INFORMATION REGISTRATION AND DATA PROCESSING CONSENT

DECLARATION:

I declare that the information I will give are true and correct. I hereby release Insular Health Care, Inc. ("InLife Health Care") and its officers, employees, agents, doctors, nurses and staff from any liability arising from any action taken based on this declaration.

I further declare that I am voluntarily filling out this form as I seek or avail HMO coverage from, or as I undergo medical examination, treatment or other health care services at/through InLife Health Care.

______________________________	______________________	______________________
Client/ Patient's Signature above Printed Name (Thumbmark if unable to sign)	Date (MMM/DD/YYYY)	Time (0000H)

TO THE CLIENT/ PATIENT: You have the right to be informed about your personal data that will be entered into InLife Health Care's system and the purpose for which it will be processed. Kindly read all the information on this form before accomplishing and signing it.

Date today (MMM/DD/YYYY)			
Name (Last Name, First Name, Middle Name)			
Birthday (MMM/DD/1989)		Sex (at birth) ☐ Male ☐ Female	
Permanent Address			
Present Address (If different from Permanent Add.)			
Contact Number		Email Address	
Person to notify In case of Emergency		Contact Number	
Religion*		ID Presented	

*Please note any conscientious objection (objection to any medical treatment due to religious beliefs).

IMPORTANT: You may request the staff of InLife Health Care to explain, or refer you to someone who can explain, your data privacy rights under RA 10173 or the Data Privacy Act of 2012.

I understand that in the course of my HMO coverage, or of my examination, treatment or availment of other health care services, InLife Health Care will process my personal information ("Personal Data") such as but not limited to my age, address, nationality, sex, civil status, religious affiliation, contact information, medical history, records and information, medication, genetic or sexual life and other information relevant or connected with my HMO coverage from, or of my diagnosis, treatment or availment of health care services at InLife Health Care.

I understand that the processing of my personal data may include its collection, recording, organization, storage, updating or modification, retrieval, consultation, use, consolidation, blocking, erasure or destruction by InLife Health Care and other persons or entities herein authorized.

By signing this consent form, I am specifically:

1. Consenting to making my personal data available to InLife Health Care, its affiliates, related entities and partners (including its officers, employees, agents, brokers, service providers as well as members of its medical staff, house staff, doctors, nurses, allied health care personnel and other clinical staff including interns, trainees, etc. – "InLife Related Entities"), and permitting InLife Health Care and InLife Related Entities to make my personal data available to (a) third parties who provide products and services to InLife Health Care for the same or related purposes as described above; (b) regulatory authorities and government agencies such as, but not limited to, the Insurance Commission, the Anti-Money Laundering Council and the Department of Health, and (c) other third parties such as, but not limited to, **(for those referred by a corporate client; may be excluded hereunder)** my employer or prospective employer including its officers and agents, where required or permitted by law or contract.

   [Please check only if you are (1) referred by a corporate client <u>and</u> (2) you object to the disclosure of your personal data to your employer or prospective employer]

   ☐ I do not allow InLife Health Care to make available my personal data to my employer or prospective employer. As a consequence of this objection, I authorize InLife Health Care to inform my employer or prospective employer that I have made such objection.

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2. Authorizing InLife Health Care to obtain from my health care provider/doctor/hospital any of my medical records/information that the provider has in his/her/its possession, including records/information relating to any of my medical history or mental and physical condition, or any treatment I have received in connection with my HMO coverage from InLife Health Care;

3. Consenting to the processing of my personal data as provided under applicable laws, regulations, and InLife Health Care's Privacy Policy, including its subsequent amendments, as stated in its website (www.insularhealthcare.com.ph/privacy-policy/). I understand that my personal data may be used to comply with legitimate purposes, including any examination, diagnosis, treatment, procedure, and/or my availment of other health care services at InLife Health Care;

4. Consenting to the processing of my personal data for purposes of direct marketing, cross-selling and relationship management. These include receiving news and updates about InLife Health Care's products, promos and offers through SMS, emails or letters. I further consent to making my personal data available to InLife Health Care's affiliates and related entities for the same purpose.
   - I prefer not to receive any marketing-related communication through ☐ SMS, ☐ emails or ☐ letters

5. Consenting to the processing of my personal data for research and education, profiling, historical or scientific purpose, as well as to generate statistical data relevant to InLife Health Care's operations in order to aid InLife Health Care's management team, board of directors and shareholders to review and analyze data relating to InLife Health Care's operations and financial performance.

   ☐ I am withholding my consent for number(s) _____ above.

I warrant that before providing InLife Health Care with the personal data of my next of kin/legal representative, I have obtained their consent (a) for me to collect their personal data; (b) for me to share the same with InLife Health Care and the third parties that InLife Health Care are dealing with as provided above; and (c) for the processing of their personal data by InLife Health Care, InLife Related Entities and third parties as provided herein, and for the purposes stated herein.

The personal data I have provided will be retained by InLife Health Care and InLife Related Entities as prescribed by law, or as long as necessary for the purpose of maintaining my medical records and to comply with applicable laws, rules and regulations. Through this form, I have been made aware that I and my next of kin/legal representative are entitled to certain rights in relation to the personal data that may be collected from me and my next of kin/legal representative, including the right to access, correction, and to object to the processing of the same. I have been made aware that a more detailed description of my rights under RA 10173 or the Data Privacy Act of 2012, and its implementing rules and regulations may be accessed and downloaded at www.privacy.gov.ph. I have likewise been made aware that should I have any privacy concern regarding my personal data, I may consult InLife Health Care's Data Protection Officer at dataprivacy@insularhealthcare.com.ph or Tel: 813-0131 loc 8505, or the National Privacy Commission at www.privacy.gov.ph

ACKNOWLEDGEMENT: I hereby confirm that I understand the foregoing and that I am voluntarily giving my consent to the processing of my personal data under the terms and conditions provided above. I understand that the consent I am giving through this form is in addition to any other consent that I may have already given InLife Health Care and its affiliates regarding the processing of my personal data (e.g. in relation to HMO coverage/ availment, examination, diagnosis, treatment or procedure). I likewise understand that the consent I have given shall remain in full force until revoked in writing except to the extent that action has already been taken based therein. I hereby release InLife Health Care and InLife Related Entities from any liability arising from any disclosure and/or processing made in accordance with the consent I have given. A photographic copy of this authorization shall be as valid as the original.

[Maaaring tawagin ang pansin ng tauhan ng InLife Health Care kung hindi nakakaunawa ng Ingles. Huwag pumirma kung mayroong hindi naiintindihan.]

_______________________________	_______________________	_______________________
Client/ Patient's Signature above Printed Name (Thumbmark if unable to sign)	Date (MMM/DD/YYYY)	Time (0000H)

IF CLIENT/PATIENT IS A MINOR OR INCAPABLE TO GIVE CONSENT

_______________________________	_______________________	_______________________
Signature above Printed Name (Thumbmark if unable to sign)	Relationship to Client/ Patient	Date (MMM/DD/YYYY)

Reason why the Client/ Patient cannot accomplish this form:

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