KAISER INTERNATIONAL
HEALTHGROUP, INC

HEALTH CARE PROGRAM MEMBERSHIP APPLICATION

I hereby apply for membership in the Health Care Program of Kaiser International Healthgroup, Inc. (Kaiser) describe herein subject to the Contract Provisions set forth in this Application. I agree that this Application and my declarations and answers below, written by me or under my direction, shall be the basis, and deemed part of the contract between Kaiser and myself.

Family Name	First Name	Middle Name	Age	Gender

Date of Birth (mm/dd/yy)	Place of Birth	Height	Weight

Address

No. of Home	Street	Brgy	City	Province

Home Tel. No.	Office Tel. No.	Mobile No.	Email	GSIS ID No.	SSS ID No.

Civil Status	Occupation	Company Name	Designation

Plan Type ☐ Individual ☐ Family | Plan Name | Premium

Contact person in case of emergency? | Contact No. :

INFORMATION OF DEPENDENTS UNDER NATIONAL HEALTHCARE SHIELD:

DEPENDENT 1

Last Name _____ First Name _____ Middle Name _____ Relation to Principal _____

Address _____ Date of Birth _____

Gender _____ Civil Status _____ Height _____ Weight _____ Occupation _____

Telephone _____ Mobile No. _____

DEPENDENT 2

Last Name _____ First Name _____ Middle Name _____ Relation to Principal _____

Address _____ Date of Birth _____

Gender _____ Civil Status _____ Height _____ Weight _____ Occupation _____

Telephone _____ Mobile No. _____

DEPENDENT 3

Last Name _____ First Name _____ Middle Name _____ Relation to Principal _____

Address _____ Date of Birth _____

Gender _____ Civil Status _____ Height _____ Weight _____ Occupation _____

Telephone _____ Mobile No. _____

MEDICAL REFERENCES (DEPENDENT)

Please provide information or explanatory notes for every question with a YES answer.

1. Have you ever been treated for or ever had any known indication of:
   a. Disorder of eyes, ears, nose, or throat? NO____ YES ____
   b. Dizziness, fainting, convulsions, headache, speech defect paralysis or stroke, mental or nervous disorder? NO____ YES ____
   c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? NO____ YES ____
   d. Diabetes thyroid or other endorcrine disorder? NO ___YES ___
   e. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or any other disorder of the heart or blood vessles? NO____ YES ____
   f. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, diverticulitis, colitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach intestine, liver or gall bladder? NO____ YES ____
   g. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate or reproductive organs? NO____ YES ____
   h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, such as spine, back or joints? NO____ YES ____

i. Deformity, lameness or amputation? NO___ YES___

j. Disorder of skin, lymph glands, cysts, tumor or cancer? NO___ YES___

k. Allergies, anemia or other disorder of the blood? NO___ YES___

l. Excessive use of alcohol, tabacco or any habit-forming drug? NO___ YES___

2. Are you now under observation or taking treatment? NO___ YES___

3. Do you smoke? NO___ YES___

4. Other than above, have you:

a. Had any physical disorder or any known indication thereof? NO___ YES___

b. Had a medical examination, consultations, illness, injury, surgery? NO___ YES___

c. Been a patient in a hospital, clinic, sanitarium, or other medical facility? NO___ YES___

d. Had electrocardiogram, x-ray or other diagnostic test? NO___ YES___

5. Have you ever had military service deferment, rejection or discharge because of physical or mental condition? NO___ YES___

6. Have you ever applied for or receive a pension, payment, or benefit due to injury, sickness or disability? NO___ YES___

7. Have you a parent, brother, sister who died of or had high blood pressure, tuberculosis, diabetes, cancer, heart or kidney disease, or mental illness? NO___ YES___

8. FOR FEMALES ONLY:

a. Fave you ever had any abnormal menstruation, prenancy, childbirth or disorder of the female organs or breast? NO___ YES___

b. Are you now pregnant? NO___ YES___

c. Are you taking contraceptive pills? NO___ YES___

9. Have you ever been rejected or terminated for medical Insurance including KAISER program, or have been offered Insurance at a higher (rated-up) premium? NO___ YES___

I declare that the statements and answers contained herein are full, complete and true, and if found otherwise, I agree that the Health Care agreement may be invalidated. I hereby authorize any person or entity having a record or knowledge of my health to give to Kaiser all information relative to hospitalization, medical treatment or consultation that I may have undergone.

I agree that no binding agreement is created by the mere signing of this application until it is accepted and approved by Kaiser International Healthgroup Inc, containing the Contract Provisions signed by the duly authorize officials of Kaiser International Healthgroup , Inc., is issued to me.

IN WITNESS THEREOF, I have signed this Application this _____ day of _____ ,
20 _____ in _____ (city / province where Applicant purchased the Kaiser Plan)

_____
Signature of Applicant

_____
Printed Name

_____
Signature of Sales Counselor

_____
Printed Name

_____
Counselor's Code

_____
Signature of Sales Counselor

_____
Printed Name

_____
Counselor's Code

_____
Name of Marketing Director / Sales Manager & Code