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

Application Form

Health and Accident for General Group and Organizational Group

Allianz Ayudhya General Insurance Public Company Limited. 898 Ploenchit Tower, Ploenchit Road, Khwang Lumpini, Khet Pathumwan, Bangkok 10330

Insured's Information

1. Name of Insurance Policy Holder .....
   Building ..... Floor ..... Room No ..... Address: No .....
   Alley ..... Road ..... Sub-district .....
   District ..... Province ..... Zip code. .....
   Telephone No ..... Telefax No ..... Email .....
   Contact person .....
   Business category .....
   First Date of Insurance Coverage .....
2. Do you need the insurance to cover the officer and employee of the company in the same group?
   ◯ No ◯ Yes, Please complete the name of the company in the same group
   1) Name .....
      Address ..... Zip code .....
   2) Name .....
      Address ..... Zip code .....
   3) Name .....
      Address ..... Zip code .....
3. At present, Have you already purchased the health insurance or accident insurance with other insurance company or not?
   ◯ No ◯ Yes, Please specify the name of the insurance company
   1) .....
   2) .....
4. This group insurance of health and accident shall cover
   ◯ All employees of the Company ( ) including the Dependants ( ) excluding the Dependants
   ◯ Only the employees passing the probationary period ( ) including the Dependants ( ) excluding the Dependants
   ◯ .....
5. Premium Payment
   ◯ The employer pays the whole premium for the employee. ( ) including the Dependants ( ) excluding the Dependants
   ◯ The employer pays partial premium for the employee.
6. The date on which the Insured Person entitled to the coverage
   ◯ The first date on which the Insured Person works for the Company
   ◯ The date after the Insured Person passed the probationary period
   ◯ Other
7. Number of the insured employees
   ◯ Single employees ..... Male Employees ..... Female Employees
   ◯ Married Employees ..... Male Employees ..... Female Employees
   ◯ Number of Dependants (spouse and child) .....
   ◯ Number of persons who are over 60 years old .....
8. Benefits of Coverage
   Please attach the Quotation No. .....

(English translation for the convenience of foreigner applicant only)

9. Which method do you intend to receive the compensation?

◯ To pay in cheque, specifying the Company's name as payee

◯ To remit money to the Company's bank account, Please attach the details for the transfer of money via bank

- Bank's name .....
- Branch office .....
- Account type ◯ Saving account ◯ Current account ◯ Other .....
- Account No .....
- Account name .....

◯ To pay in cheque directly to each employee

◯ To transfer money to each employee's bank account, Please attach name of the Bank, its branch office including the bank account number of each employee

10. You intend to receive the documents relating to the invoice or the credit note when you notify the employee starting to work for the Company or quitting the Company

◯ Every time that you notify the employee starting to work or quitting the Company

◯ Every month

◯ Every 3 months

◯ Every 6 months

◯ Annually

10.1 Which method do you intend to receive the returned premium?

◯ To pay in cheque, specifying the Company's name as payee

◯ To remit money to the Company's bank account, Please attach the details for the transfer of money via bank

- Bank's name .....
- Branch office .....
- Account type ◯ Saving account ◯ Current account ◯ Other .....
- Account No .....
- Account name .....

11. Which channel that you would like to receive policy?

◯ Receive E-policy to the specified email.

◯ Receive physical policy by post to the specified address.

12. I, as the Applicant, agree and consent that

1) If the statement of myself or either employee is false or if I, employee, omits to disclose facts, I hereby consent to the Allianz Ayudhya General Insurance Public Company Limited. ("Company") who is the insurer to avoid all agreements or only specific agreement;

2) I, do hereby, appoint Company, as the Attorney-in-fact to request any kinds of information of my health record or health conditions from any physician or healthcare provider or any other organization (who has my health record or health conditions) on my behalf until completion. A photocopy of this statement of authorization shall be as effective and valid as the original in order to underwrite and claim.

3) 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.

4) The insured hereby consent to the Company's keeping, use, and disclose of the facts about my health and information to the OIC for the benefits of supervision of the insurance business.

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Warning of the Office of the Insurance Commission

The Applicant must reply all above-mentioned questions with the fact. If the Applicant omits to disclose facts or makes false statement, this insurance agreement shall be voidable. Then, the Company shall be entitled to avoid the insurance agreement in accordance with the Civil and Commercial Code, Section 865.

Company's Name and Seal.....Applicant

by.....

Title.....

Date..... Month..... Year.....

Signed.....Agent/Broker

License Number.....

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