ValuCare
HealthCare You Can Count On

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APPLICATION FOR MEMBERSHIP

MNR: ☐☐–☐☐☐☐☐☐☐☐–☐☐☐–☐☐

AGENT CODE: ☐☐☐☐☐–☐☐☐

EFFECTIVE DATE: ☐☐–☐☐–☐☐☐☐

MM-DD-YYYY

INSTRUCTIONS:

Please use ink or typewriter to complete the questionnaire. Use separate questionnaire for each member of your family who is applying for membership. **ALL QUESTIONS MUST BE ANSWERED**. Failure to do so shall forfeit application for membership. **ALL ERASURES MUST BE COUNTER SIGNED**. Shaded portions are for VALUCARE's use only. Please submit photocopy of any valid ID with picture (Passport, SSS, Driver's License, and PRC License ID). Foreign nationals need to present valid passport, Alien Certificate of Registration, Alien Employment Permit, or any government issued identification document bearing the photograph of the customer.

IMPORTANT

ANY FORM OF MATERIAL MISREPRESENTATION AND/OR NON-DISCLOSURE OF PRE-EXISTING CONDITION OR ILLNESS WILL VOID YOUR COVERAGE.

1. LAST NAME

❑ Network Access Without MMC, SLMC, CSMC, DDH,TMC and AHMC
❑ Network Access with MMC, SLMC, CSMC, DDH, TMC and AHMC

2. FIRST NAME

23. MODE OF PAYMENT
❑ ANNUAL ❑ QUARTERLY
❑ SEMI-ANNUAL ❑ MONTHLY

23. DENTAL
❑ YES
❑ NO

3. MIDDLE NAME

24. MEMBERSHIP STATUS
❑ PRINCIPAL ❑ DEPENDENT OF _____
RELATIONSHIP TO PRINCIPAL: _____

4. PRESENT ADDRESS

25. PHILHEALTH NO.
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

5. PERMANENT ADDRESS

26. SPOUSE NAME (IF APPLICABLE)

6. HOME PHONE | 7. MOBILE NO. | 8. E-MAIL ADDRESS

27. SPOUSE PHILHEALTH NO.
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

9. PLACE OF BIRTH

28. TELEPHONE NUMBER | 29. CELLPHONE NUMBER

10. DATE OF BIRTH (MM/DD/YYYY) | 11. AGE | 12. HEIGHT (FT/IN) | 13. WEIGHT (KG)

30. NAME OF BENEFICIAL OWNER *(IF APPLICABLE)*

14. CITIZENSHIP

15. SEX
❑ MALE
❑ FEMALE

16. CIVIL STATUS
❑ SINGLE ❑ WIDOWER
❑ MARRIED ❑ LEGALLY SEPARATED

31. NAME OF BENEFICIARY

17. EMPLOYMENT STATUS
❑ EMPLOYED IN PRIVATE ❑ SELF-EMPLOYED ❑ OTHERS:_____
❑ EMPLOYED IN GOVERNMENT ❑ OCW

32. NATIONALITY | 33. PROOF OF IDENTIFICATION AND ID NUMBER

18. EMPLOYER / BUSINESS NAME | 19. NATURE OF BUSINESS

34. SOURCES OF FUNDS OR PROPERTY

20. BUSINESS ADDRESS

35. TAX IDENTIFICATION NO. (TIN)

21. TYPE OF ACCOUNT
❑ INDIVIDUAL ❑ GROUP ❑ ASO
❑ FAMILY ❑ CORPORATE ❑ OTHERS:_____

36. SOCIAL SECURITY SYSTEM (SSS) / GOVERNMENT SERVICE INSURANCE SYSTEM (GSIS) NUMBER (IF APPLICABLE)

22. TYPE OF PROGRAM
❑ SUITE PLAN ❑ REGULAR PRIVATE ❑ WARD
❑ LARGE PRIVATE ❑ SEMI-PRIVATE ❑ OTHERS:_____

MEDICAL QUESTIONNAIRE

37. Were you a previous member of any HealthCare company? ❑ Yes ❑ No If YES, please give name of company:

_____ When did your former membership begin_____ and end? _____

38. Have you been treated/examined/hospitalized while a member of this HealthCare company? ❑ Yes ❑ No If YES, please list location and last exam of treatment._____

39. Have you ever been rejected for medical insurance, including HealthCare plan, or been offered insurance at a higher (rated up) premium?

❑ Yes ❑ No If YES, please explain _____

40. Do you regularly drink alcohol? ❑ Yes ❑ No If YES, please pick ❑ Beer ❑ Wine ❑ Hard Liquor

How much do you consume? _____

Do you smoke? ❑ Yes ❑ No If YES, how many sticks per day? _____ How long have you smoked? _____

IF YOU QUIT, how many years did you smoke? _____ How long since you've quit? _____

41. PHYSICAL EXAM HISTORY: Check the appropriate box and state the name and address of examining M.D. date of exam.

❑ Routine examination _____

❑ OB-GYN (Obstetrics-Gynecology) _____

❑ Other (Please specify) _____

42. Have you ever been advised to have surgery which you have not yet undergone? ❑ Yes ❑ No

If YES, please give details._____

43. How many times have you visited a physician in the last 12 months? _____

Please list reasons for visit (symptoms, complaints, etc.)_____

FOR COMPANY USE ONLY	
CASHIER	MEMBERSHIP DATA ADMINISTRATION

QUESTIONS NO. 46-48 MUST BE ANSWERED BY ALL FEMALE APPLICANTS OVER THE AGE OF 13

44. Date of you last menstrual period: ☐☐ ☐☐ ☐☐ (MO DAY YEAR) 46. Are you pregnant? ❑ Yes ❑ No

45. History of menstrual flow: ❑ Regular ❑ Irregular ❑ Dysmenorrhea

47. Have you ever been hospitalized, diagnosed, or treated for any of the following? If YES, please place a check in the box ☑.

(FOR EVERY BOX CHECKED, PLEASE UNDERLINE THE ILLNESS & EXPLAIN IN NUMBER 51)

- ❑ Alcoholism
- ❑ Serious anemia or other blood diseases
- ❑ Arthritis, gout or painful joints
- ❑ Asthma/wheezing
- ❑ Chronic cough, emphysema or other chronic lung diseases
- ❑ Back ache or back injury
- ❑ Serious bodily injury or disability
- ❑ Cancer, leukemia or tumors
- ❑ Convulsions, seizures or epilepsy
- ❑ Diabetes mellitus
- ❑ Diarrhea or colitis (chronic), rectal bleeding or other rectal ailment
- ❑ Ear problems or loss of hearing
- ❑ Tubes now present in ear for otitis media
- ❑ Heart attack or other heart trouble
- ❑ Heart murmur
- ❑ Hypertension or high blood pressure
- ❑ Hernia surgically repaired? ❑Yes ❑ No
- ❑ Immune Deficiency Syndromes, example AIDS
- ❑ Ulcers of stomach or duodenum
- ❑ Venereal disease
- ❑ Persistent Indigestion or peptic symptoms
- ❑ Kidney condition, kidney stones
- ❑ Loss of urine control, bladder problems or difficulty in urination
- ❑ Prostate problems
- ❑ Liver conditions ❑ Cirrhosis ❑ Jaundice ❑Hepatitis
- ❑ Paralysis/Strokes

❑ Eye condition (cataract, iritis, etc.)
❑ Glaucoma
❑ Gall bladder stones surgically removed? ❑ Yes ❑No
❑ Goiter or thyroid condition
❑ Hay fever or allergies
❑ Currently on allergy injections
❑ Migraine headache
❑ Serious skin disease, melanoma, psoriasis
❑ Female organ abnormality
❑ Irregular vaginal bleeding
❑ Mental/emotional disorders
❑ Psychiatric counseling
❑ Drug addiction or abuse (Please specify)

48. Have you ever been treated for any other condition not listed above? ❑Yes❑ No If Yes, Please describe:_____
_____

49. If YES is checked for any condition in items 49 through 50, give details below:

CONDITION	HOSPITAL NAME (If hospitalized)	ATTENDING PHYSICIAN	PHYSICIAN'S ADDRESS	DATE OF LAST TREAMENT

(IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET)

50. Do you have or have you had unexplained and/or undiagnosed symptoms, such as weight loss, swollen glands, fever, skin lesions, rash or rectal problems? ❑ Yes ❑ No If YES, please explain: _____

51. Are you currently taking medications for any of the conditions noted in items 39 or 40? ❑ Yes ❑ No If YES, pls. list medicines.
_____

Are you currently or regularly taking any other medications or drugs? ❑ Yes ❑ No If YES, please list them down:
_____

52. Are any of the above conditions now present? ❑ Yes ❑ No If YES, which condition(s)?
_____

53. Do you engage in any hazard sports or activities? ❑ Yes ❑ No If YES, please explain:
_____

54. State the name and address of your family physician.
_____

I M P O R T A N T

THIS APPLICATION FORM AND MEDICAL QUESTIONNAIRE MUST BE UPDATED TO INCLUDE ANY CHANGES IN CONDITION OR DISEASE, WHICH OCCURS AFTER DATE OF SUBMISSION OF APPLICATION AND PRIOR TO VALUCARE ACCEPTANCE. FAILURE TO PROVIDE THIS INFORMATION TO VALUCARE WILL CONSTITUTE A MISREPRESENTATION OF THE PRESENCE OF PRE-EXISTING CONDITION OR DISEASE AND MAY VOID THE COVERAGE. RECEIPT OF MEMBERSHIP FEES BY VALUCARE DOES NOT CONSTITUTE APPROVAL OF THE APPLICATION AS VALUCARE MEMBER. AS SUCH, PAYMENT IS TREATED AS A DEPOSIT. VALUCARE RESERVES THE RIGHT TO REJECT ANY APPLICANT AND IS NOT OBLIGATED TO DISCLOSE THE REASON FOR REJECTION.

DATA PRIVACY ACT OF 2012

In accordance with these issuances, we wish to notify you that **VALUE CARE HEALTH SYSTEMS, INC. (VALUCARE)** will continue to process your personal information, sensitive personal information and privileged information (collectively "Personal Data") in the course of our servicing of your account/s with us.

- **Personal information** refers to any information, whether recorded in the material form, or not, that will directly of an individual. This includes your name, address and contact information.
- **Sensitive personal information** is personal information that includes your age, date and birth, marital status, social security and other government identification numbers, policy information and financial information.
- **Privileged Information** is any and all forms of information which under the Rules of the Court and other pertinent laws constitute privileged communication, such as, but not limited to, information acquired in fiduciary relationships.

Authorization and Consent

As a data subject of VALUCARE who avails of VALUCARE product and services:

- You warrant that all personal data given to VALUCARE are true and correct to the best of your knowledge, freely and voluntarily given for purposes which relevant and necessary in the administration of your insurance policy, in providing services to you or for other reasonable services it provides or improvements/upgrades in its systems and business processes, including but not limited to data analytics and automated processing, in transacting a business or any activity with VALUCARE.
- You explicitly authorize VALUCARE, its director, officers, consultants, employees, and duly authorized representatives to keep, store, update, use, access, process and enter in the processing system the data given to it, and share, transfer or disclose the data to all VALUCARE'S accredited providers, Hospitals, Clinics, Doctors and Dentists and all other activities consistent with the provisions of the Data Privacy Act and subject to appropriate security safeguards.
- You have the right to access your given information and you undertake to correct, rectify or supplement information should any data be found to be inaccurate or incomplete such as members listing, medical and utilization report.
- You will hold VALUCARE free and harmless from any liability that may arise as a result of the authorization given.

By signing this membership application, you give your full consent to VALUCARE in processing and disclosing any necessary data to a third party.

STATEMENT BY APPLICANT

I HEREBY CERTIFY THAT THE FOREGOING ANSWERS ARE THE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. MY HEALTH STATUS AND ALL OTHER INFORMATION IS ACCURATELY REPRESENTED EXAMINATION IN THE ABOVE STATEMENTS. I UNDERSTAND THAT VALUCARE MAY REQUIRE ME TO HAVE A PHYSICAL EXAMINATION, AND I AUTHORIZE THE RELEASE OF ANY INFORMATION FROM SUCH VALUCARE FOR USE IN CONSIDERING MY APPLICATION. I ALSO UNDERSTAND AND AGREE THAT WHENEVER NECESSARY IN THE ADMINISTRATION OF THE SERVICE AGREEMENT, VALUCARE PHYSICIANS MAY DISCUSS WITH ANY HOSPITAL, HEALTHCARE FACILITY, PHYSICIAN AND SURGEON OR OTHER HEALTH CARE PROFESSIONALS, MEDICAL INFORMATION RELATED TO THIS APPLICATION. I UNDERSTAND AND THIS INFORMATION IS COLLECTED IN CONNECTION WITH THE EVALUATION AND PROCESSING OF MY APPLICATION FOR COVERAGE OR A CHANGE OF BENEFITS OR TO DETERMINE ELIGIBILITY BENEFITS.

I APPLY FOR VALUCARE PROGRAM MEMBERSHIP AND AGREE THAT I SHALL ABIDE BY THE PROVISIONS OF THE CONTRACT AND VALUCARE REGULATIONS. I UNDERSTAND THAT THERE IS NO COVERAGE IN EFFECT UNLESS MY APPLICATION IS APPROVED BY VALUCARE, AND THAT VALUCARE WILL NOT BE LIABLE FOR ANY MEDICAL BILLS BETWEEN THE TIME I SIGN THIS APPLICATION AND EFFECTIVE DATE OF ITS APPROVAL. ANY MONEY I/WE MAY HAVE PAID WILL BE RETURNED IF THE APPLICATION IS REJECTED, MINUS PROCESSING FEE.

IN THE EVENT APPLICANT IS APPLYING ALONE OR IS A MINOR, THE APPLICANT'S NAME SHOULD BE ENTERED ON THE SIGNATURE OF APPLICANT LINE, AND THE APPLICANT'S PAYOR PARENT OR GUARDIAN SHOULD SIGN WHERE INDICATED.

_____	_____	_____
PRINTED NAME AND SIGNATURE OF GA/CODE NO.	SIGNATURE OF APPLICANT	DATE
_____	_____	_____
PRINTED NAME AND SIGNATURE OF DA/CODE NO.	PRINTED NAME AND SIGNATURE OF PRINCIPAL	DATE