Allianz Ayudhya General Insurance Public Company Limited
898 Ploenchit Tower, Ploenchit Road, Khwang Lumpini,
Khet Pathumwan, Bangkok 10330
Tel. +66 2677 0000 Fax. +66 2230 6500

Insurance Application Form

Insured's Information

1. Name of Insured ..... Sex .....
   Address of Insured .....
   .....
   Contact Address .....
   .....
   Contact Number (Home) ..... (Work) ..... (Mobile) .....
   (Fax) ..... E-mail .....
2. Personal Information, ID Card Number ..... Date of Birth ..... Age ..... Year
   Weight (kg) ..... Height (cm) ..... Place of Birth ..... Country of Residence .....
3. Occupation of Insured ..... Position .....
   Work Address .....
   Work Description (Occupation) .....
   Salary/Month .....
4. Name of Beneficiary 1 ..... Relationship .....
   Address ..... Contact Number .....
   Name of Beneficiary 2 ..... Relationship .....
   Address ..... Contact Number .....
5. Insurance Period Applied for: Commencing from ..... Ending on .....
   (The policy will be effective after underwriting have been approved by the company Aetna Health Insurance (Thailand) Public Company Limited ("Company") and the premium has been paid.)
6. Please specify the name of the insurance plan you have selected ..... Benefit Amount ..... Baht
   Additional Coverage ◯ Child Delivery; ◯ Outpatient; ◯ Personal Accident; or
   ◯ Others (Please specify) .....
7. Automatic Renewal
   ◯ I wish to renew the Insurance Policy upon each expiration date, and I hereby provide my consent for the Company to collect insurance premiums through the credit card or the bank deposit notified to the Company.
8. Please select the method for receiving of compensation: ◯ Cheque ◯ Bank Transfer
   Name of the bank account you wish for the bank transfer in case of a compensation claim
   Bank ..... Branch ..... Account Number .....
9. The company will deliver the insurance policy by post to the address specified. Would you like to receive E-policy to the specified email?
   ◯ Receive E-policy ◯ Do not wish to receive E-policy
10. Do you have or have you ever had any health insurance, life insurance, or accident insurance with Aetna or other insurance companies?
    ◯ No ◯ Yes (If yes, please specify the insurance company name .....
    benefit amount ..... Baht)
11. Do you or have you ever had any income compensation insurance?
    ◯ No ◯ Yes (If yes, please specify the insurance company name .....
    total aggregate benefit amount from all insurance companies .....Baht/day)

12. Have you ever received any rejection or cancellation with respect to any insurance application increase of insurance premium, or coverage exemption by Aetna or any insurance company?

◯No ◯Yes (If yes, please specify the insurance company name .....

Benefit amount .....Baht)

13. During the past 5 years until present, have you ever seen a physician/doctor as an outpatient (OPD) or admitted in a hospital (IPD) to receive a medical consultation, medical diagnosis, as well as medical treatment, medication, or therapy due to injury, sickness, or surgery?

◯*No* ◯*Yes* *(Please specify the details in the table below)*

14. Have you ever been treated or diagnosed by a doctor/physician that you have had a condition of high blood pressure, hyperlipidemia, diabetes, heart disease, epilepsy, brain and nervous system disease, paralysis, cerebral atrophy, cerebral hemorrhage, any type of tumor, cyst or cancer, kidney disease, liver disease, blood disease, immunodeficiency syndrome (AIDS), bone disease and joint disease, thyroid disease, gout, autoimmune disease, respiratory and lung disease such as asthma, emphysema, chronic obstructive pulmonary disease, tuberculosis or other diseases?

◯No ◯Yes *(Please specify the details in the table below)*

15. Have you ever had a surgery or been diagnosed by a doctor/physician to have a surgery?

◯No ◯Yes *(Please specify the details in the table below)*

In the case of declaring "Yes" in 13 -15, please specify the details in the following table. If the table provided below contains insufficient space, please specify additional information in the additional table at the back.

Disease	D/M/Y of Treatment (Please describe if you have been diagnosed or treated or observed by a doctor/physician)	Treatment and Current Symptoms	Medical Facility Providing the Treatment (If possible, please provide the name of the doctor/physician)

16. Until now, have you ever had any symptom or been diagnosed, received treatments, or is in the rehabilitation process, as well as had received any consultation and advice from a doctor/physician on any developmental problem, psychosis, alcoholism, substance use, disability, handicap?

◯No ◯Yes Please specify .....

17. You are currently in the recovery period of a sickness or injury from an accident or from a hospitalization in a hospital or a medical facility?

◯No ◯Yes In recovery period/hospitalization, please specify .....

18. Are you currently sick or have any abnormal symptom (such as pain, tumor, bleeding disorder, etc.) that has not been treated or consulted by a doctor/physician?

◯No ◯Yes Please specify .....

19. Do you currently take medication regularly or continuously or do you have any congenital disease or other diseases?

◯No ◯Yes Please specify the name of the medication, cause, disease .....

20. Have you ever had any symptom or been treated due to a fever, skin rash, enlarged lymph node, pleurisy, peritonitis, muscle ache, muscle inflammation, joint pain, arthritis, for a period of 3 consecutive months or more?

◯No ◯Yes Please specify .....

I hereby provide my consent for the Company to collect, use, and disclose my health data and information to the Office of Insurance Commission for the purpose of managing and overseeing the insurance business

Does the Insured wish to **exercise the right of income tax exemption** under the taxation law?

◯ Yes, the Insured wishes and provides the consent for the non-life insurance company to send and disclose information regarding insurance premiums to the Revenue Department in accordance with the rules and procedures prescribed by the Revenue Department, and if the Insured is a foreigner (Non-Thai Residence) who is obliged to pay income tax under the taxation law, please specify the taxpayer identification number obtained from the Revenue Department, No.....

◯ No.

Does the Insured consent for the **"Company"** to submit and disclose your information (the Insured or Dependent to the Revenue Department in order to **exercise the right of income tax exemption of the premium payer** under the taxation law?

◯ Yes, the Insured consents for the Company to submit and disclose the Insured's information and information relating to this Insurance Policy in order to exercise the right of income tax exemption of the premium payer to the Revenue Department in accordance with the rules and procedures prescribed by the Revenue Department. Please specify the taxpayer identification number obtained from the Revenue Department, No. ..... (In the case that you select to consent, please complete the information with respect to the premium payer in the attachment.)

◯ No.

I hereby certify that the statements/declarations given in this insurance application form are true in all respects. If my statement/declaration is false or if I conceal a fact, I agree that the Company can terminate the insurance contract.

The Company has the right to, at the Company's expense, examine the Insured's history/records of medical treatments and diagnosis as necessary for the purpose of this insurance and has the right to perform an autopsy in necessary cases, provided that it is not against the law to do so.

If the Insured refuses to allow the Company to examine the Insured's history/records of medical treatments and diagnosis for consideration of compensation payment, the Company may refuse to provide coverage under this Insurance Policy to the Insured.

I hereby authorize Aetna Health Insurance (Thailand) Public Company Limited to request the details of my medical history/records and physical conditions from the doctors/physicians, hospitals or any other organizations who have records or know about me or my health. A copy of this authorization is valid and complete as if it is the original.

I have read and agree to the contents of this document as well as acknowledge the personal data protection policy of the Company and the Office of Insurance Commission, and then sign the name below.

.....	.....	.....
Insured	Signature of Legal Representative (In case of age below 20 years old)	Date of Application (D/ M/ Y)

◯ Agent ◯ Broker License No. .....

Within 15 days from the date on which the Insured receives the Insurance Policy from the Company, the Insured can cancel the Insurance Policy (Free Look Period) by returning the Insurance Policy to the Company, and the Company will return the remaining premium after a deduction of the actual health check-up fee and the Company's expenses in the amount of Baht 0 per Insurance Policy (if any) within 15 days from the date on which the Company receives the insurance policy cancellation notice. If the Insured does not do so, the Company will deem that the Insured agrees that the details and information stated above are correct and this insurance contract will continue to be effective until the Company has been notified by you in writing of any change.

Caution - Office of Insurance Commission (OIC): The Insured should answer all questions truthfully. If the Insured conceals a fact or make a false statement, it will result in this insurance contract being voidable, which the Company has the right to cancel the insurance contract pursuant to Section 865 of the Civil and Commercial Code.

Attachment

Disease	D/M/Y of Treatment (Please describe if you have been diagnosed or treated or observed by a doctor/physician)	Treatment and Current Symptoms	Medical Facility Providing the Treatment (If possible, please provide the name of the doctor/physician)