AIR NIUGINI SAVINGS & LOAN SOCIETY LTD
Your Key for a Better Future *www.angsl.com.pg*

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INDIVIDUAL MEDICAL APPLICATION FORM

1. POLICY INFORMATION

Policy No: _____ Policy Holder: _____

2. PLAN TYPE

☐ Single Plan ☐ Couple Plan ☐ Family Plan

3. EMPLOYEE INFORMATION

First Name: _____ Last Name: _____
ID Type & No: _____ Date of Birth: _____
Gender: ☐ Male ☐ Female
Email Address: _____ Telephone No: _____

4. SPOUSE INFORMATION (Please complete for Couple & Family Plan)

First Name: _____ Last Name: _____
ID Type & No: _____ Date of Birth: _____
Gender: ☐ Male ☐ Female
Email Address: _____ Telephone No: _____

5. DEPENDENT CHILDREN INFORMATION (Please complete for Family Plan)

5.1 Child 1

First Name: _____ Last Name: _____
ID Type & No: _____ Date of Birth: _____
Gender: ☐ Male ☐ Female ☐ Natural Child ☐ Legally Adopted Child
Is this child a full-time student? ☐ Yes ☐ No

5.2 Child 2

First Name: _____ Last Name: _____
ID Type & No: _____ Date of Birth: _____
Gender: ☐ Male ☐ Female ☐ Natural Child ☐ Legally Adopted Child
Is this child a full-time student? ☐ Yes ☐ No

5.3 Child 3

First Name: _____ Last Name: _____
ID Type & No: _____ Date of Birth: _____
Gender: ☐ Male ☐ Female ☐ Natural Child ☐ Legally Adopted Child
Is this child a full-time student? ☐ Yes ☐ No

5.4 Child 4

First Name: _____ Last Name: _____
ID Type & No: _____ Date of Birth: _____
Gender: ☐ Male ☐ Female ☐ Natural Child ☐ Legally Adopted Child
Is this child a full-time student? ☐ Yes ☐ No

5.5 Child 5

First Name: _____ Last Name: _____
ID Type & No: _____ Date of Birth: _____
Gender: ☐ Male ☐ Female ☐ Natural Child ☐ Legally Adopted Child
Is this child a full-time student? ☐ Yes ☐ No

6. MEDICAL HISTORY

Do your Spouse or your Dependent Children have or previously had any illnesses/diseases? Yes No

If Yes, please provide details: _____

7. EMPLOYEE DECLARATION

All personal information obtained herein is collected for the purpose of assessing the application for insurance for myself/my Spouse/my Dependent Children.

I hereby declare that the information given on this form is true and complete to the best of my knowledge.

I understand that failure to disclose any material fact known to me may invalidate the insurance policy and hereby authorize PHA to obtain information and/or records from any organisation, institute or individual that has any record or knowledge of myself/my Spouse's/my Children's sick records, medical history, or medical treatment.

Date: _____ Signature of Employee: _____

8. SPOUSE DECLARATION

I hereby declare that I am the legal Spouse of the Applicant and that the information given in this form is true and correct to the best of my knowledge.

Date: _____ Signature of Employee: _____

9. DECLARATION FOR CHILD/CHILDREN

I hereby declare that the Child/Children stated above is/are my natural or legally adopted Child/Children

Date: _____ Signature of Employee: _____