VanCare
INSURANCE LIMITED

MEDICAL INSURANCE APPLICATION FORM

Your Duty of Disclosure

Please ensure that you understand all information before signing this form. You the main applicant only must complete this form. It is very important that the answers on your application are true, correct and complete. Claims can be refused, if it is later found that wrong information has been provided.

Applicant Name(s) **Sex** **Height** **Weight** **Date of Birth** **Marital Status**
Smoker or not

Employer: **VNPF#**

Residential Address
Telephone:

Postal Address: **Date of Emp:**

	Name	**Country/State/City/Province**	**Email Address/Phone**
Hospital/Clinic/Doctor:			

Dependent Name(s) **Sex** **Relationship to Applicant** **Height** **Weight** **DOB**
Hosp/Clinic/Dr Folder #

Few standard exclusion of the policy listed below however; refer to policy document for full detail exclusions:

Congenital condition, Geriatric condition, Transplants, Ebola, Bird Flu & Infectious diseases, Work related injury or sickness, Chemical, biological, nuclear, Pre-existing condition, Professional sports, Psychiatric condition, War, coup, riot, strike, Diagnostics overseas, Sleep apnea, HIV & AIDS, Self-inflicted injury or sickness

Compliant with STATE LAW OFFICE - FINANCIAL INTELLIGENT UNIT - RBV – Anti Money Laundering and Counter Terrorism / NZ & AUST Medical Visa Application

Ever had any illegal record with these Authorities - Court, Police, Data Bureau, Bankruptcy, Tax & Customs, Land Transport and Immigration. If yes, complete below:

Name of Office: **Country/City/Province:** **Phone/Email Address:** **Reason** **File #**

_____
_____
_____
_____

PERSONAL STATEMENT - To the best of your knowledge have you, or any of your listed dependents:
YES/NO

1. Ever had treatment or been informed that you have blood pressure problems, heart trouble, cancer, diabetes, kidney or liver or bowel disease, digestive disorder, lung disease, stroke, fits, mental illness or nervous disorder, suffered serious personal injury, AIDS, **Ebola, Bird Flu or any infectious diseases**? ☐
2. Ever consulted a doctor for medical or surgical advice or treatment of any ailment, injury or sickness. ☐
3. Ever had an application for Life and/or Dread Disease Insurance declined or deferred by a life or general insurance company or society or accepted with a loading or otherwise as submitted or received a disability benefit? ☐
4. Ever engaged or intend to engage in any hazardous occupation, sport or other pursuit, or intend to engage in aviation other than as a fare-paying passenger on a commercial airline? ☐

If you have answered "YES" to any of the questions, please give full details below, showing:
Date: Doctor's Name: Hospital: Reason:

It is important that you answer all questions to the best of your knowledge and belief and disclose all relevant facts. These are facts that an insurer would regard as likely to influence the assessment and acceptance of an application. If you fail to do so and a policy is issued, all or part of the benefit may not be available. If you are in any doubt as to whether certain facts are relevant, you should disclose them. Details of "YES" answers to the above questions:

Declaration - I/We, the life to be insured, fully understand the Coverage, Exclusions, Personal statement questions and my answers on this form and declare that:

1. I/We hereby apply for membership to VanCare and certify that the declaration listing dependants is true and correct.
2. The answers given above and/or to the Medical Examiner for VanCare Insurance Limited are true.
3. Any Medical Practitioner who has or may be consulted by me or any of my dependants is authorized to divulge at any time to VanCare Insurance Limited any information with regard to myself & my dependents.
4. I/We waive all professional confidence and provisions of the law relating to privilege forbidding disclosure material to the insurance cover.
5. Any untrue statements I/We may have made, or material information I/We may have withheld may result in the contract being declared void.
6. The company will be free from all liability until the proposal has been accepted and the policy issued.
7. All notices shall be sent to VanCare Insurance Limited, P. O. Box 1319, Port Vila, Vanuatu or email: lemeki@vancare.com.vu

Signature of Applicant:_____ **Date:** _____

Witness: _____ **Date:** _____

PRE-EXISTING CONDITION REPORT

Please complete a separate report for each pre-existing condition. Be specific, as this report may be referred to a medical panel.

NAME	**AGE**
1. **Name and description of Condition.**	
2. **When did the symptoms relating to the condition first appear?**	
3. **When did you first seek medical assistance or advice in relation to the condition?**	
4. **What diagnosis was made by the treating doctor?**	
5. **What treatment or surgery have you received in relation to the condition?**	
6. **Is the treatment described above still continuing? If so, how long do you expect it to continue?**	
7. **What has been the result of the treatment or surgery described above?**	
8. **What has been the result of the treatment or surgery described above?**	

9. **When was the last occurrence of the symptoms of the condition?**

10. **Do you expect the symptoms of the condition to continue to continue or re-occur? If so for how long or how often?**

11. **Do you regularly use, or has a Doctor recommended the regular use of any drug relation to the condition?**

12. **Is the condition hereditary?**

13. **State the name and address of the original treating doctor?**

14. **State the name and address of the current treating doctor?**

I authorize any Physician ot Hospital to release details of my medical history and agree that a copy of this authority is as valid as the original.

15. **SIGNED** **NAME**

DATE