



**MEMBERSHIP APPLICATION  
MEDICard OFW – Dependents / Beneficiaries Program  
MALAYSIA**

**INSTRUCTION:** Please print or type answer to questions applicable to applicant and check the appropriate box where applicable.

<b>OVERSEAS FILIPINO PAYOR'S DATA</b>			
NAME OF OVERSEAS FILIPINO PAYOR			
ADDRESS ABROAD			
			COUNTRY
TELEPHONE NO.:	MOBILE PHONE NO.:	EMAIL ADDRESS:	FAX NO.:

<b>PLAN HOLDER'S DATA</b>					
1.	FAMILY NAME	FIRST NAME	MI		
COMPLETE HOME ADDRESS ( NUMBER, STREET, BRGY., CITY/PROVINCE, AREA CODE) *please give complete & specific address for easy delivery of documents*					
TELEPHONE NO.:		MOBILE PHONE NO.:	EMAIL ADDRESS:	FAX NO.:	
DATE OF BIRTH (MM/DD/YY)	GENDER	CIVIL STATUS	NATIONALITY	MEDICARD ID NO. (IF RENEWAL)	
/	/				
2.	FAMILY NAME	FIRST NAME	MI		
COMPLETE HOME ADDRESS ( NUMBER, STREET, BRGY., CITY/PROVINCE, AREA CODE)					
TELEPHONE NO.:		MOBILE PHONE NO.:	EMAIL ADDRESS:	FAX NO.:	
DATE OF BIRTH (MM/DD/YY)	GENDER	CIVIL STATUS	NATIONALITY	MEDICARD ID NO. (IF RENEWAL)	
/	/				
3.	FAMILY NAME	FIRST NAME	MI		
COMPLETE HOME ADDRESS ( NUMBER, STREET, BRGY., CITY/PROVINCE, AREA CODE)					
TELEPHONE NO.:		MOBILE PHONE NO.:	EMAIL ADDRESS:	FAX NO.:	
DATE OF BIRTH (MM/DD/YY)	GENDER	CIVIL STATUS	NATIONALITY	MEDICARD ID NO. (IF RENEWAL)	
/	/				

<b>AMOUNT PAID: (in Philippine Peso)</b>
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<b>FOR MEDICARD USE ONLY</b>					
RECEIVED BY: (DSD)	RECEIVED BY : (RMD)	O.R. NO. (CASHIER)	AMOUNT: (IN PHP)	EFFECTIVITY DATE:	REMARKS:
DATE	DATE	DATE			

Remit payments to: **FOREX MALAYSIA**  
 Lot 2.16, Level 2 Kota Raya Complex, Jalan Cheng Lock,  
 50000 Kuala Lumpur, Malaysia

Tel Numbers: (603) 2078-3000 / (603) 2078 - 5000

Please submit **PROPERLY AND COMPLETELY** filled-up application form to **FOREX MALAYSIA** for immediate processing of membership application.

For further inquiries, Visit, E-mail or Call:

**CM ALLIANCE INSURANCE AGENCY**  
**MS. DORIE MAÑEBO**  
 Telefax: (632) 645-0094  
 Email Address: [amanebo@yahoo.com](mailto:amanebo@yahoo.com)  
 Mobile No. 0917-5346042 / 0922-8626320

**BERNADETTE RAZON-REFERENTE**  
**Servicing Officer**  
**SALES AND BUSINESS DEVELOPMENT I**  
**MEDICard Philippines Inc.**  
 9<sup>th</sup> Floor, The World Center Building,  
 330 Sen. Gil Puyat Ave., 1227 Makati City, Philippines 1227  
 Tel Nos.: (632) 884-9906 to 07  
 Fax Nos. : (632) 88-6453 to 54

**PLAN INFORMATION**

PLEASE CHECK	ROOM & BOARD	ANNUAL MEMBERSHIP FEE			DREADED DISEASE LIMIT
		3 mos. – 60 yrs. old	61 – 65 yrs. old	66 – 70 yrs. old	
	Small Private up to Plan P1500	P12,774	P18,634	P30,353	P 60,000
	Large Private up to Plan P2500	16,304	23,929	39,178	70,000
	Suite up to Plan P3000	20,692	30,511	50,148	100,000
	Suite up to Plan P4000	24,524	36,259	59,728	150,000

*Above rates are inclusive of (AHMC)Asian Hospital & Medical Center,(MMC)Makati Medical Center; (SLMC)St. Luke’s Medical Center; (CMC)Capitol Medical Center; (MCGH)Medical City General Hospital;(CSMC)Cardinal Santos Medical Center,(PHMC)Perpetual Help*

PLEASE CHECK	ROOM & BOARD	ANNUAL MEMBERSHIP FEE			DREADED DISEASE LIMIT
		3 mos. – 60 yrs. old	61 – 65 yrs. old	66 – 70 yrs. old	
	Ward up to Plan 450	P 7,684	P 11,099	P 17,928	P 40,000
	Semi-Private up to Plan 700	P 8,647	P 12,543	P 20,335	P 50,000
	Small Private up to Plan 1200	P 11,482	P 16,756	P 27,303	P 60,000
	Large Private up to Plan 1800	P 14,659	P 21,522	P 35,246	P 75,000
	Suite up to Plan 2500	P 18,608	P 27,445	P 45,119	P 100,000

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I hereby certify that the above information is true and correct. I understand that failure to disclose or misrepresentation of any material information, whether intentional or not, shall entitle MEDICard to terminate this Agreement, and is sufficient ground for legal action and rejection of my application and/or medical coverage. Moreover, I have read and understand the coverage and limits of the MEDICard Overseas Program (Please refer to **MEDICARD OVERSEAS PROGRAM –MALAYSIA BROCHURE**).

I apply my dependents and/or beneficiaries for MEDICard program membership and agree that I shall abide by the provisions of the contract and MEDICard regulations. I understand that there is no coverage unless our application is approved and that MEDICard will not be liable for any medical bills between the time that we sign this application and pay the membership fees, and the effective date of our coverage if our application is approved.

By signing below, I acknowledge and signify that all benefits and important details pertaining to the MEDICard Overseas Program were explained and was clearly understood. In addition, I understand that coverage will start only upon receipt of MEDICard of both the duly filled up application form & full payment based on cut-off dates specified on MEDICARD OVERSEAS PROGRAM BROCHURE;

Witnessed by: \_\_\_\_\_  
 SIGNATURE ABOVE PRINTED NAME ( PAYOR ) \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
 SIGNATURE ABOVE PRINTED NAME FOREX MALAYSIA \_\_\_\_\_ Date \_\_\_\_\_