# GLOBALIS

## Individual Application Form

### You'd like to Apply? Great! Some important information first...

This product is insured by PT. Asuransi Dayin Mitra Tbk. The terms and conditions of this policy shall be governed by and construed in accordance with the laws of Indonesia.

When completing this form, you are required to disclose all required information, and answer all questions honestly. Failure to disclose information may result in your Policy being terminated without refund of premium. If you are in any doubt whether an illness, medical condition, symptom, or suspicion should be declared, you should declare it to avoid having your insurance terminated for non-disclosure when you need it the most.

Please complete this form clearly in BLOCK letters.

### Don't forget!

- ☐ Have you completed all sections in full and accurately?
- ☐ Have you read, signed, and dated the declaration in section 12?
- ☐ Have you included a copy of the national identity card or passport for each individual to be covered by the Policy?

## ① Policy Start Date?

When would you like to start your policy? ☐ On Acceptance ☐ Another Date (dd/mm/yyyy):

Note: If you are applying for an individual or family policy, your Policy cannot start before we receive your application. Cover is conditional upon your Application being accepted and is only confirmed when we notify you in writing.

## ② Applicant's Details

The Applicant will become the Policyholder if this Application is accepted. A Policyholder must be between the ages of 18 and 74 at the time of application. If children are being enrolled on their own and are between the ages of 31 days and 17 years, the Policyholder must be a parent or guardian until they reach the age of 18. In the case of a child-only policy, the Policyholder (the parent or guardian) will not be eligible for benefits.

| | | |
|---|---|---|
| For child-only cover, please tick here: ☐ | | |
| Salutation: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. | Gender: ☐ Male ☐ Female | |
| Given Name: | Surname: | |
| Preferred Name: | Date of Birth (dd/mm/yyyy): | |
| Nationality: | National ID / Passport Number[1]: | |
| Marital Status: | Occupation: | |
| Mobile Number[2] (+country code): | Telephone Number (+country code): | |
| Email Address[2]: | | |
| Residential Address: | | |
| City: | Postal Code: | Country: |
| Mailing Address (if different from Residential Address): | | |
| City: | Postal Code: | Country: |

1 Our Direct Settlement Providers will request this and your Health Insurance Card for identification purposes.
2 We require your mobile number and a unique email address to create your MemberOnline access.

## ③ Dependants to be Covered

Dependants may include your spouse/partner, any unmarried children who are under 18 years of age, and any unmarried children under the age of 26 if they are enrolled as full-time students at a recognized educational institution and are dependent upon you for financial support. For child dependants between 18 and 25 years of age, please attach a copy of their Student ID (or a letter from their college/university confirming their full-time student status). Your spouse/partner may be up to 74 years of age at the date of policy commencement. If there is insufficient space for all Dependants, please use two Forms.

| | Dependant 1 | Dependant 2 | Dependant 3 | Dependant 4 |
|---|---|---|---|---|
| Relationship to Applicant | ☐ Spouse ☐ Child | Child | Child | Child |
| Given Name | | | | |
| Surname | | | | |
| Preferred Name | | | | |
| Date of Birth (dd/mm/yyyy) | | | | |
| Gender | ☐ Male ☐ Female | ☐ Male ☐ Female | ☐ Male ☐ Female | ☐ Male ☐ Female |
| Nationality | | | | |
| National ID / Passport No.* | | | | |
| Marital Status | | | | |
| Occupation | | | | |
| Country of Residence | | | | |

* Our Direct Settlement Providers will request this and your Health Insurance Card for identification purposes.

## ④ Choose your Cover

**If you would like your Dependants to be provided the same plan and options as yourself, just tick here:** ☐

| Your Plan Options | |
|---|---|
| Main Plan | ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum |
| Area of Cover | ☐ Area 1: Worldwide excluding USA<br>☐ Area 2: Southeast Asia including Singapore, Australia & New Zealand<br>☐ Area 3: Southeast Asia excluding Singapore, Australia & New Zealand |
| Overall Annual Plan Limit | ☐ USD 3,000,000<br>☐ USD 1,500,000<br>☐ USD 500,000 |
| High-Cost Providers Access[1] | ☐ Full Access ☐ Access with 15% coinsurance ☐ No Access |
| Deductible | ☐ Nil<br>☐ USD 1,000 ☐ USD 5,000[2]<br>☐ USD 2,500 ☐ USD 10,000[2] |
| Hospital Room Type | ☐ Standard Single Room ☐ Semi-Private Room |
| Outpatient Annual Limit[3] | ☐ Up to Overall Annual Plan Limit ☐ USD 15,000 ☐ USD 7,500 |
| Outpatient Direct Billing (OPDB) Services[3] | ☐ Yes ☐ No |
| Coinsurance[3] | ☐ Nil ☐ 10% coinsurance ☐ 20% coinsurance |

1 Only available to those residing in Singapore, Indonesia, Hong Kong, Macau, China
2 These deductibles are available only with the Bronze plan
3 These options are not available with the Bronze plan

**If you would like your Dependants to be provided different plans or options to your own, provide us the details below:**

| | Dependant 1 | Dependant 2 | Dependant 3 | Dependant 4 |
|---|---|---|---|---|
| Main Plan | ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum | ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum | ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum | ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum |
| Area of Cover | ☐ Area 1 ☐ Area 2 ☐ Area 3 | ☐ Area 1 ☐ Area 2 ☐ Area 3 | ☐ Area 1 ☐ Area 2 ☐ Area 3 | ☐ Area 1 ☐ Area 2 ☐ Area 3 |
| Overall Annual Plan Limit | ☐ USD 3m ☐ USD 1.5m ☐ USD 500k | ☐ USD 3m ☐ USD 1.5m ☐ USD 500k | ☐ USD 3m ☐ USD 1.5m ☐ USD 500k | ☐ USD 3m ☐ USD 1.5m ☐ USD 500k |
| High-Cost Providers Access[1] | ☐ Full Access ☐ Access with 15% Coins ☐ No Access | ☐ Full Access ☐ Access with 15% Coins ☐ No Access | ☐ Full Access ☐ Access with 15% Coins ☐ No Access | ☐ Full Access ☐ Access with 15% Coins ☐ No Access |
| Deductible | ☐ Nil ☐ USD 1,000 ☐ USD 2,500 ☐ USD 5,000[2] ☐ USD 10,000[2] | ☐ Nil ☐ USD 1,000 ☐ USD 2,500 ☐ USD 5,000[2] ☐ USD 10,000[2] | ☐ Nil ☐ USD 1,000 ☐ USD 2,500 ☐ USD 5,000[2] ☐ USD 10,000[2] | ☐ Nil ☐ USD 1,000 ☐ USD 2,500 ☐ USD 5,000[2] ☐ USD 10,000[2] |
| Hospital Room Type | ☐ Standard Single Room ☐ Semi-Private Room | ☐ Standard Single Room ☐ Semi-Private Room | ☐ Standard Single Room ☐ Semi-Private Room | ☐ Standard Single Room ☐ Semi-Private Room |
| Outpatient Annual Limit[3] | ☐ Up to Overall Annual Plan Limit ☐ USD 15,000 ☐ USD 7,500 | ☐ Up to Overall Annual Plan Limit ☐ USD 15,000 ☐ USD 7,500 | ☐ Up to Overall Annual Plan Limit ☐ USD 15,000 ☐ USD 7,500 | ☐ Up to Overall Annual Plan Limit ☐ USD 15,000 ☐ USD 7,500 |
| OPDB Services[3] | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Coinsurance[3] | ☐ Nil ☐ 10% coinsurance ☐ 20% coinsurance | ☐ Nil ☐ 10% coinsurance ☐ 20% coinsurance | ☐ Nil ☐ 10% coinsurance ☐ 20% coinsurance | ☐ Nil ☐ 10% coinsurance ☐ 20% coinsurance |

1 Only available to those residing in Singapore, Indonesia, Hong Kong, Macau, China
2 These deductibles are available only with the Bronze plan
3 These options are not available with the Bronze plan

**Areas of Cover Descriptions** (note that the Country of Residence of each individual must fall within their chosen Area of Cover)

| | | |
|---|---|---|
| **Area 1** | Worldwide excluding USA | |
| **Area 2** | Southeast Asia including Singapore, Australia & New Zealand | Brunei, Cambodia, East Timor, Indonesia, Laos, Malaysia, Myanmar, Papua New Guinea, Philippines, Thailand, Vietnam, Singapore, Australia, New Zealand |
| **Area 3** | Southeast Asia excluding Singapore, Australia & New Zealand | Brunei, Cambodia, East Timor, Indonesia, Laos, Malaysia, Myanmar, Papua New Guinea, Philippines, Thailand, Vietnam |

## ⑤ Insurance Details

Are you or your Dependants currently insured with another health insurance company? ☐ Yes ☐ No
If 'Yes', please provide the name of insurer/product:

Have you or your Dependants ever been declined or had a policy cancelled by another health insurer? ☐ Yes ☐ No
If 'Yes', please provide the reason for rejection/cancellation:

Have you or your Dependants ever been accepted with special terms or conditions applied by another health insurer? ☐ Yes ☐ No
If 'Yes', please provide the terms or conditions applied:

## ⑥ Medical Declaration

Please answer all of the following questions in respect of each person to be covered by the Policy. We rely upon this information to determine whether or not to accept your application. **Failure to fully declare medical conditions or symptoms may invalidate the policy without refund of paid premium and we may seek the return of any benefits already paid to you**. If you are in any doubt as to whether a fact is material, declare it to avoid possible delays or issues later.

If, between completing the Medical History Declaration and the start date of the Policy, any changes occur in the facts you have declared in this Medical History Declaration, such as a change in your state of health or the state of health of any of your Dependants, you must inform us in writing about the change immediately. Note that we reserve the right to decline or accept your Application with special terms and conditions.

| | Applicant | Dependant 1 | Dependant 2 | Dependant 3 | Dependant 4 |
|---|---|---|---|---|---|
| Height (cm/ft) | | | | | |
| Weight (kg/lbs) | | | | | |
| Do you smoke?<br>If yes, sticks per week? | ☐ Yes ☐ No<br>____ /week | ☐ Yes ☐ No<br>____ /week | ☐ Yes ☐ No<br>____ /week | ☐ Yes ☐ No<br>____ /week | ☐ Yes ☐ No<br>____ /week |

### 1. Has any person named in this application ever experienced symptoms, been diagnosed with, been in hospital for, suffered from, received treatment, tests or investigations for:

| | | |
|---|---|---|
| (a) | Any heart or circulatory condition or disorder, arrhythmia (abnormal heartbeat or valve function), aneurysms, stroke, murmur, chest pain, haemorrhage, abnormal or high blood pressure or high cholesterol? | ☐ Yes ☐ No |
| (b) | Any blood or immune condition or disorder, abnormal blood tests, blood clotting problems, haemophilia, thalassemia, anaemia, Lupus (SLE), tested positive for HIV/AIDS, Hepatitis B or C, or any auto-immune disorder? | ☐ Yes ☐ No |
| (c) | Asthma, bronchitis or any other respiratory condition or disorder such as but not limited to rhinitis, sinusitis, sleep apnoea, chronic obstructive pulmonary disease (COPD), shortness of breath, chest infections, pneumonia, tuberculosis (TB), or allergies? | ☐ Yes ☐ No |
| (d) | Rheumatism, gout, arthritis, paralysis, muscular or skeletal/bone disorder or injury, or any form of neck, back, spine or joint disorder or injury? | ☐ Yes ☐ No |
| (e) | Any other neurological, brain or nervous system condition or disorder such as but not limited to epilepsy, migraine, multiple sclerosis, dementia, meningitis, or nerve pain? | ☐ Yes ☐ No |
| (f) | Anxiety, depression, compulsive or eating disorder, chronic fatigue syndrome, psychological, psychiatric or any other mental condition or disorder? | ☐ Yes ☐ No |
| (g) | Any digestive condition or disorder, such as oesophageal, stomach, ulcer, gastritis, or bowel/colon problems? | ☐ Yes ☐ No |
| (h) | Any condition or disorder of the kidneys, liver, gall bladder, spleen, pancreas, bladder, prostate, renal, or recurrent urinary conditions? | ☐ Yes ☐ No |
| (i) | Any reproductive system, gynaecological, genital, or breast condition or disorder? | ☐ Yes ☐ No |
| (j) | Any cancer, tumours, lumps, cysts or abnormal growth whether cancerous or benign? | ☐ Yes ☐ No |
| (k) | Any eye, ear, nose, throat or skin disorder such as acne, eczema, or dermatitis? | ☐ Yes ☐ No |
| (l) | Diabetes, thyroid, weight management problem, or any other glandular/endocrine disorder? | ☐ Yes ☐ No |
| (m) | Drug and/or alcohol addiction or abuse? | ☐ Yes ☐ No |
| (n) | Any other medical condition, hereditary or congenital disorder, symptom, sudden weight loss, fatigue, illness or injury relating to your health that has not been mentioned above? | ☐ Yes ☐ No |
| (o) | Any condition not mentioned in the questions above, that has required more than two doctor visits per year, or which might require ongoing treatments, monitoring or assessment? | ☐ Yes ☐ No |

### 2. Is/has any person named in this application:

| | | |
|---|---|---|
| (a) | Currently taking any medication (including over the counter medication such as paracetamol, antacid and antihistamine) on a regular basis, prescribed or otherwise? | ☐ Yes ☐ No |
| (b) | Currently pregnant, undergoing any treatment or testing for any fertility or assisted conception, or had any childbirth other than full-term, natural delivery? | ☐ Yes ☐ No |
| (c) | Undergone cancer screening or medical check-up with anything other than a normal result within the last 7 years? | ☐ Yes ☐ No |

## 3. Supplementary Information

If you answered 'Yes' to any question under Part 1 or 2 above, please provide full details in the table below, and on a separate sheet of paper if necessary.

| Section/ Question number | Name of Person Affected by the Condition | **Details** – Please provide as accurately as possible:<br>▪ The diagnosis (or symptoms if a final diagnosis is not available)<br>▪ The date(s) each illness or injury was experienced and the date it ended<br>▪ How frequently a condition occurs and how severe it is each time<br>▪ Past, current, or future treatments, details of medications, tests performed and their results<br>▪ Outcome of treatment (ongoing, completely recovered, recurrent, or likely to recur?)<br>▪ The name & address of your treating doctor, clinic, or hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## 4. Your Family Doctor's Contact Details

Please provide details of the Medical Practitioner who is the most familiar with the medical history of each person named in this application. If there is more than one doctor, please provide their details on a separate sheet of paper.

| | | |
|---|---|---|
| Doctor's Name: | | |
| Address: | | |
| City: | Postal Code: | Country: |
| Telephone Number (+country code): | | |
| Email Address: | | |
| Length of time you have known this doctor: | | |
| Date and reason for last visit: | | |

And just so you know: Upon review of the information needed to consider your Application, we may:

- Agree to accept some or all of the medical conditions you have declared
- Apply a loading to usual premiums because of your existing health conditions
- Exclude some or all of the medical conditions you have declared (these will be noted on your Insurance Certificate); or
- Decline the Application entirely.

All other terms and conditions of the Policy Wording and Member Handbook will still apply.

## ⑦ Payment Options

How would you like to pay your Premium?

| | Annually | Semi-annually (2% loading added) | Quarterly (4% loading added) | Monthly (6% loading added) |
|---|---|---|---|---|
| By Credit Card | ☐ | ☐ | ☐ | ☐ |
| By Bank Transfer | ☐ | ☐ | ☐ | N/A |

### Payment Details

**Credit Cards:** We accept MasterCard and Visa. Please complete the separate Credit Card Payment & Authorization Form.

**Bank Transfers:** Please ensure the Policy Number is indicated in the transfer details when making payment to the corresponding account indicated below. You must also ensure that the amount received by our bank is the amount we have invoiced you. Any transfer fees charged by your bank and its agents must be paid by you.

**For payment by bank transfer:**

| | |
|---|---|
| Account Name | Safe Meridian Pte. Ltd. (Great Eastern USD Premium) |
| Account Number | 2000567608 |
| Bank Name | CIMB Bank Berhad |
| Bank Code | 7986 |
| Branch Code | 001 |
| BIC/Swift Code | CIBBSGSG |
| Branch Address | 50 Raffles Place, #09-01 Singapore Land Tower, Singapore 048623 |

## ⑧ Bank Details for Claim Reimbursement

We pay benefits by bank transfer. If you provide us your bank account details here, you won't have to include them on claim forms later. You can change them at any time by completing the Bank Account Details section of your Claim Form.

| | |
|---|---|
| Currency of Account: | |
| Account Holder[1]: | |
| Account Number: | IBAN[2]: |
| Bank Name: | BIC/Swift Code: |
| Bank Code: | Branch Code: |
| Branch Address: | |

1 You must be insured under the policy to receive claim reimbursement(s).
2 IBAN is required if your bank is within the EU, or if your country requires an IBAN (e.g. Qatar, Saudi Arabia, Turkey).

## ⑨ Document Delivery Arrangements

We're committed to doing our part to help the Planet, so with a mind to being environmentally-friendly, all Policy related material will be emailed to you including Policy Wording and Handbooks. You will also find them in your MemberOnline portal (available once premium has been paid) and we'll be happy to email you copies at any time (just drop us an email at member.services@safemeridian.com). Each person enrolled into the Policy will be mailed a Health Insurance Card.

## ⑩ Data Protection Notice

**We take the protection of your personal data seriously. We describe below how we collect, use and protect it.**

We will need to collect, use, process, and/or disclose your personal data or personal information about you to process, administer, and/or manage your relationship, account and Policy with us. Such personal data includes (i) information set out in this form and any other personal information provided by you or possessed by us; and (ii) your claims.

Such personal data will be collected, used, processed, and/or disclosed by us for the purposes of:

a. considering whether to provide you with the insurance for which you applied;
b. processing your application for underwriting and insurance;
c. administering and/or managing your relationship, account and/or policy with us;
d. processing and/or dealing with any claims, including the settlement of claims and any necessary investigations relating to the claims, under your Policy;
e. carrying out due diligence or other screening activities (including background checks) in accordance with legal or regulatory obligations or risk management procedures that are required by law or that have been put in place by us;
f. carrying out your instructions or responding to any enquiries by you;
g. dealing in any matters related to the products and services to which you are entitled under this Policy and for which you are applying or have applied - including the mailing of correspondence, statements, invoices, reports or notices to you, which could involve disclosure of personal data;
h. investigating fraud, misconduct, any unlawful action or omission, whether relating to your application, your claims or any other matter related to your policy, and whether or not there is any suspicion of the aforementioned;
i. complying with applicable law in administering and managing your relationship with us; and/or
j. sending you marketing, advertising, promotional information about our products and services that we may be selling or marketing (unless you have specifically opted out or have written to us to stop sending you such information), through such modes of communication as: post/mail, telephone calls, text messages (SMS or WhatsApp), emails, and facsimiles.

(collectively the "Purposes").

We may collect personal data from sources other than yourself, personal data about you, for one or more of the above Purposes, and thereafter using, processing, and/or disclosing such personal data for one or more of the above Purposes.

Your personal data may be disclosed by us to the participating Insurers, Claim Administrators, Assistance Companies, third-party service providers or vendors, and to our professional advisors, wherever they are sited, for one or more of the above Purposes, as such parties, if engaged by us, would be processing your personal data for us for one or more of the above Purposes.

We may share, if necessary, your medical information with your any doctor, clinic or hospital to ensure appropriate care is provided to you and to ensure any claims from you can be properly assessed for benefits. We may also share your information with your Intermediary, if you have requested and authorized us to do so.

If you have declared any personal data relating to other individuals, you agree to inform the individual(s) about the content of our Data Privacy Policy and obtain their prior consent to act on their behalf to allow for the collection, use, disclosure, and transfer of their personal data in accordance with our Data Privacy Policy.

You have the right to request a copy of any information we hold on you, and to seek correction of any incorrect information held. Where possible, we will correct the information held in our files or on our systems as quickly as possible from such a request being made.

For full details about our Data Privacy Policy, please visit our website: https://www.safemeridian.com

By signing this form, you confirm you have read, understood, agreed to the above provisions, and consented to Safe Meridian:

- collecting, using, processing and/or disclosing your personal data for one or more of the Purposes as described above;
- collecting personal data about you from sources other than yourself and using, processing and/or disclosing the same, for one or more of the Purposes as described above; and
- disclosing and/or transferring your personal data to the participating Insurers, Claim Administrators, Assistance Companies, third-party service providers or vendors, and to our professional advisors, wherever they are sited, for one or more of the Purposes as described above.

We may, from time to time, contact you to share information about our products and services that may be of interest to you. Please tell us how you wish to receive this information:

☐ By email ☐ By SMS or WhatsApp ☐ By telephone ☐ I do not wish to receive any marketing information

## ⑪ Declaration & Authorization

**Please read the following declarations carefully and only sign below if you understand and accept them.**

1. I understand that I am applying for a Safe Meridian policy, underwritten by Great Eastern, on behalf of all the person(s) named in this application, and that this application is subject to Safe Meridian's written acceptance.
2. I acknowledge that I have received, read and understood the brochure and policy wording which explains the terms and conditions, Table of Benefits, definitions and exclusions of the policy. I understand that this Application Form, Policy Wording, Insurance Certificate, and the Member Handbook are contractual documents of the Individual policy for which I am applying, and the terms stipulated will be binding upon me and the person(s) named in this application. I accept that cover shall be provided in accordance with these documents.
3. I declare that I have the authority to act on behalf of the person(s) named in this application and have obtained their authorization to release the sensitive personal information provided herein, and that all information supplied herein is true and complete, including answers that are not in my own handwriting.
4. I understand that if the information provided in this application is false, incomplete or misleading, or if a submitted claim is false, fraudulent or intentionally exaggerated or incomplete, it may result in the claims being rejected or not fully paid, I may become responsible for any costs which were incurred in respect of the said claims, and that the Insurer may terminate this policy without refund of the premiums already paid.
5. For the purpose of this application, I hereby consent and authorize any doctor who has ever treated or advised any of the person(s) named in this application, to provide Safe Meridian with any and all information it may require in connection with the underwriting of the application and/or in respect of any claims or use of direct billing services under this policy. I understand that should further medical information be required in connection with the underwriting of this application and/or in respect of any claims under this policy for the person(s) named in this application, Safe Meridian reserves the right to request a copy of the latest medical reports from me at my own expense.
6. I understand that, as the legal policyholder of this policy, all correspondence, including claims correspondence for any person(s) named in this application will be sent to me. I understand that if any person covered by the policy and aged 18 or over wants that to change, they must take out a policy in their own right.
7. I agree that in the event Safe Meridian incurs any costs not eligible for benefits under the policy from medical treatment received within the Direct Billing Provider Network by any of the person(s) named in this application, I will be liable to repay the amounts in full to Safe Meridian within 60 days of being notified. I understand and confirm that should I not repay Safe Meridian these costs by the deadline provided, my policy may be suspended until such amount has been repaid in full and/or Safe Meridian may offset the amounts from future eligible claims submitted. I accept that regardless of these being implemented, I shall remain legally liable to repay Safe Meridian until the debt is repaid in full.
8. I recognize that should Safe Meridian receive late claims from me or from a Direct Billing Provider for any person(s) named in this application for treatments obtained in a period which has been determined to be a "no claims period", any discount on usual premiums payable that may have been granted as a result will be cancelled and I will be liable to pay the full premium otherwise due for the renewal in question. I accept that my policy may be suspended until such outstanding amount is paid.
9. If I have indicated that I wish to pay by credit card, I authorize Safe Meridian to charge the premiums invoiced on or before their due dates to my card, and the premiums for all subsequent renewals of the policy, until such time as I provide written notice that I wish to terminate my policy or change my method of payment. I accept that any such notice from me will apply only to premiums not already charged to my card.
10. I understand that should I fail to pay premiums in full due by their due dates for any reason, my policy shall lapse and Safe Meridian, its participating Insurers, Claim Administrators and Assistance Companies will not be liable for and will not pay any claims or provide any service.

11. I understand that if I am able to claim any cost incurred to my employer or to another insurer or government program, the Globalis policy will only be liable to pay eligible costs not covered by those entities.
12. I undertake to inform Safe Meridian immediately in writing of any changes in the facts declared in this application, such as a change in the state of health of any person(s) named in it, that occurs before the start date of the policy.
13. I understand that this application form is valid for two (2) months from the date of completion and signing.
14. I understand that upon receipt of my insurance documents, if I feel that the policy does not meet my needs, I may cancel the policy from inception and receive a full refund of the premium I have paid, provided I notify Safe Meridian within 14 days of joining and provided no claims has been submitted and no direct billing services have been obtained.
15. I understand that my policy will be automatically cancelled for any person(s) named in this application that becomes a resident of a country that is not covered by this policy (e.g. USA).
16. I acknowledge that it is my responsibility to check whether any person(s) named in this application is/are subject to any local compulsory health insurance requirements and to ensure that my chosen healthcare cover is legally appropriate in my country of residence. I acknowledge that neither Safe Meridian nor Great Eastern may be held liable for any regulatory, tax or other issue affecting me as the buyer within my own country of residence.
17. I agree to the above declarations and authorizations required to process this application and understand that any cover will be provided in accordance with the terms and conditions of the Globalis policy upon acceptance.

Applicant's Name

Applicant's Signature

Date Signed (dd/mm/yyyy)

Underwritten by: PT. Great Eastern General Insurance Indonesia
A member of the OCBC Group
Registered and supervised by the Financial Services Authority (OJK)
MidPlaza 2, 23rd Floor, Jl. Jend. Sudirman Kav. 10, Jakarta, 10220
Indonesia

Arranged by: Safe Meridian Pte. Ltd.
Singapore Company Registration No. 201541480K
3 Church Street, #12-02 Samsung Hub, Singapore 049483
Tel: +65 6692 9151 • Website: https://www.safemeridian.com

# GLOBALIS

## Credit Card Payment & Authorization Form

**Name of Policyholder:**

**Policy Number:**

I, the undersigned, hereby authorize Safe Meridian Pte Ltd to charge to my credit card account in respect of my health insurance premium (upon the acceptance of cover, renewal of cover, or a request made by me which impacts my premium, such as adding a dependant), and/or for any uncovered medical expenses incurred such as deductibles or coinsurances. This will continue until the instruction is cancelled by me giving written notice to Safe Meridian. I understand I will be given one month's notice of any annual premium rate increase.

**Declaration:**

1. This authorization form supersedes any previous payment instructions given on this insurance policy.
2. Where a third-party's Credit Card is used, I declare that the Cardholder has authorized and consented to such use, and that I am authorized to agree to the payment method, frequency, and terms on the Cardholder's behalf. I agree a scan or photocopy of this authorization shall be effective and valid as the original.
3. If the Cardholder is not the Policyholder, I recognized that he/she will have no right under the Article 1340 of the Civil Law, to enforce any of the terms and conditions of the Globalis policy I am applying for.
4. Upon approval of this application, I accept the premium amount will be charged to the Cardholder's Credit Card, and his/her Credit Card statement will show the amount deducted.
5. Should payment not be successfully effected pursuant to this authorization for any reason, I acknowledge that Safe Meridian shall under no circumstances be held responsible or liable in any manner whatsoever, including for any subsequent expiry of this policy due to late or non-payment of premiums.
6. I acknowledge that any refundable premium on my policy will be credited to the Cardholder's Credit Card account, and I will not contest the refund of the premium.

Card Type: ☐ MasterCard ☐ Visa

Cardholder's Name (as appears on card):

Card Number: Card Expiry Date (mm/yyyy):

Relationship to Policyholder (e.g. self, spouse, parent):

| Cardholder's signature | Date (dd/mm/yyyy) |
|---|---|
| | |

Underwritten by: PT. Asuransi Dayin Mitra Tbk
Wisma Hayam Wuruk
Jl. Hayam Wuruk No. 8, Jakarta Pusat, 10120
Indonesia

Arranged by: Safe Meridian Pte. Ltd.
Singapore Company Registration No. 201541480K
3 Church Street, #25-00 Samsung Hub, Singapore 049483
Tel: +65 6351 5598 • Website: https://www.safemeridian.com