terms and conditions relating to all transactions undertaken, including but not limited to receipt of notices, presentation and purchase.

22. I/We authorize AXA Philippines to credit new business payment refund or AXA initiated payments, if any, to my nominated bank account number as may be indicated on my signed Auto-Debit Arrangement Form (ADA Form).

- ◯ I understand and agree that by filling out my personal information above, I authorize AXA Philippines, including its affiliates, subsidiaries, third parties contracted by AXA Philippines, to use said personal information to evaluate and assess my request.
- ◯ I consent to receive notices and announcements for marketing purposes via Short Messaging Services (SMS), email, other electronic platform, or telephone call from AXA Philippines, its affiliates, subsidiaries, including any person or entities providing services on AXA's behalf, consistent with the purpose for which the information was obtained.
- ◯ I agree for my agent/financial advisor to have access to my policy details and claims transactions, and I authorize AXA Philippines to discuss and/or share claims and medical information to my agent/financial advisor.

Signature (Proposed Principal Insured)	Signature (Proposed Owner)
Date of Signing: *(yyyy/mm/dd)*	Place of Signing:

**(If this form was filled out by an Advisor/FE) I certify that I have acted under the direction and authority of the Owner and that the Owner and/or Proposed Principal Insured signed this Application Form in my presence.

Name of Advisor/FE:	Name of Advisor/FE:
Code:	Code:
Signature:	Signature:

10. DISTRIBUTOR'S DECLARATION

I ensure that I, as the distributor, have guided the client in completing all relevant and necessary information to assist the Company in assessing the application. I further declare that:

1. The information provided by the client in the application form are accurate and complete;
2. I/We also certify that I/we saw the Proposed Insured (and Owner, if applicable) and have verified his/her identity at the time of signing this application;
3. I shall make known to the Company any and all factors which, if known to the Company, may result in an applicant receiving rated or no coverage at all; and
4. Any additional information that shall be required by the Company in order to determine any particular application shall be provided on a timely basis.

Name of Advisor/FE	Signature of Advisor/FE

CONTACT US

For any concerns or queries, you are welcome to contact us on the details below:
Customer Service Hotline: (+632) 8-5815-AXA (292), Operating Hours: 8:00 AM - 8:00 PM, Monday - Friday
Email: customer.service@axa.com.ph

Alternatively, you can write to:
AXA Philippines - Customer Service Department
34th Floor, GT Tower International
6813 Ayala Ave. corner H.V. Dela Costa St.
Makati City, Philippines 1226

IMPORTANT NOTICE

The Insurance Commission, with offices in Manila, Cebu and Davao, is the government office in charge of the enforcement of all laws related to insurance and has supervision over insurance providers and intermediaries. It is ready at all times to assist the general public in matters pertaining to insurance. For any inquiries or complaints please contact the Public Assistance and Mediation Division (PAMeD) of the Insurance Commission at 1071 United Nations Avenue, Manila with telephone numbers +632-8-5238461 to 70 and email address pubassist@insurance.gov.ph.
The official website of the Insurance Commission is www.insurance.gov.ph

This will appear if the Proposed Principal Insured has an existing International Health cover

DECLARATION OF EXISTING INTERNATIONAL HEALTH INSURANCE OF PROPOSED PRINCIPAL INSURED

Name of Existing Insurer:	
Type/Name of Plan:	
Effective Date	
Expiry Date	
Has the Policy been accepted on Standard Cover? ◯Yes ◯No this means that the existing policy was accepted WITHOUT any of the following: • extra premium loading • exclusion(s) • limitation(s)	

**There should not be any gap in cover between the date of cover with the previous insurer to the date covered with Global Health Access.*

For evaluation purposes, we will require you to provide us a copy of your complete Policy Contract with your existing insurer or existing terms and conditions of your written insurance plan above with your existing insurer.

This will appear if there is a family member covered under the same International Health cover as the Proposed Principal Insured

DECLARATION OF EXISTING INTERNATIONAL HEALTH INSURANCE OF FAMILY MEMBER 1

Name of Existing Insurer:	
Type/Name of Plan:	
Effective Date	
Expiry Date	
Has the Policy been accepted on Standard Cover? ◯Yes ◯No this means that the existing policy was accepted WITHOUT any of the following: • extra premium loading • exclusion(s) • limitation(s)	

DECLARATION OF EXISTING INTERNATIONAL HEALTH INSURANCE OF FAMILY MEMBER 2

Name of Existing Insurer:	
Type/Name of Plan:	
Effective Date	
Expiry Date	
Has the Policy been accepted on Standard Cover? ◯Yes ◯No this means that the existing policy was accepted WITHOUT any of the following: • extra premium loading • exclusion(s) • limitation(s)	

DECLARATION OF EXISTING INTERNATIONAL HEALTH INSURANCE OF FAMILY MEMBER 3

Name of Existing Insurer:	
Type/Name of Plan:	
Effective Date	
Expiry Date	
Has the Policy been accepted on Standard Cover? ◯Yes ◯No this means that the existing policy was accepted WITHOUT any of the following: • extra premium loading • exclusion(s) • limitation(s)	

**There should not be any gap in cover between the date of cover with the previous insurer to the date covered with Global Health Access.*

For evaluation purposes, we will require you to provide us a copy of your complete Policy Contract with your existing insurer or existing terms and conditions of your written insurance plan above with your existing insurer.