Application form group (Employees) health and accident insurance
InternationalExclusive

1. DETAILS OF THE EMPLOYER		
The Company (Registered Name)		
Address		

1. DETAILS OF THE APPLICANT		
Name – Surname (Mr. / Mrs. / Ms.)		Age Years Months
Date of Birth (DD/MM/YYYY)		Height (cm) Weight (kg)
ID Card No. / Passport No. Nationality		Marital Status ☐ Married ☐ Single ☐ Others
Principal Country of Residence*	Telephone No.	Email
Present Address		
Occupation (Position)	Nature of Work	
Name of Employing Company	Nature of Business	
Name-Surname of the Beneficiary		Relationship

3. DETAILS OF BANK ACCOUNT (IF CLAIMS PAYMENT TO BE MADE BY BANK TRANSFER)		
Name of Account Holder		
Bank	Branch	Account No.

4. PLEASE ADVISE PHYSICIAN'S NAME(S) YOU MOSTLY VISITED IN THE PAST 5 YEARS (IF ANY)	
Name - Surname of Physician	Name of Hospital
Address	Telephone No.
Name - Surname of Physician	Name of Hospital
Address	Telephone No.

5. NAME OF PERSON(S) TO BE INSURED (PLEASE TICK THE REQUIRED BOX)

☐ You want the insurance to cover yourself only ☐ You want the insurance to include your family member(s)**, as follows:

5.1	Name - Surname		Age Years Months
	Date of Birth (DD/MM/YYYY)	Relationship	Height (cm) Weight (kg)
	ID Card No. / Passport No.	Telephone No.	Principal Country of Residence*
	Occupation	Nature of Work	
5.2	Name - Surname		Age Years Months
	Date of Birth (DD/MM/YYYY)	Relationship	Height (cm) Weight (kg)
	ID Card No. / Passport No.	Telephone No.	Principal Country of Residence*
	Occupation	Nature of Work	
5.3	Name - Surname		Age Years Months
	Date of Birth (DD/MM/YYYY)	Relationship	Height (cm) Weight (kg)
	ID Card No. / Passport No.	Telephone No.	Principal Country of Residence*
	Occupation	Nature of Work	

5.4	Name - Surname		Age Years Months
	Date of Birth (DD/MM/YYYY)	Relationship	Height (cm) Weight (kg)
	ID Card No. / Passport No.	Telephone No.	Principal Country of Residence*
	Occupation	Nature of Work	

* Principal Country of Residence means the country where the Applicant lives for more than 185 days/year which will be shown as the Covered Person's address in the Policy. The Insured must inform the Company if any Covered Person changes his/her Principal Country of Residence, as this may affect his/her eligible benefits afforded by this Policy. If the Insured fails to inform the Company about such change, the Company may deny paying eligible benefits.
* *Family Member(s) in this Application Form must be the person(s) living together with the Applicant. If not, please use a separate Application Form.

6. OTHER HEALTH INSURANCE POLICIES

Do you have other health insurance policy(ies) with AXA Insurance PCL or other insurance company(ies) or not?	☐ YES ☐ NO
Has the Applicant or family members to be insured ever been declined for insurance or accepted with special conditions or refused for insurance renewal by the insurance company or not ?	☐ YES ☐ NO

If your answer is "YES" to any of the above questions, please give details (including Company's name, insurance plan, period of insurance, and the policy number, if any.)

7. HEALTH DATA

Part 1: Please truthfully declare health data by ticking "YES" or "NO" to each question, as follows:

Questions	The Applicant Name	Member #2 Name	Member #3 Name	Member #4 Name	Member #5 Name
1. Have you ever been hospitalized as an inpatient for the past 5 years or not?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
2. Have you ever had medical consultation with a physician or a medical specialist for the past 5 years or not?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
3. Have you ever experienced or had symptoms of physical abnormality but failed to consult with a physician for the past 5 years or not?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
4. Have you ever visited a physician for the past 2 years or not?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
5. Do you have any pre-existing chronic disease or receiving continuing treatment or physical abnormality or recurrent disease for the past 5 years or not?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
6. Must you consult with a physician in the foreseeable future or not?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Part 2: If the Applicant or any family member's answer is "YES" to the above questions, please give following details:

1. Name	2. Question No.	3. Cause of Injury or Sickness	4. Onset Date	5. Duration	6. Any continuing treatment needed?	7. Current status of disease

If there are more than 1 diseases or injuries, please give details separately.

I warrant that the information provided above is correct. If any statement is misrepresented or omitted of any relevant facts, I agree for AXA Insurance Public Company Limited to terminate the insurance contract. In addition, I authorize AXA Insurance Public Company Limited or the Company's representative to have access to details of information, news of my medical record and physical conditions (including those of my spouse and children if they are included in this Policy). The copy of this authorization is valid and complete in same manner as the original copy. I understand and know thoroughly that this insurance shall be effective upon receiving confirmation from AXA Insurance Public Company Limited.

I authorize AXA Insurance (Public) Company Limited to keep, use and disclose health facts as well as details of the Applicant to the Office of Insurance Commission (OIC) for the benefits in supervising insurance business.

I wish to apply for the insurance with AXA Insurance (Public) Company Limited in accordance with the conditions of the Policy related to this insurance and I declare that the information given above is correct and complete. I agree that the information given in my application shall be the basis of the insurance contract between I and AXA Insurance (Public) Company Limited.

This document is not the insurance contract. You will be covered upon receiving confirmation from the Company.

_____ _____ / _____ / _____

Signature - The Applicant
(and as representative of spouse and children)

Applying Date (DD/MM/YYYY)

REMINDER FROM THE OFFICE OF INSURANCE COMMISSION (OIC)
Please give answers to all questions truthfully otherwise the Company may have cause to deny liability under the Policy in accordance with Section 865 of the Civil and Commercial Code.

Please attach following documents:
The Applicant 1. Copy of ID Card 2. Copy of House Registration

บริษัท แอกซ่าประกันภัย จำกัด (มหาชน)
AXA Insurance Public Company Limited

1168/67 อาคารลุมพินีทาวเวอร์ ชั้น 23 ถนนพระรามสี่ แขวงทุ่งมหาเมฆ เขตสาทร กรุงเทพฯ 10120
1168/67 Lumpini Tower 23rd Fl., Rama 4 Rd., Thung Mahamek, Sathorn, Bangkok 10120
Tel. +66 2118 8111 Fax: +66 2285 6383 Email: axathai@axa.co.th - **axa.co.th**

CX201802-14

ADDITIONAL INFORMATION

บริษัท แอกซ่าประกันภัย จำกัด (มหาชน)
AXA Insurance Public Company Limited

1168/67 อาคารลุมพินีทาวเวอร์ ชั้น 23 ถนนพระรามสี่ แขวงทุ่งมหาเมฆ เขตสาทร กรุงเทพฯ 10120
1168/67 Lumpini Tower 23rd Fl., Rama 4 Rd., Thung Mahamek, Sathorn, Bangkok 10120
Tel. +66 2118 8111 Fax: +66 2285 6383 Email: axathai@axa.co.th - **axa.co.th**

CX201802-14