PhilCare
A Member of the Philippines First Group (Since 1900)

IPER Care Program

Application No.

To our Prospective Valued Client:

We are pleased to offer you the PhilCare health package! This letter intends to re-affirm with you the main features of the plan of your choice.

What is PhilCare?

PhilCare puts together and causes the delivery of a package of comprehensive health services, including out-patient treatments, preventive health care and hospitalization to its members. In lieu of charging a fee for each service rendered, the Company collects regular membership fees from its members upon enrollment or membership and at fixed intervals thereafter. The organization's primary thrust is to prevent illness or at least detect and treat it at an early stage.

For this reason, the Company encourages and puts emphasis on out-patient and preventive health care, while at the same time providing coverage for hospitalization expenses when needed.

What are your advantages as a member of PhilCare?

As a member of PhilCare, you enjoy the following advantages:
First, the probability of financial loss due to illness or accident is diminished if not entirely prevented.

Second, your medical expenditures are determinable because most of the essential services you will be needing are covered by the regular membership fees.

Third, you are guaranteed access to a team of primary physicians as well as medical specialists for the whole range of medical quality assurance programs to ensure that you are provided with accepted standards of health care.

What is IPER Care Program?

IPER CARE PROGRAM is a comprehensive healthcare product which covers in-patient benefits and emergency cases, depending on the package you choose. Specifically, the coverage includes:

1. Services of physician including surgical services
2. Room and Board
3. General Nursing Services
4. Operating and Recovery room
5. Anesthesia and its administration
6. Drug and medication during confinement
7. ICU confinement
8. Other In-patient services deemed medically necessary
9. Emergency cases leading to confinement

Emergency cases not leading to confinement may be covered depending on the package you choose. Please refer to the table of product variants and benefits for details.

What are the limitations of your health plan?

Just like any other HMO, PhilCare carries with it certain limitations, which are necessary in order to maintain high quality medical services at affordable membership fees for our members.
The following are the limitations of the program. We encourage you to familiarize yourselves with these limitations.

No coverage for Out-patient Services
Out-Patient consultations, laboratories, x-rays, ultrasound and any procedure deemed as out-patient services are not covered.

1. Non-coverage of Pre-Existing Conditions

Your contract does not cover pre-existing conditions.

An illness or condition shall be considered Pre-existing if, prior to the effective date of your health care coverage (the Agreement) or the approval date of reinstatement in case of lapsation, a) any professional advise or treatment was given for such illness or condition; or b) such illness or condition was in any way evident to the Member; or c) the pathogenesis of such illness or condition has started, whether or not the member is aware of such illness or condition.
In addition to the foregoing, the following conditions but not limited to, when occurring during the first year of coverage after the Effective Date or reinstatement, are considered Pre-existing: (a) endometriosis; (b) hemorrhoids; (c) diseased tonsils requiring surgery; (d) pathological abnormalities of nasal septum and turbinates; (e) thyroid condition ; (f) cataracts; (g) sinus conditions requiring surgery; (h) epilepsy; (i) asthma; (j) cirrhosis of the liver; (k) tuberculosis; (l) anal fistulae; (m) cholecystitis/cholelithiasis; (n) calculi of the urinary system; (o) gastric or duodenal ulcer; (p) hallux valgus; (q) tumors, whether benign or malignant, of all organs and organ systems, including malignancies of the blood or bone marrow; (r) diabetes mellitus; (s) hypertension; (t) collagen disease; (u) cardio-vascular diseases; (v) hernia; (w) HIV/AIDS; (x) chronic skin conditions; (y) obesity, dyslipidemia and other metabolic conditions; (z) auto immune conditions; (aa) degeneration conditions; (ab) neurologic conditions; and (ac) cerebrovascular diseases.

On your second year, after 12 months of continuous coverage, the Pre-existing Condition Clause shall no longer be applicable except for illnesses and conditions which have been specifically stated as exclusions in an Endorsement form which was made part of your contract provided there is continuous coverage for the past 12 months.

2. Annual Benefit Limit
All coverable illnesses will be covered under one Annual Benefit Limit depending on the applicable limit for each particular plan chosen.

3. Renewal of Agreement

The Agreement may be renewed for another year subject to the approval of PhilCare and subject to the payment by the Member of the renewal membership fees on or before the renewal date.

Further, the following conditions shall apply to the coverage of renewal years:
A) Pre-existing conditions diagnosed during the first year of coverage shall be excluded in the coverage of renewal years; and
B) The Annual Benefit limit shall be replenished.

4. Permanent and General Exclusions

Some conditions are permanently excluded from your coverage, i.e., any claim(s) arising from such conditions will not be covered permanently by PhilCare. Such exclusions can be specific for particular members. Our health care contract will indicate whether or not you will be subject to a permanent exclusion. Our contract also enumerates conditions that are not included in the coverage. Such conditions are referred to as "General Exclusions".

5. Access Procedures

To maximize our effectiveness and efficiency in the delivery of health care services to you, we have instituted simple procedures that you will be required to follow in availing of your benefits.

The basic procedures, which you have to remember, are as follows:

- For emergency conditions, proceed to the Emergency Room of the nearest PhilCare-affiliated hospital. You will be provided with a list of affiliated hospitals in the member guide.
- Hospitalization services should only be availed in PhilCare and selected affiliated hospitals and should be recommended only by PhilCare accredited physicians.
- PhilCare will not cover expenses for elective and emergency cases in non-affiliated hospitals.

(Please turn to next page)

(This portion is to be accomplished by agents) **Application No.**

DEPOSIT ON APPLICATION RECORD FOR AGENT		☐ IE ☐ FAMILY	☐ IPER CARE PROGRAM ☐ IPER CARE FAMILY PROGRAM ☐ IPER CARE PLUS PROGRAM	☐ Dental
AGREEMENT NO.	APPLICANT'S NAME		Membership Fee : P	Others (Pls. Specify):
			PhilCare PhilHealth Rider: P	
EFFECTIVE DATE	AGENT'S NAME/CODE		Processing Fee : P	
			Value Added Tax : P	
	Receipt Number		TOTAL : P	

IMPORTANT:
1. **FEES SHALL BE SUBJECT TO ADJUSTMENTS FOR ANY TAXES AND OTHER CHARGES THAT MAY BE INCURRED DUE TO CHANGE IN LAWS, REGULATIONS AND/OR TAXATION.**
2. **MAKE SURE THAT THE APPLICATION NUMBER IS SHOWN CORRECTLY ON THE OFFICIAL RECEIPT TO SPEED UP PROCESSING AND RECORDING.**
3. **USE THE AGREEMENT NUMBER IN MAKING A FOLLOW-UP**

Emergency shall mean the sudden, unexpected onset of illness or injury, which at the time of contract reasonably appeared as having the potential of causing immediate disability or death or requiring immediate alleviation of severe pain and discomfort.

- If no confinement is required, you may have to pay emergency out-patient treatment services.
- For cards with consultation benefits, please proceed to any of our PhilCare clinics or selected affiliated clinics.
- Inform the PhilCare Customer Service Hotline within 24 hours of your confinement.

6. Room Assignment

You are entitled to a room accommodation corresponding to your type of plan. Should you occupy a room that is higher than your room limit, you will pay only for the excess in room charges, provided that you are staying in a room classification corresponding to your program. If you stay in a room classification higher than your program, you will have to pay also for the excess in professional fees and other hospital ancillary charges. It is important to know that fees charged for various procedures done in the hospital, including professional fees, are based on the type of the patient's room accommodation.

7. PhilHealth

In case you are covered under PhilHealth, you or your representative must submit a duly accomplished PhilHealth form prior to your discharge from the hospital. Otherwise, the hospital will require you to pay the PHILHEALTH portion, which will only be refundable when you submit the required forms. Your failure to submit your PhilHealth form could result in your payment of a certain amount which should have been covered by said PhilHealth. Please see PhilHealth Eligibility Requirements below.

PhilHealth Eligibility Requirements:

- Payment of at least three (3) monthly premiums within the immediate six (6) months prior to the month of confinement.
- For dialysis (except those undergoing emergency dialysis service during confinement), chemotherapy, radiotherapy and selected surgical procedures, payment of nine (9) monthly premium contributions within the last twelve (12) months shall be required except for those enrolled under the KASAPI program.
- Confinement in an accredited hospital for at least 24 hours (except when availing of out-patient care and special packages) due to an illness or injury requiring hospitalization.
- Attending physicians must also be PhilHealth-accredited.
- Availment is within the 45-day allowance for room and board

What are your responsibilities as a PhilCare member?

A. You must be up-to-date in your payment of Membership Fees.

Your membership fees are payable under the mode you have originally chosen. While PhilCare endeavors to remind you of your membership fee due either through Billing Notice sent by mail or by a phone call from PhilCare representatives, payment of membership fees on time remains the responsibility of the Member. Non-receipt of billing notices or inability of respective servicing agents to collect payments shall not serve as ground to contest any decision of the company to deny benefits because the contract is no longer in force due to nonpayment.

B. Follow the proper procedures for you to fully enjoy the benefits of the program and prevent the occurrence of problems.

C. Read your PhilCare Contract
The moment you receive your PhilCare Agreement (following the approval of your application), thoroughly go through the Agreement. For any clarification, kindly consult your servicing agents or call PhilCare Customer Service Hotline at (+632) 462-1800. Our PhilCare Representatives will be happy to answer your inquiries.

What are the benefits of your health programs?

BENEFITS	IPER Care	IPER Care Plus	IPER Care Family
ANNUAL BENEFIT LIMIT (for all illnesses)	Annual benefit limit ; amount based on the desired program: P 120,000 P 60,000 P 50,000		
ROOM AND BOARD ACCOMMODATION	Based on the desired program: • Regular Private • Semi-Private • Ward		
EMERGENCY HOSPITALIZATION CARE	Covers diagnostic and therapeutic procedures (as medically indicated during confinement) including special modalities of treatment (as medically indicated during confinement and subject to inner limits) for services availed in PhilCare-affiliated hospitals and managed by PhilCare-affiliated physicians in the said hospital		
ELECTIVE HOSPITALIZATION CARE	Covers diagnostic and therapeutic procedures (as medically indicated during confinement), including special modalities of treatment (as medically indicated during confinement and subject to inner limits) for services availed in PhilCare-affiliated hospitals and confinement recommended by PhilCare-affiliated physician in the said hospital		
OUT-PATIENT EMERGENCY CARE	N/A	Covers out-patient emergency care done in PhilCare clinics or affiliated hospitals	N/A
CONSULTATION WITH PRIMARY CARE PHYSICIAN, GENERAL PRACTITIONER OR FAMILY MEDICINE SPECIALIST			Allows five (5) out-patient consultations with Primary Care Physician, General Practitioner or Family Medicine Specialist in PhilCare clinics and selected affiliate clinics for every enrolled family member

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APPLICATION FOR IPER CARE PROGRAM

NOTE: TO FACILITATE PROCESSING OF THIS APPLICATION, PLEASE ACCOMPLISH THIS FORM COMPLETELY AND SUBMIT THIS WITH YOUR SIGNED CONFORME ON THE RE-AFFIIRMATION BELOW TOGETHER WITH THE 1X1 ID PHOTO.

Application No.

Agreement No.

☐ NEW BUSINESS ☐ RE-APPLICATION ☐ GROUP TO IPER CARE ☐ CLASSIC IE TO IPER CARE

PART I

LAST NAME	FIRST NAME	MI

PERMANENT ADDRESS — ZIP CODE

RESIDENCE TEL. NO.

OFFICE ADDRESS — BUSINESS TEL. NO.

MOBILE NO.

OCCUPATION/JOB TITLE	NATURE OF BUSINESS	TIN	E-MAIL

BIRTHDATE (MM/DD/YYYY)	PLACE OF BIRTH	CITIZENSHIP: ☐ FILIPINO ☐ OTHERS: _____	SEX	NO. OF CHILDREN: (SINGLE AND BELOW 21 YEARS OF AGE)

AGE	HEIGHT	WEIGHT	CIVIL STATUS: ☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ SEPARATED	ESTIMATED TOTAL MONTHLY HOUSEHOLD INCOME ☐ 10,000 or below ☐ 10,001 – 20,000 ☐ 20,001 – 50,000 ☐ 50,001 – 100,000 ☐ 100,001 and up

PART II

TYPE OF PRODUCT ☐ IPER CARE ☐ IPER CARE PLUS ☐ IPER CARE FAMILY

PROGRAM TYPE
☐ 120,000 ABL
☐ 60,000 ABL
☐ 50,000 ABL

PHILHEALTH
☐ with PhilHealth
☐ without PhilHealth and willing to pay for PhilHealth chargeable expense
☐ without PhilHealth and willing to get the PhilCare PhilHealth rider

MODE OF PAYMENT
☐ ANNUAL ☐ SEMI-ANNUAL

FORM OF PAYMENT
☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ OVER THE COUNTER ☐ AUTO DEBIT ARRANGEMENT
CARD NAME _____
CARD NUMBER _____

PART III ☐ CHECK THIS BOX IF YOU ARE APPLYING ONLY FOR YOUR SPOUSE AND/OR CHILDREN (with principal as Payor)

FAMILY MEMBERS APPLYING FOR MEMBERSHIP	DOB	AGE	SEX	HT	WT	RELATIONSHIP TO PRINCIPAL / PAYOR	OCCUPATION	CITIZENSHIP

ENROLLMENT OF DEPENDENTS SHOULD FOLLOW THE HIERARCHY RULE. BIRTH CERTIFICATE OF DEPENDENT ENROLLEE IS REQUIRED.

LEARNED ABOUT PHILCARE THROUGH:
☐ PRINT AD ☐ INTERNET ☐ FRIENDS ☐ AGENTS ☐ PHILCARE OFFICE ☐ OTHERS _____

PHILCARE

RE: LETTER OF RE-AFFIRMATION

Please be informed that I have read and understood the contents of the application and the limitations of my coverage.
I hereby certify that the data and other information stated herein are written by me or under my supervision.
I am submitting with this letter the accomplished application form and my initial payment.

_____ Signature over Printed Name of Principal Applicant

_____ DATE

TO BE FILLED UP BY THE SERVICING AGENT:

PHILCARE .

RE: LETTER OF RE-AFFIRMATION

Please be informed that I have explained well to my client the contents of the application and the limitations of his/her coverage.
I hereby certify that the data and other information stated herein are written by my client or by me under his/her supervision.

_____ Signature over Printed Name of Servicing Agent / _____ Signature over Printed Name of Servicing Agent

AGENCY – UNIT – PERSONAL AGENT'S CODE / AGENCY – UNIT – PERSONAL AGENT'S CODE

DATE: _____ / DATE: _____

HOW DO YOU WANT THE AGREEMENT AND MEMBERSHIP PACKAGE TO BE SENT?
☐ TO BE PICKED UP BY AGENT ☐ TO BE PICKED-UP BY MEMBER ☐ TO BE DELIVERED AT MEMBERS: ☐ PERMANENT ADDRESS ☐ OFFICE ADDRESS

HOW DO YOU WANT YOUR SUCCEEDING BILLING TO BE SENT?
☐ MAILED TO PERMANENT ADDRESS ☐ MAILED TO OFFICE ADDRESS ☐ VIA SMS (TEXT MESSAGING) ☐ VIA EMAIL

I agree and authorize the Company to use and disclose any information (collected or held) with regards to the matters pertaining to this application to enable the Company, its associated individuals, organizations or independent third parties, to provide advice or information covering products or services which the Company believes maybe of interest to me or to communicate with me for any purpose.

FOR PHILCARE USE ONLY

MEMBERSHIP WORKSHEET

COMPUTATIONS

CERTIFICATE #	ENROLLEE'S NAME	ISSUE AGE	MEMBERSHIP FEE	DENTAL FEE	GROUP LIFE FEE	TOTAL MF

REMARKS: _____

TOTAL MF

☐ EF/PF

GRAND TOTAL

PAYMENT OR #	AMOUNT:	DATE:	BY:

UNDERWRITING ACTIONS

☐ APPROVED ☐ CANCELLED ☐ DISAPPROVED ☐ RECONSIDERED ☐ ADDITIONAL REQTS.

DATE: SIGNATURE:

NAME	REASONS

☐ EXCLUSIONS	CODE

EFFECTIVE DATE: TERMINATION DATE:

ENCODED BY/DATE: VERIFIED BY/DATE:

DATE	REQUIREMENTS/RECOMMENDATIONS/ACTIONS	NAME/SIGNATURE

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MEDICAL QUESTIONNAIRE : Answer all the following questions in the appropriate check box provided below. If you are applying for a family coverage, all questions are applicable to each applicant. Use the space provided below to give full details of items with "YES" answers.

	Check Box YES	NO
1. Have you ever had a history of, and/or treatment, consultation or known indication for:		
a. Disorder of eyes, nose, or throat ?	☐	☐
b. Dizziness, fainting, convulsion, headache, speech defect, paralysis or stroke, mental or nervous disorder ?	☐	☐
c. Shortness of breath, persistent hoarseness or cough, blood-spitting, tuberculosis, asthma or other chronic respiratory disorders ?	☐	☐
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels ?	☐	☐
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestines, liver or gall bladder ?	☐	☐
f. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate, or reproductive organs ?	☐	☐
g. Diabetes, thyroid or other endocrine disorder ?	☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones, such as spine, back or joints ?	☐	☐
i. Deformity, lameness or amputation ?	☐	☐
j. Disorder of skin, lymph glands, cysts, tumor or cancer ?	☐	☐
k. Allergies, anemia, or other disorder of the blood ?	☐	☐
l. Excessive use of alcohol, tobacco, or any habit forming drugs ?	☐	☐
2. Are you now under observation or taking treatment ?	☐	☐
3. Have you had any change in weight in the past years ?	☐	☐
4. Other than the above, have you:		
a. Had any physical disorder or any known indication thereof ?	☐	☐
b. Had a medical examination, consultation, illness, injury, or surgery ?	☐	☐
c. Been a patient in a hospital, clinic, sanitarium, or other medical facility ?	☐	☐
d. Had electrocardiogram, x-ray, or other diagnostic tests ?	☐	☐
e. Been advised to have any diagnostic test, hospitalization or surgery which was not completed ?	☐	☐
5. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition ?	☐	☐
6. Have you ever applied for or received a pension payment, or benefit due to injury, sickness or disability ?	☐	☐
7. Have you a parent, brother or sister who died of or had high blood pressure, tuberculosis, diabetes, cancer, heart or kidney disease, or mental illness ? If so, at what age ?	☐	☐
8. Do you or other members of the family smoke ?	☐	☐
a. If yes, since when ? How many sticks a day ?	☐	☐
b. If you have quit smoking, since when ? How long have you smoked ? How many sticks a day ?	☐	☐
9. FOR FEMALES ONLY		
a. Have you ever had any abnormal menstruation, pregnancy, childbirth, or disorder of the female organ or breasts ?	☐	☐
b. Are you now pregnant ? If yes, how many months ?	☐	☐

_____

NAME OF FAMILY MEMBER	DATE OF HISTORY TREATMENT, CONFINEMENT, ETC.	CHIEF COMPLAINTS AND DIAGNOSIS	TREATMENT AND RESULTS	NAME AND ADDRESS OF PHYSICIAN AND HOSPITAL

(Kindly continue on the appropriate space on the reverse side of this form, if necessary.)

We hereby declare and agree that all statements and answers contained herein and in any addendum annexed to this application are full, complete and true and binds all parties in interest under the Health Care Coverage (the Agreement) herein applied for, that there shall be no contract of health care coverage unless and until an Agreement is issued on this application and the full Membership Fee according to the mode of payment is paid during the good health of proposed Member(s); that the health care coverage of any Member shall take effect only on the Effective Date as indicated in the issued Agreement or the actual date full Membership Fee was paid, whichever is later; that no information acquired by any Representative of PhilCare shall be binding upon PhilCare unless set out in writing in this application; that any physician is, by these presents, expressly authorized to disclose or give testimony at anytime relative to any information acquired by him in his professional capacity upon any question affecting the eligibility for health care coverage of the proposed Members and that the acceptance of any Agreement issued on this application shall be a ratification of any information on correction in addition to this application.

We agree and authorize PhilCare and its accredited Physicians, Clinics, and the like to use and/or disclose any medical information (collected or held) in its possession after a formal written request from the requesting party _____ (Name of Company) with regards to my medical history and that of my dependents in accordance with my healthcare coverage.

We hereby affirm that we have read and understood the contents of the health care contract as discussed in the attached Re-affirmation Letter. As proof of the foregoing, we are submitting a signed conforme of the same with this Application Form.

We hereby understand that we, the enrollees, will only start availing of the benefits of the plan upon the effectivity of the policy.

SIGNED AT _____ THIS _____ DAY OF _____

_____ SIGNATURE OF WITNESS

_____ SIGNATURE OF PRINCIPAL APPLICANT

AUTHORIZATION TO FURNISH MEDICAL INFORMATION

(The form below should be completed for each case)

I hereby authorize any person, organization, or entity that has any record or knowledge of my health and/or that of _____ _____ to give to the PhilCare any and all information relative to any hospitalization, consultation, treatment, or any other medical advice or examination. This authorization is in connection with the application for health care coverage or with any benefit availed and with any claim for benefits under such coverage. A photographic copy of this authorization shall be as valid as the original.

_____ SIGNATURE OF WITNESS

_____ SIGNATURE OF PRINCIPAL APPLICANT

_____ **PRINTED NAME OF APPLICANT**

_____ **AGENT'S NAME / CODE NO**

_____ **APPLICATION NO.**

NAME OF FAMILY MEMBER	DATE OF HISTORY TREATMENT, CONFINEMENT, ETC.	CHIEF COMPLAINTS AND DIAGNOSIS	TREATMENT AND RESULTS	NAME AND ADDRESS OF PHYSICIAN AND HOSPITAL