redefining / insurance

AXA Insurance Public Company Limited
23rd Floor, Lumpini Tower, 1168/67 Rama 4 Road,
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Smart*Care Optimum*

APPLICATION FORM FOR THE INSURED PERSON (1/2)

Insured Person # 1 : Particulars of The Insured Person

1. Applicant's Name-Surname: _____

Date of Birth d d m m y y y y Age (Years) _____ (Months) _____ Height (cm) _____ Weight (kg) _____

ID Card No./ Passport No. _____

Marital Status (please advise) ☐ Single ☐ Married ☐ Other _____

Address _____

_____

☎ Home _____ Mobile _____ E-MAIL _____

Occupation (Position) _____ Job Responsibility _____

Company Name _____ Type of Business _____

Company Address _____

☎ Office _____ Fax _____

Beneficiary Name-Surname: _____ Relationship to the applicant _____

Please advise your Smoking and Drinking habits?

Smoking ☐ No ☐ Yes _____ cigarettes/day starting from age _____ years

Drinking ☐ No ☐ Yes _____ glasses/day starting from age _____ years

CHOICE OF PLAN

Please ✓ the appropriate box for your family

1. Hospitalization and Surgery Care	☐ Basic Plan	☐ Classic Plan	☐ Deluxe Plan
2. Outpatient Care (per annual limit)	☐ Baht 20,000	☐ Baht 30,000	☐ Baht 50,000

Note: The same benefits are required for the family discount

For Premium Confirmation :	Premium	Family Discount	Premium
Insured Person # 1 Applicant			
Insured Person # 2 Spouse			
Insured Person # 3 Child 1			
Insured Person # 4 Child 2			
Total			

QUESTIONS FOR THE INSURED PERSON

Please ✓ the appropriate box	Yes	No
1. Do you have health, life or accident insurance with other Insurers?	☐	☐
2. Have you ever been declined or accepted on special terms for health, life or accident plan?	☐	☐
3. Have you ever undergone a surgical procedure of investigative nature or hospitalized or had a major accident in the last 5 years?	☐	☐
4. Have you ever been advised to have a surgical operation or investigative procedure which has not been performed?	☐	☐
5. Have you had special treatment with X - Ray, Ultrasound, CT scan, MRI Scan, Biopsy, and Electrocardiogram?	☐	☐

Remark: If your answer is "Yes" please provide details ; e.g Insurer name as name of insurer, reason of decline or details of special terms nature of surgical procedure, etc .....

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HEALTH DECLARATION OF THE INSURED PERSON

Please ✓ the appropriate box and fill in the information	Yes	No	Name of Applicant	Date of Onset	Date of Recovery
1. Any respiratory disorders, lung trouble, asthma, allergy?	☐	☐			
2. Any heart, myocardial or cardiovascular disease?	☐	☐			
3. Any skeletal - muscular system disorders, joint disorders rheumatism, arthritis, gout or back trouble?	☐	☐			
4. Any digestive disorders?	☐	☐			
5. Any enlarged glands or any form of cancer, tumor non-malignant tumor or mass or cyst?	☐	☐			
6. Any eye, ear, nose or throat disorders and abnormalities?	☐	☐			
7. Any liver and gall bladder disorder i.e. hepatitis cholecystitis gallstones?	☐	☐			
8. Any reproductive disorders and sexually transmitted diseases?	☐	☐			
9. Any urinary system disorders?	☐	☐			
10. Any circulatory and blood disorders?	☐	☐			
11. Any thyroid gland disorders i.e. hypothyroid, thyrotoxicosis?	☐	☐			
12. Any brain and nervous system disorders and cerebrovascular disease?	☐	☐			
13. Are you currently suffering or ever been following disease? Autistic, Epilepsy, Kidney, Diabetes, Tuberculosis, S.L.E, Thalassemia Dwarfish	☐	☐			
14. Except item 13, are you injury or sickness?	☐	☐			
15. Are you currently taking any medication or undergoing any treatment regularly?	☐	☐			

Remark: If your answer is "YES", please give details of the treatment received, name of medical practitioner and the hospitals or clinics providing the medical treatment hereunder :

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We declare that the above answers are full, complete and true and agree that they shall form part of my/our application which shall be the basis of the contract of insurance. We also agree that for health insurance handling, both underwriting and claim process, we authorize any hospital, physician or other person who has attended to us, or examined us or is authorized to maintain medical records, to disclose when requested to do so by AXA Insurance PCL, any and all information with respect to any illness or injury, medical history or treatment. A photocopy of this authorization shall be considered as effective and valid as the original. We understand that this insurance will not commence until the company has approved my/our application.

_____ _____ / _____ / _____

Signature of Applicant
for and on behalf of all persons (spouse & child/children) to be insured

Application Date
(DD / MM / YYYY)

WARNING: Office of Insurance Commission (OIC)
The applicant shall disclose all the known facts. Any nondisclosure shall make the policy issued hereunder voidable.
The company has the right to void the contract and refuse claims according the Civil Commercial Code Section 865.

Note: Kindly provide to us your Photocopy of ID Card or Passport (Register of birth and House Registration for your child/ children to be insured.) Thank you.

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APPLICATION FORM FOR SPOUSE AND CHILD / CHILDREN (2/2)

Insured Person # 1 : Particulars of Spouse to be Insured

1. Applicant's Name-Surname: _____

Date of Birth d d m m y y y y Age (Years) _____ (Months) _____ Height (cm) _____ Weight (kg) _____

ID Card No./ Passport No. _____

Address _____

_____

☎ Home _____ Mobile _____ E-MAIL _____

Occupation (Position) _____ Job Responsibility _____

Company Name _____ Type of Business _____

Company Address _____

☎ Office _____ Fax _____

Beneficiary Name-Surname: _____ Relationship to the applicant _____

Please advise your Smoking and Drinking habits?

Smoking ☐ No ☐ Yes _____ cigarettes/day starting from age _____ years

Drinking ☐ No ☐ Yes _____ glasses/day starting from age _____ years

Insured Person # 2 and 3 : Particulars of Child / Children to be Insured

2. Applicant's Name - Surname: _____

Date of Birth d d m m y y y y Age (Years) ..... (Months) ..... Height (cm) ..... Weight (kg) .....

ID Card No./ Passport No. _____

Beneficiary Name-Surname: Relationship to the child .....

3. Applicant's Name - Surname: _____

Date of Birth d d m m y y y y Age (Years) ..... (Months) ..... Height (cm) ..... Weight (kg) .....

ID Card No./ Passport No. _____

Beneficiary Name - Surname: ..... Relationship to the child .....

QUESTIONS FOR SPOUSE and CHILD/CHILDREN TO BE INSURED

Please ✓ the appropriate box	NO	YES
1. Have you or your child / children proposed for insurance have health, life or accident insurance with other insurers?	☐	☐
2. Have you or your child / children proposed for insurance ever been declined or accepted on special terms for health, life or accident plan?	☐	☐
3. Have you or your child / children proposed for insurance ever undergone a surgical procedure of investigative nature or hospitalized or had a major accident in the last 5 years?	☐	☐
4. Have you or your child / children proposed for insurance ever been advised to have a surgical operation or investigative procedure which has not been performed?	☐	☐
5. Have you or your child / children proposed for insurance had special treatment with x-ray, Ultrasound, CT Scan MRI Scan, Biopsy, Electrocardiogram?	☐	☐

Remark: If your answer is "Yes" please provide details ; e.g Insurer name as name of insurer, reason of decline or details of special terms nature of surgical procedure, etc .....

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HEALTH DECLARATION OF THE INSURED PERSON

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2. Any heart, myocardial or cardiovascular disease?	☐	☐			
3. Any skeletal - muscular system disorders, joint disorders rheumatism, arthritis, gout or back trouble?	☐	☐			
4. Any digestive disorders?	☐	☐			
5. Any enlarged glands or any form of cancer, tumor non-malignant tumor or mass or cyst?	☐	☐			
6. Any eye, ear, nose or throat disorders and abnormalities?	☐	☐			
7. Any liver and gall bladder disorder i.e. hepatitis cholecystitis gallstones?	☐	☐			
8. Any reproductive disorders and sexually transmitted diseases?	☐	☐			
9. Any urinary system disorders?	☐	☐			
10. Any circulatory and blood disorders?	☐	☐			
11. Any thyroid gland disorders i.e. hypothyroid, thyrotoxicosis?	☐	☐			
12. Any brain and nervous system disorders and cerebrovascular disease?	☐	☐			
13. Are you currently suffering or ever been following disease? Autistic, Epilepsy, Kidney, Diabetes, Tuberculosis, S.L.E, Thalassemia Dwarfish	☐	☐			
14. Except item 13, are you injury or sickness?	☐	☐			
15. Are you currently taking any medication or undergoing any treatment regularly?	☐	☐			

Remark: If your answer is "YES", please give details of the treatment received, name of medical practitioner and the hospitals or clinics providing the medical treatment hereunder :

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We declare that the above answers are full, complete and true and agree that they shall form part of my/our application which shall be the basis of the contract of insurance. We also agree that for health insurance handling, both underwriting and claim process, we authorize any hospital, physician or other person who has attended to us, or examined us or is authorized to maintain medical records, to disclose when requested to do so by AXA Insurance PCL, any and all information with respect to any illness or injury, medical history or treatment. A photocopy of this authorization shall be considered as effective and valid as the original. We understand that this insurance will not commence until the company has approved my/our application.

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Signature of Applicant
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