

Please fill out the form with capital letters

<p>This form, duly completed and signed, should be returned prior to admission to:</p> <p style="color: green;">Medical Administrators International Suite 1412-13, World Commerce Centre 11 Cannton Road, Kowloon Hong Kong Tel: +852 3516 8181</p>	<p>You can also send this form by:</p> <p>1 - Scan and email to: aplus@medical-administrators.com 2 - Fax: +852 2529 9200</p> <p><small>* Original invoices must be kept for a minimum period of 12 months. During this period, the Insurer reserves the right to ask for the original invoices.</small></p>
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* Please keep the original form for a minimum of 12 months. During this period the insurer reserves the right to ask for the originals at any time.

Cost estimate for the hospitalisation of: Mr. Mrs. Ms.

Full Name of insured member _____

Personal reference number _____ / _____ Date of birth (dd-mm-yyyy) _____

Expected date of admission (dd-mm-yyyy) _____ Expected date of discharge (dd-mm-yyyy) _____

To be completed by the hospital and / or physician

Diagnosis and reason for admission⁽¹⁾⁽²⁾ _____

Present Medical History / Current situation _____

Date of first symptoms _____ Date of first diagnosis _____

Principal Procedure / Type of surgery / Treatment _____

Follow-up plan and Discharge Medication _____

Name, address, tel/fax, email address of hospital, Name of contact person (For USA Hospitals: please also mention the area code)	Name, address, tel/fax of physician
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	All-in rate = _____ /day _____ / total		
Option A:	Private	Semi-private	Ward
Option B: Type of room			
Hospitalisation expenses (e.g. medicines, x-rays, lab, etc)			
Doctor's fees ⁽³⁾ (for USA, please use CPT-code)			
Surgeon's fee			
Anesthetist's fee			
Others _____			

Total			

Should a letter of guarantee be sent to the above mentioned hospital? Yes No

In case of accident, please complete the "Disability / Accident Claim Form I".

Please attach a medical report.

Declaration: I hereby certify that the above information is true and correct to the best of my knowledge.

I certify that I have been made aware of the obligation to respond to the above questions and understand that incomplete or inaccurate answers would lead to the application of the Insurance Code article L 113-8 (contract nullity) or L 113-9 (benefits reduction). I undertake to communicate to the insurer information about the proposed insured and his dependents in strict compliance of the legislation on the processing of personal data in force.

This information may be disclosed to authorized professional bodies, as well as all those involved in the management and execution of this contract.

I have, as well as the members of the contract, the right to access and correct information concerning ourselves, with the Informations Clients Service - AXA 313 Terrasses de l'Arche 92727 Nanterre Cedex, France. The contract takes effect, subject to the payment of the premium, on the date stated in the policy schedule. This is based on the date of receipt of the application form and the results of the medical questionnaires and any medical reports. The decision of the insurer applies to all members under the same policy.

Date and signature of insured person ⁽⁴⁾

Stamp of the hospital / Signature of physician

(1) All information subject to medical secrecy may be sent for the attention of our medical consultant in a sealed envelope.

(2) Diagnosis and medical reports should be legible and without abbreviations.

(3) In case of surgery, the fee of each member of the surgical team; in case of conservative treatment, the fee of the main treating physicians.

(4) In view of a smooth administration of the contract and / or settlement of the insurance claim, and only for that purpose, I hereby give my specific and informed consent regarding the processing of the medical data concerning myself and / or the members of my family.