

PassportCard International Health Insurance Plan Newborn (0-6 months) Application Form

If you are adding a newborn to an existing Plan, please provide us with your existing policy no. as stated on your Membership Certificate:

1. Member Details:

Parent Surname:	Parent First Name:
Newborn Surname:	Newborn First Name:
Gender / Date of Birth	
Passport Country	Passport No.

2. Health Status Questionnaire:

Please answer the following questions on the basis of the newborn's complete medical history. All material facts must be disclosed. Failure to do so may invalidate or severely limit entitlement to cover or benefits under the PassportCard Plan. If you are in any doubt as to whether a fact is material, then such fact should be disclosed.

- A.** Please note that your answers to the following medical questionnaire will enable PassportCard to perform a risk evaluation concerning your newborn's medical insurance cover. Incomplete or incorrect answers may affect entitlement for cover.
- B.** The questionnaire must be filled-in separately for each newborn seeking cover under this insurance plan.
- C.** The Parent/Applicant may answer on the newborn's behalf.
- D.** Any positive answer to the questions in the questionnaire will require an additional description to be given in Section 3. If a certain question is not clear, or if you wish to receive additional information concerning the disclosure obligation or pre-existing conditions, do not hesitate to contact your broker or PassportCard directly via the phone number listed at the bottom of each page.



QUESTIONS		Newborn Applicant	
		Yes	No
Weight in kg.	Height in cm.		
1 Does or did your child suffer, are they being treated or were they treated or diagnosed with disorders or diseases of the heart or of the blood vessels, including abnormal blood tests?			
2 Does or did your child suffer, are they being treated or were they treated or diagnosed with disorders or diseases of the nervous system?			
3 Does or did your child suffer, are they being treated or were they treated or diagnosed with disorders of the digestive system (esophagus, stomach, intestines, or anus)?			
4 Does or did your child suffer, are they being treated or were they treated or diagnosed with disorders or diseases of the skeleton, joints, muscle system or joint tissue?			
5 Does or did your child suffer, are they being treated or were they treated or diagnosed with disorders of the respiratory system, including lung diseases and/or diseases of the respiratory airways (anomaly of nasal septum, sinusitis, or asthma)?			
6 Does or did your child suffer, are they being treated or were they treated or diagnosed with disorders of the genital system?			
7 Does or did your child suffer, are they being treated or were they treated or diagnosed with disorders or diseases of the urinary tract and kidneys?			
8 Does or did your child suffer, are they being treated or were they treated or diagnosed with hormonal or metabolic disorders, including disorders of the thyroid gland?			
9 Does or did your child suffer, are they being treated or were they treated or diagnosed with congenital diseases?			
10 Does or did your child suffer, are they being treated or were they treated or diagnosed with disorders of undescended testis?			
11 Was your child born prematurely (under 37 weeks) or were they admitted to the neonatal & premature baby ward due to low birth weight or other medical problems?			

3. Medical Details

Please describe in detail (according to the questions you answered positively in the questionnaire) the status of the condition, dates of medical treatment, diagnosis, prognosis, course of treatment and data of the primary care physician.

Question No.

Question No.

Question No.

Question No.

* An additional page for providing a more detailed description may be attached to this application form, if necessary.

4. Declarations

I hereby declare that:

1. I have checked and confirm the completeness, accuracy and truthfulness of the statements and information provided in the application form.
2. I understand that providing answers to the questions contained in this application form including the medical questionnaire that are either incomplete, incorrect, untruthful or imprecise may affect the cover or entitlement to benefits under the PassportCard Plan.
3. If a medical condition develops after submitting a completed application form to PassportCard, but before the insurance cover comes into effect, I am required to notify PassportCard and update the answers that were provided in the medical questionnaire above. Failure to do so will infringe upon the rights as aforementioned in declaration number 2 above.
4. I understand that the insurance cover will only be effective subject to acceptance to the PassportCard Plan.
5. I understand that the entitlement to benefits under the PassportCard Plan is subject to the terms and conditions of the PassportCard Plan and the Table of Benefits in effect at the time the insurance cover under the PassportCard Plan comes into effect.
6. It is my responsibility to check the accuracy of the information contained within the Membership Certificate, once issued.
If the content is not in accordance with the Application Form, and I do not notify PassportCard otherwise, the information on the Membership Certificate will be assumed to be correct.
7. I understand that it is my obligation to update PassportCard about any change to any details contained in this Application form including general and personal details.

5. Parent Signature

Full Name

Signature

Date

The newborn birth certificate must be submitted to the Plan Administrator within three months of the child's birth.