LIFESTYLE SERIES APPLICATION

A New Lifestyle for a New Generation

Experience Matters
## รายละเอียดของผู้ขอเอาประกันภัย (ตามที่ระบุในบัตรประจำตัวประชาชนหรือหนังสือเดินทาง)

### Applicant’s Details (as stated on ID Card or Passport)

<table>
<thead>
<tr>
<th>รายการ</th>
<th>รายละเอียด</th>
</tr>
</thead>
<tbody>
<tr>
<td>ชื่อ :</td>
<td>First Name</td>
</tr>
<tr>
<td>ชื่อกลาง :</td>
<td>Middle Name</td>
</tr>
<tr>
<td>นามสกุล :</td>
<td>Family Name</td>
</tr>
<tr>
<td>วัน/เดือน/ปีเกิด (ค.ศ.) :</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>สัญชาติ :</td>
<td>Nationality</td>
</tr>
<tr>
<td>ที่อยู่ปัจจุบัน :</td>
<td>Current Address</td>
</tr>
</tbody>
</table>

### Beneficiary Details and Relationship to Insured (as stated on ID Card or Passport)

#### 1. Beneficiary Name 1

<table>
<thead>
<tr>
<th>รายการ</th>
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</tr>
</thead>
<tbody>
<tr>
<td>ชื่อ :</td>
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</tr>
<tr>
<td>ชื่อกลาง :</td>
<td>Middle Name</td>
</tr>
<tr>
<td>ความสัมพันธ์กับผู้ขอเอาประกันภัย :</td>
<td>Relationship to the Applicant</td>
</tr>
<tr>
<td>เพศ :</td>
<td>Gender</td>
</tr>
<tr>
<td>โทรศัพท์ :</td>
<td>Contact Phone No.</td>
</tr>
<tr>
<td>อีเมล :</td>
<td>E-mail Address</td>
</tr>
</tbody>
</table>

#### 2. Beneficiary Name 2

<table>
<thead>
<tr>
<th>รายการ</th>
<th>รายละเอียด</th>
</tr>
</thead>
<tbody>
<tr>
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<td>ชื่อกลาง :</td>
<td>Middle Name</td>
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</tr>
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<td>เพศ :</td>
<td>Gender</td>
</tr>
<tr>
<td>โทรศัพท์ :</td>
<td>Contact Phone No.</td>
</tr>
<tr>
<td>อีเมล :</td>
<td>E-mail Address</td>
</tr>
</tbody>
</table>
### 1. Select your Protection Plan

<table>
<thead>
<tr>
<th>Plan</th>
<th>Base Premium (Baht)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard</td>
<td></td>
</tr>
<tr>
<td>Premier</td>
<td></td>
</tr>
<tr>
<td>Maxima</td>
<td></td>
</tr>
<tr>
<td>Ultima</td>
<td></td>
</tr>
<tr>
<td>Standard Plus</td>
<td></td>
</tr>
<tr>
<td>Premier Plus</td>
<td></td>
</tr>
<tr>
<td>Maxima Plus</td>
<td></td>
</tr>
<tr>
<td>Ultima Plus</td>
<td></td>
</tr>
<tr>
<td>Standard Extra</td>
<td></td>
</tr>
</tbody>
</table>

### 2. Premium Discount Options

#### Exclusion of Outpatient Benefit

<table>
<thead>
<tr>
<th>Deductible (Person/Policy Year)</th>
<th>Deductible Options Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>20,000 Baht</td>
<td>Yes</td>
</tr>
<tr>
<td>40,000 Baht</td>
<td>Yes</td>
</tr>
<tr>
<td>100,000 Baht</td>
<td>Yes</td>
</tr>
<tr>
<td>200,000 Baht</td>
<td>Yes</td>
</tr>
<tr>
<td>300,000 Baht</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### 3. Additional Benefits

#### Personal Accident (PA)

<table>
<thead>
<tr>
<th>Base Premium (Baht)</th>
<th>Additional Premium (Baht)</th>
<th>Coverage (Insert Amount)</th>
</tr>
</thead>
<tbody>
<tr>
<td>145</td>
<td>145</td>
<td></td>
</tr>
</tbody>
</table>

### 4. Annual Premium

<table>
<thead>
<tr>
<th>Net Premium Sub-Total</th>
<th>Base Premium (Baht)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Important Note

- **Elective Treatment** in North America, Japan, Hong Kong, Singapore, EU Countries and Switzerland.
- This Benefit is permitted only on a case by case basis with no guarantee of acceptance by the Insurer.

### Medical Questions

1. Are you currently covered by any other Health Insurance policy? (If Yes, please enclose a copy of the policy and benefit schedule)

2. Have you ever had any Health or Life Insurance policy declined, postponed, rate adjusted, restricted or cancelled?

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**Application Form Rev. October/2019**
In the past 10 years, have you ever had symptoms of, or been made aware of, or diagnosed with, or treated for any of the following?

Please underline the specific condition.

### 3.1 Headaches, Migraines
- Headaches, Migraines
- Cerebrovascular Disease or Disorders
- Any other Disease or Disorders of Neurological System
- Chest Pain / Heart Disease
- Palse, Arrhythmias
- Any Disorders of Lungs, Heart or Blood Circulation System
- Dyslipidemia
- Any Breathing Problems, please specify

### 3.2 Respiratory System
- Emphysema
- COPD
- Asthma
- Bronchial Hyperresponsiveness
- Bronchial Hyperresponsiveness
- Respiratory Allergy
- Any other Breathing Problems, please specify

### 3.3 Psychosis
- Psychiatric Disorders
- Stress, Anxiety, Insomnia
- Mood Disorder
- Panic Disorders
- Depression

### 3.4 Seizures or Epilepsy
- Fainting or Black-out Spells

### 3.5 Gastrointestinal Problems
- Acid Reflux
- Stomach or Intestinal Ulcers, Gastrointestinal Bleeding
- Inflammatory Bowel Disease (IBD), Diverticular Disease
- Pancreatitis, Hepatitis, Fatty Liver
- Gallbladder Disease, Gallstones, Bile Duct Disease
- Anemia
- Hernias, Hemorrhoid
- Food Allergy
- Other Disorders of Stomach, Liver or Intestines

### 3.6 Disorders of Prostate or Genitourinary Tract
- Disorders of Kidneys, Ureters
- Kidney Stones
- Disorders of Bladder
- Urinary Tract Infection
- Immune System Disease
- HIV, AIDS, AIDS Related Complex

### 3.7 Neck, Back or Shoulder Pain
- Fibromyalgia
- Myofascial Pain Syndrome
- Bulging or Herniated Discs

### 3.8 Muscle, Joint or Bone Disease or Condition
- Muscle, Joint or Bone Disease or Condition
- Myositis, Polymyositis
- Myofascial Pain Syndrome
- Rheumatoid Arthritis
- Osteoarthritis, Gout
- Systemic Lupus Erythematosus
- Lupus

### 3.9 Disorders of the Eyes, Ears, Nose, Sinuses or Throat
- Pterygium, Cataracts, Glaucoma, Retina Disorders
- Blindness or Visual Loss
แบบสอบถาม – ต่อเนื่อง (Medical Questions – Continued)

๑๐ ท่านเคยสูบยาสูบ เพื่อการสูบ หรือสูบเพื่อการตรวจวินิจฉัยหรือไม่? ถ้าใช่ โปรดระบุ
Do you currently smoke a pipe, cigars or cigarettes? How many sticks do you smoke per day? ………….…........ Sticks

๑๑ ในระยะ 10 ปีที่ผ่านมา ท่านเคยมีโรคหรือความผิดปกติเกี่ยวกับเต้านม มดลูก รังไข่ ทอรังไข่ ปากมดลูก ประจำเดือน ระบบสืบพันธุ์ การตั้งครรภ์หรือการคลอดบุตรรวมถึงภาวะแทรกซ้อน การแท้งบุตร หรือเคยรับการตรวจวินิจฉัยและ/หรือรักษาภาวะมีบุตรยากหรือไม่?
In the past 10 years, have you had any diseases or disorders of the breast, uterus, ovaries, fallopian tubes, cervix, menstruation, reproductive system, abortion, miscarriage or have been diagnosed and treated for infertility or not?

<table>
<thead>
<tr>
<th>วัน/เดือน/ปี ที่รักษา</th>
<th>ชื่อสถานพยาบาล</th>
<th>คำวินิจฉัยโรค</th>
<th>ผลการรักษา</th>
<th>วันที่ติดตามการรักษาครั้งล่าสุด</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Date (DD/MM/YYYY)</td>
<td>(Name of Healthcare Provider)</td>
<td>(Diagnosis)</td>
<td>(Result of Treatment)</td>
<td>(Latest Follow-up date)</td>
</tr>
</tbody>
</table>

๑๑. ท่านเคยได้รับคำแนะนำให้ตรวจวินิจฉัย ตรวจสุขภาพ หรือวิธีการอื่นใดนอกเหนือจากที่ระบุไว้ข้างต้นหรือไม่? ถ้าใช่ โปรดระบุ
Have you ever been advised to have any medical test, medical check-up or procedure other than as noted above?

When you answered “Yes” to any question in this form, please give details in the space below or put on additional paper.

Application Form Rev. October/2019 | 04
Would you like to claim for Personal Income Tax Deduction with this health insurance premium?

Yes, I would like to claim for Personal Income Tax Deduction with this health insurance premium.

[Signature]
[Date/Month/Year]

[Applicant's Name]

Yes, and I permit the insurer to send and reveal the information about this insurance premium to the Revenue Department as long as the policy remains in force. If the applicant is a non-Thai resident, please enter the taxpayer ID Number given by the Revenue Department:

[Revenue Department ID Number]

[Date/Month/Year]

[Applicant's Signature]

I hereby give my consent to Pacific Cross Health Insurance PCL to collect, use and disclose information pertaining to my health and any other information to insurance company or reinsurer companies or the Office of Insurance Commission (OIC) or legal authorities or medical professional personnel for the purpose of Insurance Business Compliance or The Company's underwriting decision or benefit payment decision or medical use.

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[Revenue Department ID Number]

[Applicant's Signature]

Date/Month/Year

[Applicant's Name]

I hereby give my consent to Pacific Cross Health Insurance PCL or its representative to request copies of any kind of information regarding my health records or health condition from any physician, healthcare provider, or any organization until completion. A photocopy of this statement shall be as effective and valid as the original.

I hereby give my consent to Pacific Cross Health Insurance PCL to collect, use and disclose information pertaining to my health and any other information to insurance company or reinsurer companies or the Office of Insurance Commission (OIC) or legal authorities or medical professional personnel for the purpose of Insurance Business Compliance or The Company's underwriting decision or benefit payment decision or medical use.

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Date/Month/Year

[Applicant's Signature]