



Unit 502 DY International Building, 1011 Gen. Malvar St. corner San Marcelino, Malate, Manila 1004  
 Telephone No.: (+632) 5314-CARE (2273) Email: customercare.forticare@gmail.com Website: www.forticareph.com

## FORTE HEALTH CARE MEMBERSHIP APPLICATION

I hereby apply for membership in the Health Care Program of Forticare Health Systems International, Inc., specified herein in accordance with the Contract Provisions stated in this Application, I agree that this Application and my declarations and answers below written by me or under my direction, shall be the basis, and deemed part of the contract between Forticare Health Systems International, Inc. and myself.

(KINDLY PRINT/WRITE IN BLOCK LETTERS)

PERSONAL DATA								
LAST NAME		FIRST NAME			MIDDLE NAME			
AGE	DATE OF BIRTH	PLACE OF BIRTH		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	WEIGHT	HEIGHT		
CIVIL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHERS: _____		NATIONALITY	TIN	GSIS/SSS	<input type="checkbox"/> WITH PHILHEALTH No: _____ <input type="checkbox"/> WITHOUT PHILHEALTH			
BUSINESS, RESIDENCE AND CONTACT INFORMATIONS								
MAILING ADDRESS				TELEPHONE NO.	MOBILE NO.			
				EMAIL ADDRESS				
OCCUPATION	DESIGNATION	EMPLOYER/BUSINESS NAME		SOURCE OF FUNDS/INCOME	COMPANY ADDRESS			
PLAN DATA								
PLAN NAME		NO. OF UNITS		MAXIMUM BENEFIT LIMIT		MAXIMUM ROOM RATE		
MEMBERSHIP FEE		<input type="checkbox"/> SPOT CASH <input type="checkbox"/> LEVEL		MODE OF PAYMENT <input type="checkbox"/> ANNUAL <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> QUARTERLY			DISCOUNT	
FIRSTPAYMENT	PR NO.	PR DATE	PR AMOUNT	OR NO.	OR DATE	OR AMOUNT		
FOR EMERGENCY								
EMERGENCY CONTACT (LAST NAME, FIRST NAME, MIDDLE NAME)				CONTACT NUMBER		RELATIONSHIP TO MEMBER		

This Membership Application, with the information and data provided above and the Medical Declaration and Representation specified on the succeeding page shall be the basis of the contract between Forticare Health Systems International, Inc. and myself.

I agree that no binding agreement is created by the mere signing of this Membership Application until it is accepted and approved by Forticare Health Systems International, Inc. and until the Proof of Coverage or Policy containing the Contract Provisions sealed and signed by the duly authorized officials of Forticare Health Systems International, Inc. is issued

\_\_\_\_\_  
Signature of **APPLICANT** over printed name

\_\_\_\_\_  
Printed name & signature of **PARENT OR GUARDIAN**  
(If Applicant is below eighteen (18) years old)

\_\_\_\_\_  
Signature of **HEALTH SPECIALIST/SO/PO** over printed name

**MEDICAL DECLARATION AND REPRESENTATIONS**

Please answer the following with **YES** or **NO** by putting a checkmark (  ) on the appropriate box.

- |  |  |
|--|--|
| <p>1. Are you taking any medications now? For how long?<br/>( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes, Please give details:<br/>_____</p> <p>2. Have you been admitted to a hospital or receiving home health Care? ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes, Please give details:<br/>_____</p> <p>3. Have you ever availed of any surgical treatment?<br/>( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes, Please give details:<br/>_____</p> <p>4. Have you ever undergone a biopsy?<br/>( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes, Please give details:<br/>_____</p> <p>5. Have you performed diagnostics testing in the last twelve (12) Months for an unidentified condition? ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes, Please give details: _____</p> | <p>6. Have you been recommended by a medical professional any diagnostics treatment, hospitalizations or surgery which was not done or completed?<br/>( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes, Please give details:<br/>_____</p> <p>7. Do you smoke, take alcohol, use recreational or habit-forming drugs?<br/>( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes, Please give details:<br/>_____</p> <p>8. Have you been rejected for life or health insurance or accepted at higher premium rates? ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes, Please give details:<br/>_____</p> <p>9. For women only<br/>Have you given birth? ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes Date of last Delivery: _____<br/>Are you pregnant? ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes Number of weeks: _____<br/>Have you ever had an abortion, miscarriage, abnormal pregnancy?<br/>( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes, Please give details:<br/>_____</p> |
|--|--|

**MEDICAL HISTORY AND DIAGNOSIS**

Have you been discharged or have a personal history of any of the following?

- |   |   |  |
|---|---|--|
| <p>1. Arthritis/Rheumatism ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>2. Bronchial Asthma ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>3. Tuberculosis ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>4. Blood dyscrasia/Leukemia ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>5. Cataract ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>6. Cancer/Malignant Tumor ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>7. Central Nervous Disease ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>8. Cerebral Palsy ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>9. Congenital Heart Disease/MPV/VSD ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>10. Congenital Illness/Autism/ADHD ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>11. COPD/Emphysema/Chronic Bronchitis ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>12. Craniotomy/VP Shunt ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>13. Cyst/Tumor of the Breast ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>14. Cyst/Tumor of the Organ/s ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>15. Cyst/Tumor of Eyes, Nose or Throat ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>16. Diabetes Mellitus ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>17. Diverticulosis ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>18. Endometriosis ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>19. Epilepsy/Seizure Disorder ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>20. Fistula-in-ano/Anal Fistula ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>21. Gall Bladder/Biliary stone/s ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>22. Glaucoma ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>23. Goiter/Hyper &amp; Hypothyroidism ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>24. Heart Attack/Heart Disease ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>25. Hemorrhoids ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> | <p>26. Hernia ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>27. Hepatitis ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>28. High Cholesterol/Dyslipidemia ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>29. High Blood Pressure/Hypertension ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>30. Injury from Accident or Assault ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>31. Intestinal Colitis ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>32. Kidney/Urologic Disease ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>33. Liver Disease/Cirrhosis ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>34. Meningitis/Encephalitis ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>35. Myoma ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>36. Obstructive Sleep Apnea (OSA) ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>37. Ovarian Cyst/Mass ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>38. Organ Transplant ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>39. Peptic Ulcer ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>40. Physical Deformity/Disability ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>41. Prostate Problem ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>42. Psoriasis ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>43. Psychiatric Problem/Psychosis ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>44. Rheumatic Fever ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>45. Rheumatic Heart Disease ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>46. Sexually Transmitted Disease/AIDS ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>47. Spondylosis/Disease of Spine ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>48. Stroke/Cerebrovascular Accident ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>49. Urinary Track/Kidney Stones ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> <p>50. Varicosities/Venous Thrombosis ( <input type="checkbox"/> )No ( <input type="checkbox"/> )Yes</p> | <p>A. Please give details of all the YES in Medical History and Diagnosis:<br/>_____</p> <p>B. Please give details of any other disease, illness or conditions not mentioned in Medical History and Diagnosis. _____</p> |
|---|---|--|

I declare that answer given above are full, complete and true and if found otherwise, I understand that the Health Care Agreement may be invalidated. I hereby authorize any entity or person having knowledge of my health to provide to Forticare Health Systems International, I nc. any information concerning any hospitalization, medical treatment or consultation that I may have undergone.

IN WITNESS HEREOF, I have signed this application on \_\_\_\_\_ in \_\_\_\_\_.

\_\_\_\_\_  
Signature of **APPLICANT** over printed name

\_\_\_\_\_  
Printed name & Signature of **PARENT OR GUARDIAN**  
(if Applicant is below eighteen (18) years old)

\_\_\_\_\_  
Signature of **HEALTH SPECIALIST/PO/SO** over printed name

Please paste  
2' x 2'  
Colored ID picture

<b>Reviewed by:</b> (Name & Date)	<b>Branch Manager</b>	<b>Regional Head</b>	<b>Health Specialist Code</b>
<b>Encoded by:</b>		<b>Contract Issued by:</b>	

Signature of Member should not exceed outside the box

**FORTICARE FORTE HEALTHCARD**  
**CONTRACT PROVISIONS (without insurance)**

**ARTICLE I - CONTRACT**

This Health Care Program Agreement (Agreement), the duly-signed Membership Application Form, the Forticare Identification Card that will be subsequently issued to the Member, together with any duly authenticated annex, rider, stipulation, endorsement or addendum, written or posted in this document, shall constitute the entire CONTRACT between the Member and Forticare Health Systems International, Inc. (Forticare) with address at Unit 502, DY International Building, #1011 Gen. Malvar St. cor. San Marcelino St., Malate, City of Manila, Philippines.

This **CONTRACT** shall take effect on the indicated date of issue and upon payment of the Membership fees as mentioned in Article VII. The date of issue shall refer to the date of approval of the Membership Application Form signed by the Member, accepted by the authorized official of Forticare and confirmed by the subsequent issuance of the Health Care Program Policy to the former. The Member is given a Free-look up period of not less than fifteen (15) days from receipt of this Agreement to evaluate the contract provisions and conditions. In the event the Member disagrees, he may return or cancel the contract within the said period and any amount paid shall be returned in full.

This Agreement shall take effect on \_\_\_\_\_. It shall remain in effect for a period of one (1) year and shall be renewable at the instance of the Member. Provided, that Forticare shall have the right to review the Member's records or Membership fees for the purpose of validating the eligibility of the Member.

**ARTICLE II – DEFINITION OF TERMS**

1. **ACCIDENT.** A visible, external, sudden and violent event occasioned by a physical or natural cause and occurring entirely beyond the Member's control causing damage to the health of the Member.
2. **ACCREDITED HOSPITAL.** A duly licensed hospital included in the list of accredited hospitals of Forticare with which the Forticare has an existing and valid service Agreement and where a Member can avail of medical services pursuant to this Agreement.
3. **ACCREDITED MEDICAL CLINIC.** A duly licensed medical health care facility included in the list of accredited medical clinics of Forticare which has an existing and valid affiliation Agreement with Forticare and where a Member can avail of medical services pursuant to this Agreement.
4. **ACCREDITED PHYSICIAN.** A duly licensed physician or specialist accredited by Forticare and named in the list of Forticare's accredited Physician with whom Forticare has made arrangements to provide the required services under this Agreement.

5. **ANESTHESIOLOGIST.** A specialist duly licensed and registered to administer anesthetic agents and conduct other anesthesia procedures during **medical operation.**
6. **ATTENDING PHYSICIAN.** An Accredited Physician who is part of the medical staff of an Accredited Hospital or Accredited Medical Clinic, and legally responsible for the care given to a Member while the hospital or on out-patient basis.
7. **AUTHORIZED REPRESENTATIVE.** A person duly Authorized by Forticare to approve the provision of medical services or claims reimbursements to a Member
8. **CUSTODIAL OR MAINTENANCE CARE.** Care which is primarily for the purpose of assisting the Member in the activities of daily living or in meeting personal rather than medical needs , which is not specific therapy for an illness or injury and is not skilled care.
9. **DEVELOPMENTAL, CONGENITAL CONDITION, BIRTH DEFECT .** A medical abnormally existing all the time of birth as well as neonatal physical or mental abnormalities developing thereafter because of causal factors or conditions present at the time of birth
10. **DISABILITY .** An illness or injury and any other symptoms ,sequelae , or complications thereof requiring treatment . All injuries from the same event or series of continuous events are considered as one Disability .
11. **DURABLE MEDICAL EQUIPMENT.** As determined by the Forticare , medically prescribed items of medical equipment for repeated use , owned or rented , such as but not limited to crutches and wheelchairs which are placed in the home of a Member to facilitate treatment and/or rehabilitation of illness or injury.
12. **EFFECTIVE DATE.** The date the Agreement shall take effect on the indicated date of issue and upon payment of the Membership fees by the Member through any licensed representative of Forticare or any Forticare business office, supported by duly-recognized official and/or provisional receipt.
13. **ELIGIBLE EXPENSES.** Expenses incurred in the treatment of a covered illness or injury which are medically Necessary and not Exceeding the Member's Maximum Benefit Limit.
14. **EMERGENCY CONDITION.** A life threatening or accidental injury or a sudden and unexpected onset of a condition or illness which at the time of the occurrence

\_\_\_\_\_  
Signature of **MEMBER** over printed name

\_\_\_\_\_  
Printed name & signature of **PARENT OR GUARDIAN**  
(If Applicant is below eighteen (18) years old)

reasonably appears to have the potential of causing immediate Disability or Death, or which requires the immediate action or alleviation of pain or discomfort. These illnesses or injuries require urgent medical or surgical care and attention which the Member secures immediately after the onset or as soon as the care may be made available.

15. **EXPIRY DATE.** The date the Agreement is scheduled to terminate which is one (1) year from the effective date.
16. **ID CARD.** The identification card issued by Forticare to a Member containing the latter's name and signature, ID reference number, and other matters pertaining to his Membership.
17. **ILLNESS.** A poor health or poor physical condition marked by a pathological deviation from the normal healthy state caused by disease or sickness.
18. **INJURY.** Physical damage or trauma arising wholly and exclusively from an accident or other events of violent or external, and visible nature.
19. **LETTER OF AUTHORIZATION (LOA).** Letter of authorization duly issued by Forticare to, and signed by, the Member which shall serve as the authority of the latter to avail the medical services.
20. **MATERIAL INFORMATION.** An information is deemed material if its disclosure would have resulted in the (a) declination of the application for Membership of the applicant, (b) the assessment of a higher Membership fee or (c) the inclusion to the benefits of the Member under this Agreement.
21. **MAXIMUM BENEFIT LIMIT.** The maximum liability that Forticare shall assume per covered services rendered within the one-year term of this Agreement. MBL is replenished upon the renewal of this Agreement but not during the extension.
22. **MEDICALLY NECESSARY.** A medical service, as determined by Forticare, which is (a) consistent with the diagnosis and customary medical treatment of the condition, (b) in accordance with the standards of management care and good medical practice, (c) not for the convenience of the Member or the Accredited Physician, (d) performed in the most cost effective manner required by the medical condition and (e) consistent with the terms and conditions of this Agreement.
23. **MEDICINE AND DRUGS.** Those for which a licensed medical practitioner has prescribed for dispensing, which are specifically required for the treatment of covered illness or injury under this Agreement.
24. **MEMBER.** A Principal who is eligible, has been accepted for Membership by after complying with the eligibility provision, and is currently enrolled under his Agreement.
25. **MEMBERSHIP.** Refers to a Membership in Forticare, pursuant to this Agreement.

26. **MEMBERSHIP FEES.** Refer to the fees for the enrollment of the Members, as specified in the Membership Fees of this Agreement.
27. **PHYSICIAN, SURGEON, SPECIALIST.** A person qualified by degree and duly licensed or registered to practice medicine in the geographical area in which he serves. This person must not be a relative of the other Member up to the third degree of consanguinity and affinity.
28. **PRIVATE NURSE.** A licensed nurse providing close observation and performing special treatments, which are certified as medically necessary by the Attending Physician.
29. **PROFESSIONAL FEES.** As distinct from Surgeon and Anesthesiologist's Fee, fees paid to licensed Medically Necessary by the Attending Physician.
30. **ROOM AND BOARD ACCOMODATION.** The pre-assigned type of hospital room and board by Forticare to the Member based on the benefit and coverage of the health care plan under this Agreement.
31. **SURGERY.** The branch of medicine dealing with manual or operative procedure for the correction of deformities and defects, repair of injuries

### ARTICLE III – ELIGIBILITY REQUIREMENTS

Principal Members for Plans is a person who has attained the age of Seven (7) years old but not more than Seventy (70) years old and 30 days only. Attained age is defined as the age of last birthday. Enrollment to this Agreement is subject further to the prevailing Underwriting Guidelines of Forticare. Forticare reserves the right to require at any time the submission of such documents which Forticare may deem appropriate for the purpose of validating the eligibility of Member.

### ARTICLE IV – CONSIDERATION AND GUARANTEE

For and in consideration of the payment of the total or portion of Membership fees plus other applicable fees by the Member, and subject to the terms and conditions stipulated in this Agreement, Forticare guarantees to provide every health care benefit, other rights and privileges set forth herein.

### ARTICLE V – HEALTH CARE BENEFIT AND COVERAGE

Forticare agrees to arrange for annual physical examination, hospitalization (in-patient) and emergency health care services as well as special diagnostic and laboratory procedures for all qualified and accepted Members such as:

1. **Annual Physical Examination (APE)** may be availed of at Forticare Clinics or any designated diagnostic and laboratory center after (6) months from the date of effectivity of this Agreement and shall include:  
ANNUAL WELLNESS CHECK UP
  - a. Taking of Medical History
  - b. Medical Examination

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Signature of **MEMBER** over printed name

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Printed name & signature of **PARENT OR GUARDIAN**  
(If Applicant is below eighteen (18) years old)

- c. Chest X-ray (PA)
- d. Complete Blood Count (CBC)
- e. Fasting Blood Sugar (FBS)
- f. Urinalysis and Fecalalysis

**2. Medical Expense Benefits**

(a) **Hospitalization and In-Patient Health Care Services** in any hospital designated by Forticare which shall include:

- (1) Services and Fees of Forticare Specialist like Surgeons, Anesthesiologist, Internist and others;
- (2) Hospital Room and Board according to plant type as indicated in this agreement;
- (3) Administration of Anesthesia and/or Oxygen
- (4) Administered medicines, dressing, plaster casts, sutures and other items directly related to the medical/surgical management of the patient's chief complaint while confined in the hospital;
- (5) Blood transfusions and intravenous fluids including cost of blood products;
- (6) Charges on the use of Operating and Recovery Rooms;
- (7) Complex and non-complex diagnostic and laboratory examinations of procedures shall be covered up to the Maximum Benefit Limit (MBL); &
- (8) Assistance in Administrative requirements through Forticare Liaison Officer.

**Note:** All the above in-patient services are covered up to the Maximum Benefit Limit (MBL) as provided in Article VI of this agreement.

(b) **EMERGENCY HEALTH CARE SERVICES** may be availed of in emergency conditions as defined in ARTICLE II after his enrollment to the health care program. In which case, Emergency health care services listed previously under hospitalization and in-patient health care services, may be availed of in any Forticare accredited or non-accredited hospitals or medical centers such that:

- (1) if the **EMERGENCY HEALTH CARE is secured at an accredited hospital or medical center.** Forticare shall pay for the actual cost of health care services needed by the Member;
- (2) if the emergency treatment has been administered in an **Accredited** Hospital and the Member still requires confinement. Forticare shall provide the in-patient benefits subject the provisions of this Agreement.
- (3) If at the time of the confinement, the accredited Hospital has no available room in accordance with the Member's Room and Board Accommodation but Forticare will only cover the incremental rate differences for the room upgrade, professional fees, diagnostics and laboratory examinations, and other ancillary medical services for the first twenty-four (24) hours of confinement. The said charges and expenses shall be subject to the Member's Maximum Benefit Limit (MBL). All incremental costs incurred after the first twenty-four (24) hours shall be for the personal account of the Member except when the **Accredited** Hospital issues a certification of non-availability of the Member's Room and Board Accommodation.

- (4) If the **Emergency Health Care is secured at a non-accredited hospital or medical center,** Forticare shall reimburse 80% of the cost of health care services based on Forticare Standard Rates being used by Forticare in paying the same health services to other health partners and providers;
- (5) If emergency treatment has been administered in non-accredited hospital and the Member still requires confinement, he or his representative, as a pre-requisite for in-patient coverage, must notify within a period of twenty-four (24) hours from admission. However, in case the Member, due to his medical condition, is unable to communicate directly or through a representative, the 24-hour notification period shall be extended for twenty-four (24) hours from the time he is clinically able to do so;
- (6) In all these circumstances, Forticare reserves the right to validate whether the treatment received is emergency in nature and/ or the illness or condition is covered under the provisions of this Agreement;
- (7) **Ambulance Service** not to exceed Two Thousand Five Hundred Pesos (P2,500) per availment from a non-accredited to an accredited hospital or medical center if approved by the attending physician, Forticare shall be reimbursed and charged to the MBL or the Member; &
- (8) **Special Diagnostic and Laboratory Procedures** will be shouldered by Forticare when medically indicated and required by an accredited physician and shall include:
  - a. X-ray
  - b. Computed Tomography Scan (CT SCAN)
  - c. 2D Echocardiography with doppler
  - d. Ultrasound
  - e. Magnetic Resonance Imaging (MRI)
  - f. Other test or procedures deemed appropriate by Forticare

Note: Whether the Emergency Health Care Services are secured in any Forticare accredited or non-accredited hospital or medical center, the Member, directly or through his representative **should inform Forticare within twenty-four (24) hours from the start of the emergency.** However, in case the Member, due to his medical condition, is unable to communicate directly or through a representative, the 24-hour notification period shall be extended for twenty-four (24) hours from the time he is clinically able to do so. Otherwise, Forticare reserves the right to deny paying for any emergency health care service or benefit directly to the Member. Furthermore, the cost of any and all health care services to be provided or paid for by Forticare shall be accumulated and should not exceed the Maximum Benefit Limit (MBL) of the Member (see Article VI)

**ARTICLE VI – MAXIMUM BENEFIT LIMIT**

The **Maximum Benefit Limit (MBL)** The **Maximum Benefit Limit (MBL)** refers to the amount of health care services provided to the Member per covered illness or injury within the term of this Agreement. The Maximum Benefit Limit (MBL) each year may be derived by multiplying the benefit limit by the number of units purchased by the Member as well as the maximum room rate per year based on the schedule below:

\_\_\_\_\_  
Signature of **MEMBER** over printed name

\_\_\_\_\_  
Printed name & signature of **PARENT OR GUARDIAN**  
(If Applicant is below eighteen (18) years old)

**No. of Unit BL/UNIT/YEAR ROOMRATE/UNIT**

1                      5,000.00                      100.00  
Should be cost of medical expenses provided to the Member exceed the MBL, Forticare shall not pay for such access. If a Member is confined in a hospital room of higher category than his room and board Accommodation within the Forticare network for whatever reason except during Emergency Care referred to under Article V of this Agreement, incremental rate differences and excess charges due to voluntary or involuntary room upgrading shall be charged to the Member.

All excess and related charges brought about by the aforementioned shall be for the account of the Member and must be paid by the latter directly to the hospital before his discharge.

**ARTICLE VII – AVAILMENT OF MAXIMUM BENEFIT LIMIT, BENEFIT PAYMENT & REIMBURSEMENT CLAIMS FOR EMERGENCY CASES**

Availment of any health care service and benefit commences once the Member has complied with the underwriting requirements of Forticare. The effectivity of this Agreement starts upon the indicated date of issue, as mentioned in Article I, and payment of the Membership fee by the Member through any licensed representative of Forticare or any Forticare business office, supported by duly-recognized official and/or provisional receipt.

1. To avail of any health care services, the Member must secure first a Letter of Authorization (LOA) from Forticare. However, if an emergency exists, he must give a timely notice to Forticare before any consultation, treatment or confinement can happen
2. The Member may choose the health care provider from among those provided and accredited by Forticare
3. Payment of Health care services to any provider si made by Forticare upon receipt of all supporting documents certifying treatment by the latter. All certificates, accounts, receipts , information and evidence required by Forticare shall be furnished in such form as Forticare may require.
4. Subjects to the provisions of Article VI, Reimbursement of medical expenses in favor of the Member may be allowed only upon presentation and submission of proof of payments to Forticare within (30) days from release or administration of service.
5. Written notice of any claim given by or on behalf of the Member or Dependent to Forticare or to any authorized representative of Forticare , with information sufficient to identify the Member , shall be deemed notice to Forticare.
6. Forticare shall not pay , or not be liable for, the cost of any health service incurred by the Member after his discharge has been authorized , or if the member refuses to follow the recommended treatment or procedure, or after it is established that no professionally-accepted treatment or procedure still exist.
7. If Member has been previously discharge against medical advice or any illness related thereto, Forticare shall not be liable for the cost of any services incurred in connection therewith.
8. If any claim under this Agreement is in any respect fraudulent , all benefits payable and/or pain in relation to that claim shall be forfeited and if deemed appropriate, recoverable respectively.

9. This Agreement is integrated with benefits under the Philippine Health Insurance Corporation (PhilHealth) and/or Employee Compensation Commission (ECC). Forticare will deduct this entitlements from the amount otherwise payable. Forticare will not pay or advance the costs of such benefits, nor be responsible for filing any claims under PhilHealth or ECC. Injuries sustained from a motorcycle accident when there is NO third party involvement and the Member is clearly NOT at fault, shall be covered up to Twenty Thousand Pesos (P 20,000.00) each year.
10. Should a third party be liable for the injury or illness for which health services are provided to the Member under this agreement, Forticare shall be subrogated to the extent of the amount it shall have paid to the rights or claims that the Member may have against said third-party
11. Accordingly, the Member should extend any and all assistance to Forticare for the enforcement of this provision such as , but not limited to, execution of his affidavit and those of his witnesses , procurement of all needed object and documentary evidence including testifying in Court, if necessary . Failure of which , the Member shall reimburse Forticare for any and all payments made to any third party by reason of such injury or illness he suffered.
12. Forticare shall have the right and opportunity to examine the Member when and as often as it may reasonably require during the pendency of claim hereunder, and the right and opportunity to make an autopsy in case of death , where it is not forbidden by law.
13. **AREAS WITHOUT ACCREDITED HOSPITALS.** In areas without Accredited Hospitals, Forticare will reimburse the following:
  - a. 100% on room and board charges according to the Member’s Room and Board Accommodation;
  - b. 100% on other hospital bills according to the Member’s Room entitlement; &
  - c. Professional Fees based on Forticare rates for an Accredited Physician rendering the service in an Accredited Hospital according to the PF of the Member’s Room entitlement.
14. **DOWNGRADING OF ROOM ACCOMODATION.** Availment of a room accommodation lower than the Member’s Room and Board Accommodation can be done at the option of the Member but there shall be no refund or offsetting for the cost difference in room accommodation and other related medical benefits.
15. **EXCESS CHARGE.** Any availment that is not covered but is advanced by Forticare shall be charged to the Member and the Member shall be liable to pay such advances. These shall include but not limited to the following;
  - A. Benefit availment of lapsed or cancelled Members even if approved by Forticare.
  - B. Hospital bills and Professional fees that are in excess of Forticare rates.
  - C. Amount in excess of the Maximum Benefit Limit (MBL).
  - D. Availment that is not intended to be covered by Forticare, such as exclusions, fraudulent availments, uncoverable items, telephone calls, additional beds, etc.

**BENEFIT PAYMENT**

All benefits shall be in PHILIPPINE PESO.

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Signature of **MEMBER** over printed name

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Printed name & signature of **PARENT OR GUARDIAN**  
(If Applicant is below eighteen (18) years old)

1. **Payment of Benefits.** If a Member incurs Eligible Expenses during the effectivity of this Agreement, Forticare will pay benefits in Accordance with Benefit Coverage of this Agreement. Forticare will pay the Eligible Expenses after application of any stipulated co-payment or other deductions that may apply
2. **Coordination of Benefits.** Benefits will not exceed the total medical expenses when combined with other health care or medical coverage in force or organizations or which are provided free of charge in government or private facilities.

**REIMBURSEMENT CLAIMS FOR EMERGENCY CASES**

1. **Limitations.** The claims for reimbursement shall apply only in emergency treatments. Whether out-patient or in-patient, rendered in **Non-Accredited Hospitals.**
2. **Filing of Claims.** All claims for reimbursement must be filed using the prescribed claim form and submitted to Forticare Officers within thirty (30) days from the date of availment for out-patient or from date of discharge for in-patient.  
Failure to submit within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time.
3. **Payment of Claims.** All benefits that pertain to a Member will be paid by check to the order of Principal Member, unless the Principal Member requests otherwise, or Forticare, in its discretion, considers it preferable to make the payment in other manner. In case of death of a Member, any benefit due but remaining unpaid shall be paid to the first surviving class of the following classes of successive preference of beneficiaries: the Member's (a) widow or widower; (b) surviving children; (c) surviving parents; (d) surviving brothers and sisters; and, (e) executors or administrators.
4. **Request for Reconsideration.** If a claim for reimbursement is denied, or the Member is not satisfied/agreeable to the reimbursement paid by Forticare , a written request for reconsideration must be filed with the Forticare Head Office not later than ten (10) days from receipt of such denial or questioned reimbursement. Otherwise, the claim shall be deemed satisfied or terminated. The request for reconsideration shall contain all the reasons upon which reconsideration is sought and shall be decided upon by an authorized personnel of Forticare , whose decision shall be final. Forticare reserves the right to deny Claims for Reimbursement if the procedures and requirements have not been strictly complied with.

**ARTICLE VIII – PRE-EXISTING CONDITION**

1. Pre-existing illness or injury, counts only those conditions for which the member actually received medical advice, diagnosis, care or treatment prior to enrollment to the health care program and includes those condition that were never diagnosed. But caused symptoms for which an ordinary prudent person would have sought medical advice, care or treatment. Any pre-existing condition of the Member is **NOT** covered. However, in the event the Member opts to renew this Agreement, pre-existing illness

or injury may be accepted subject to the terms and conditions of the renewal Agreement. Forticare will provide the Health Care Benefits to the Member after the first **twelve(12) months** of membership, provided that there is no failure to disclose, misrepresent or conceal material information in the original application or application for reactivation. Non withstanding the disclosure by the Member of a pre- existing condition, Forticare may permanently exclude from coverage a specific medical condition, illness or injury upon written notice to the Member.

2. Failure to disclose or misrepresent any material information, including Pre-existing condition, by the Member in the application form or medical examination, whether intentional, shall automatically invalidate this Agreement from the very beginning, and liability of Forticare shall be limited to the return of all Membership fees paid less cost of previous services rendered or amount already refunded plus administration fee.
3. Without necessarily limiting the enumeration below, the following may be considered as pre-existing conditions if consultation or treatment was sought prior to the effectivity of this Agreement;
  - a. Any dreaded disease as defined in Article IX of this Agreement except those related to accidents and drowning;
  - b. Hypertension;
  - c. Goiter (nodular, hypo/hyperthyroidism);
  - d. Cataract/Glaucoma;
  - e. Ear, nose, throat (ENT) conditions requiring surgery;
  - f. Bronchial Asthma and other systemic allergies;
  - g. Primary Complex/ Tuberculosis / Leprosy / Sarcoidosis
  - h. Chronic cholecystitis;
  - i. Chronic pancreatitis;
  - j. Acquired hernias;
  - k. Benign prostatic hypertrophy and other prostatic disorders;
  - l. Hemorrhoids and anal fistulae;
  - m. Benign tumors;
  - n. Endometriosis and other causes of dysfunctional uterine bleeding;
  - o. Buerger's disease and other forms of vasculitis;
  - p. Varicosities;
  - q. Arthritis/Osteoporosis
  - r. Migraine headache;
  - s. Dyspepsia / gastritis / duodenal or gastric ulcer;
  - t. Ascites and other edematous states

It is understood that the foregoing stipulations shall likewise be applicable to "dreaded diseases" as defined in Article IX of this Agreement . Also, treatment or management of any declared up to Maximum Benefit Limit (MBL) defined in Article VI of this Agreement.

**ARTICLE IX – DREADED DISEASES**

Prospective Members with dreaded diseases may still be accepted for Membership to the health care program. Provided, that dreaded diseases acquired prior to his enrollment are covered after the first **twelve (12) months** of Membership and Forticare shall have the absolute right to pay for the health care benefits as herein defined up to the Member's Maximum Benefit Limit (MBL). "Dreaded Diseases" are potentially or actually life threatening conditions. They must also be considered as illness that may require unusually or uncustomary prolonged or repeated hospitalization and

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Signature of **MEMBER** over printed name

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Printed name & signature of **PARENT OR GUARDIAN**  
(If Applicant is below eighteen (18) years old)

may likewise require intensive/critical care management . The dreaded diseases include, but shall not be limited to, the following:

- a. Cerebro-vascular Accident and its complications;
- b. Central Nervous System Diseases EXCEPT neurological autoimmune diseases;
- c. Hypertension and its complications/cardiovascular Disease;
- d. Chronic Obstructive and Restricted Pulmonary Disease;
- e. Liver Parenchymal Disease EXCEPT Hepatitis A;
- f. End stage Renal Disease and other conditions that may require dialysis
- g. Chronic Urological Disease causing hydronephrosis and/or hydroueter, inflammatory bowel / Chronic Gastrointestinal Tract Disease requiring bowel resection and/or anastomosis;
- h. Collagen Disease, Diabetes Mellitus and its complications;
- i. Malignancies and Blood Dyscracias;
- j. Injuries from accidents or assaults , frustrated homicide or murder (subject to police report);
- k. Complications of an apparent ordinary illness including Multiple Organ Dysfunction (MOD) and SIRS (Systematic Inflammatory Response Syndrome);
- l. Single or Multiple organ Dysfunction and failure;
- m. Chronic pain syndrome (more than six [6] weeks);
- n. Near drowning and drowning;
- o. Shock syndrome;
- p. Any condition/illness other than the above mentioned diseases/conditions which would require Intensive/Critical Care Unit confinement.

**ARTICLE X – EXCLUSION FROM HEALTH CARE COVERAGE**

Forticare shall not be liable for any health care benefit under the following conditions:

- 1. Self-inflicted or induced injury or illness , or if arising out of attempted suicide.
- 2. Injury or illness sustained in connection with the commission of a crime or violation of law or due to unnecessary hazardous activities.
- 3. Treatment of alcohol or drug related abuse or dependency.
- 4. Cosmetic treatment and/or surgery or other forms of surgery for beautification and procurement of eyeglasses, braces, hearing aids and prosthetic appliances.
- 5. Home and/or rehabilitations services, convalescent or recuperative care and take home medicines and medical supplies.
- 6. Pregnancy-related medical care except pre-natal and post-natal consultations in Article V , child birth , miscarriage, sex transformation , artificial insemination , treatment of infertility or sex sterilization and abortion .
- 7. Acute immunodeficiency Syndrome (AIDS), AIDS-related and other sexually-transmitted diseases. A Member who was diagnosed to be infected with Human Immunodeficiency Virus (HIV) shall NOT avail of the health care benefits under this Agreement if the Member is NOT undergoing proper medical treatment; the Member has NO favorable risk profile; and the results of the Member’s medical examinations are NOT within the normal limits, as determined and declared by Forticare’s Medical Director or Accredited physicians. Forticare may suspend the acceptance of the Member’s application,

if after undergoing a Voluntary HIV Testing, he was diagnosed to the infected with HIV , for a period not exceeding twelve (12) months from the start of continuous Anti-Retroviral Therapy (ART) in order to evaluate compliance with the efficacy of treatment.

- 8. Physical examination for insurance and pre-employment purposes. Health care services not incidental to the treatment of an illness or injury including medico-legal fees.
- 9. Counselling and treatment of mental or psychiatric disorders or psychosomatic illness and psychotherapy.
- 10. Coronary angiography, percutaneous trans coronary angioplasty, open heart surgery, pacemaker insertion , complicated hypertension , organ transplant or hyperalimentation.
- 11. Latest modalities of diagnostic procedures and treatment unless deemed appropriate by and upon approval by Forticare’s Medical Director.
- 12. Cranial surgery , including but not limited to Gamma knife procedure. Except serious injuries from accident.
- 13. Executive check-up or any confinement to diagnose any medical condition or to screen any disease entity.
- 14. New modalities of diagnostic procedures and treatment, including but not limited to robotic surgery, stem cell therapy, etc. , unless deemed appropriate by, and upon prior approval of Forticare.

**ARTICLE XI – MEMBERSHIP FEES**

- 1. **AMOUNT OF MEMBERSHIP FEES.** The Member shall pay the Membership fees for the services covered under this Agreement.
- 2. **PAYMENT OF MEMBERSHIP FEES.** The Membership Fees are due on the Effective Date of this Agreement and every month thereafter for monthly for monthly mode of payment’ every quarter thereafter for semi- annual mode of payment. The Membership fees for all Members enrolled under this Agreement. The Membership fee shall be payable in advance and is subject to modification upon prior notice to the Member. Membership Fee may be paid at Forticare Head Office pr at such other places as may be designated by Forticare.
- 3. **REFUND/CREDIT OF MEMBERSHIP FEE.** If a Member’s coverage is terminated or cancelled, the unused pro rata Membership Fee paid shall be refunded to the Member only if no availment has been made by the Member prior to the termination or cancellation. Refund is available only if the Member has fully paid its annual or semi-annual Membership Fees.

There shall be no refund of Membership Fee in the event that:

- a. Membership Fee is payable on a quarterly or monthly mode;
- b. Remaining coverage of the Member is six (6) months or less;&
- c. The Member has availed of any benefits under this Agreement.

If the Membership Fees are unpaid prior to cancellation or termination of Membership , the Member shall settle the pro rata Membership Fee, inclusive of penalty charges if applicable.

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Signature of **MEMBER** over printed name

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Printed name & signature of **PARENT OR GUARDIAN**  
(If Applicant is below eighteen (18) years old)



**ARTICLE XII – LAPSATION , GRACE PERIOD,  
REACTIVATION AND CANCELLATION**

**LAPSATION**

If payment is not made on the indicated and agreed due date , this Agreement shall lapse. Such as, all benefits

shall be deemed suspended subject to the grace period provided in this Agreement.

**GRACE PERIOD**

The Member is given a maximum of thirty (30) days from due date, **without need of any notice or demand** , to pay the Membership Fee as to reactivate this Agreement and avail of the health care benefits provided herein. The Member may continue to avail of the Health Care Benefits as soon as the Membership fee has been paid. All claims incurred during the grace period shall be paid to the Member only after the due Membership fee is paid.

**REACTIVATION PERIOD**

If no payment is made on the Membership fee after the grace period, the Agreement will remain in lapsed status and availment of any Health Care Benefit is suspended, until full payment of all Membership fees due, including penalty charges equivalent to one and a half percent (1 ½ %) a month or a fraction thereof on the unpaid Membership Fees due, computed from due date.

During Reactivation period, the Member shall be given fifteen (15) calendar days from the end of the grace period to reactivate his or her coverage by (a) submitting a written request for reactivation; (b) paying the Membership fee due with arrears, including the penalty charge per Member; or (c) for modes of payment other than annual, paying in advance the Membership Fee due for the next period.

This Agreement may be reactivated upon compliance with the following procedures:

1. The Member must accomplish the Application form for Reactivation and submit the form as well as the lapsed Agreement/Policy to Forticare within fifteen (15) calendar days from the end of the thirty (30) days grace period; AND
2. Pay all the Membership Fees due, including penalty charges equivalent to one and a half percent (1 ½ %) a month or a fraction thereof on the unpaid Membership Fees due, computed from due date until full payment. In this manner. All rights, benefits and privileges specified in this Agreement shall be reactivated to the Member subject to the underwriting requirements for a new application for Membership being implemented at the time.

**Note:** If the amount due, including related fees and charges, is not paid before the end of the grace period, this Agreement shall, without need of any notice or demand to the Member, be terminated without prejudice to collect the amount due and the corresponding penalty charges that have accrued thereon, all payments made previously shall be forfeited in favor of the company as liquidated damages. The Member shall lose all rights, benefit and privileges except the right to reactivate this

Agreement . after fifteen (15) days from end of grace period and all fees required in reactivation of coverage is not yet paid and settled, Forticare reserves the right to disapprove reactivation. However , Member may re-apply subject to approval of Forticare.

**ARTICLE XIII – NON-TRANSFERABILITY AND  
TERMINATION NON-  
TRANSFERABILITY**

All benefits in this Agreement are not transferable or assignable. Member may not assign any of its rights or delegate any of its obligations under this Agreement without the prior written consent of Forticare. Forticare may assign any of its rights or delegate any of its obligations upon written notice to Member . Any purported assignment or delegations in violation of this Agreement is null and void.

**TERMINATION**

**1. PRE-TERMINATION OF THIS CONTRACT**

The Member is allowed to pre-terminate this Agreement at any time while the same is in force during the term of this Agreement upon submission of a written request to Forticare and shall surrender this Agreement.

**2. TERMINATION OF AGREEMENT BY FORTICARE**

Forticare shall have the right to immediately terminate this Agreement in the event that :

- a) Any material representation or warranty made by Member commits any act with the intent to defraud Forticare ; &
- b) Non-payment of Membership Fees and other obligations subject to agreed payment terms.

All medical services and coverage under this Agreement shall terminate on the termination date, without prejudice to any claim for covered medical services rendered to a Member prior to the termination date.

Termination under this provision shall be without prejudice to the right of Forticare to collect the Member's obligations which have become due and demandable.

**3. TERMINATION OF MEMBER'S COVERAGE.**

Coverage shall Automatically terminate on the earliest of the following:

- a. Expiry date;
- b. The date a Member ceases to be eligible for the coverage. However, when the Member's age exceeds the maximum permissible age , coverage will continue until Expiry Date ;
- c. When the Membership Fee and/or other obligations are not paid within the grace period;
- d. Effective immediately, when the Member has fraudulent availment or material misrepresentation or misstatements for the purpose of availing the benefits;
- e. Effective immediately, when the Member enters military , naval or air service of any country or international authority ;&
- f. Effective immediately, when the Member fails to observe the terms and conditions of this Agreement or fails to act when utmost good faith.

All medical expenses incurred after the date of termination of the Member's coverage shall be charged to the Member.

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Signature of **MEMBER** over printed name

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Printed name & signature of **PARENT OR GUARDIAN**  
(If Applicant is below eighteen (18) years old)

If the Membership Fees are unpaid prior to cancellation or termination of membership, Member shall settle the pro-rata Membership Fee, inclusive of penalty charges, if applicable .

**4. INVALIDATION OF AGREEMENT.** Failure to disclose or misrepresent any material information by the Member in the application form or medical examination, whether intentional or unintentional , shall automatically invalidate this Agreement from the very beginning, and liability of Forticare shall be limited to the return of all Membership Fees paid less cost of previous services rendered or amount already refunded plus administration fee.

**ARTICLE XIV – UNFORSEEN EVENTS AND FORCE MAJEURE**

1. Forticare may not be held liable for any delay, inconvenience, loss, damage, or any adverse conditions that may be sustained by any Member due to fire, flood , earthquake, war or civil disturbance, extraordinary economic upheaval, strikes and labor disputes, act of nature, government legislation or regulation or other conditions beyond its control , in connection with the discharge of its obligations under this Agreement.
2. The Member and Forticare expressly agree to waive the applicability to the Agreement of Art. 1250 of the New Civil Code of the Philippines (RA 386) which provides: "in case of Extraordinary inflation or deflation of the currency stipulated should supervene, the value of the currency at the time of establishment of the obligation shall be the basis of payment"
3. Should a new tax or fee imposed in the future by law or otherwise by ordinance affecting this Agreement, the Contact Price . or the charges for the health care and other benefits guaranteed herein . the Member shall be liable for the same, Future taxes, levies or fees referred herein are only those that affect the quoting of Membership Fees (Ex. 12% VAT) , other future taxes , levies or government imposing that do not affect the quoting of Membership Fees are therefore excluded.

**ARTICLE XV – RENEWAL OF AGREEMENT**

This Agreement may be kept in force by payment of the Membership Fee on the due date. The renewal Membership Fee for each year of coverage is based on the age of each Member on the first day of the renewal year of coverage, the Membership Fee Rate Table then in effect, and other factor which materially affect the risk of the Member. Forticare has the right to change the Membership Fee rates table on a class basis for all similar Agreements on this form. The renewal Membership Fee may be subject to adjustment based on claims experience of the Member.

Changes in plan, including upgrading or downgrading of plan and addition or deletion of benefits are allowable during the renewal of this agreement subject to the approval of Forticare.

**ARTICLE XVI – GOVERNING LAW & ARBITRATION CLAUSE**

This Agreement shall be governed by and construed in accordance with the laws of the Republic of the Philippines.

Any Difference arising between the Member and Forticare shall be referred to an arbitrator to be appointed by the parties to the dispute. If the parties are unable to agree on a single arbitrator to be appointed by the parties to the dispute. If the parties are unable to agree on a single arbitrator , two (2) arbitrators shall be appointed (one by each party). In the event of further disagreement, the arbitrators shall select an umpire. If the difference between the parties requires medical knowledge (including any question regarding the appropriate maximum indemnity for any medical service or an operation not listed in the schedule of surgical fees) the arbitrators at the discretion of Forticare, may be a registered medical practitioners and the umpire in such an instance, shall be a consultant Specialist, Surgeon , or Physician. Determination of an award shall be a condition Precedent to Any liability or right of action against Forticare.

**ARTICLE XVII – AUTHORITY TO EXAMINE MEDICAL RECORDS**

Member hereby consents and authorizes Forticare and any of its authorized representatives to: (a) obtain, examine and process the Member’s or Dependent’s personal information, including the medical records of their hospitalization, consultation, treatment or any other medical advice in connection with the benefit /claim availed under this Agreement; and (b) disclose such information to Member and his/her representatives.

**ARTICLE XVIII – CONFIDENTIALITY**

Members, agents or representatives, shall not use or reproduce, directly or indirectly any Confidential Information for the benefit of any person, or disclose to anyone such Confidential Information without the written authorization of Forticare, whether during or after the term of this Agreement, for as long as such information retains the characteristics of Confidential Information.

"Confidential Information" means any data or information, that is proprietary to Forticare and not generally known to the public , whether in tangible or intangible form, whenever and however disclosed, including , without limitations , (1) personal information , treatment and operations undergone by its Members, (2) trade secrets, confidential or secret formulae, special medical equipment and procedures, (3) medical utilization reports, directly or indirectly useful in any aspect of the business of Forticare, (4) any vendor names, Member and Supplier list, (5) marketing strategies, plans, financial information, or projections, operations, sales estimates, business plans and performance results relating to the past, present or future business activities of Forticare, (6) all intellectual or other material of Forticare, (7) all forms of confidential information including , but not limited to , loose notes, diaries , memoranda , drawings , photographs, electronic storage and computer print outs ; (8) any other information that should reasonably be recognized as confidential information of Forticare. All information which Member acquires or becomes acquainted with during the period of this Agreement, whether developed by Forticare or by others, which Member has a reasonable basis to believe to be confidential information shall be presumed to the confidential information. Confidential Information need not be novel, unique , patentable, copyrightable or constitute a trade secret in order to be designated Confidential Information.

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Signature of **MEMBER** over printed name

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Printed name & signature of **PARENT OR GUARDIAN**  
(If Applicant is below eighteen (18) years old)

**ARTICLE XIX – SEPARABILITY**

If any term or provision of this Agreement is declared invalid, legal or unenforceable under Philippine laws , such invalidity , illegal or unenforceability shall not affect or render unenforceable any other term or provision of this Agreement.

**ARTICLE XX – NOTICES**

All notices, demands and other communications required or permitted hereunder shall be made in writing and sent to Member at the address indicated in the Conforme Letter.

**ARTICLE XXI – VENUE AND PRESCRIPTION**

The venue for any action legal actions and proceedings arising out of or in connection with this contract shall be exclusively in City of Manila, Philippines.

**ARTICLE XXII – IMPORTANT NOTICE**

The Insurance Commission, with offices in Manila, Cebu and Davao , is the Government office in charge of the enforcement of all laws related to Health Maintenance Organization (HMO), and has supervision over HMOs. It is ready at all times to assist the general public in matters pertaining to HMO, pre- need and insurance. For any inquiries or complaints, please contact the Public Assistance and Mediation Division (PAMD) of the Insurance Commission at 1071 United Nations Avenue, Manila with telephone numbers +632-8-5238461 to 70 and email address publicassistance@insurance.gov.ph. The official website of the Insurance Commission is www.insurance.gov.ph

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Signature of **MEMBER** over printed name

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Printed name & signature of **PARENT OR GUARDIAN**  
*(If Applicant is below eighteen (18) years old)*