Application Form
For Health and Personal Accident (STV 90 and STV 180)

STV 180 / STV 90 PLANS

PACIFIC CROSS HEALTH INSURANCE PCL
A member of the Pacific Cross Group of Companies

152 อาคารชาร์เตอร์สแควร์ ชั้น 21 ห้อง 21-01 ถนนสาทรเหนือ แขวงสีลม เขตบางรัก กรุงเทพฯ 10500
152 Chartered Square Building, 21st Floor, Room 21-01, North Sathorn Road, Silom, Bangrak, Bangkok 10500
T: 02 401 9189 | F: 02 401 4187 | E: contactus@th.pacificcrosshealth.com | www.pacificcrosshealth.com

◯ STV 180 PLAN ◯ STV 90 PLAN

1 Applicant's Details (as stated on ID Card/Passport):

First names (Mr. / Mrs. / Miss / Other) ..... Middle name ..... Surname .....

Gender ◯ Male ◯ Female

Date of Birth (D/M/Y) ...../...../..... Age ..... years Weight (Kg.) / Height (cm.) ...../.....

ID Card or Passport No. ..... Nationality .....

Current Address .....

Telephone No. ..... Mobile No. ..... Email .....

Occupation / Position .....

Type of Work .....

2 Beneficiary Details:

Beneficiary Name ..... Relationship .....

Current Address .....

3 Period of Insurance: Effective Date (D/M/Y) ...../...../.....

Medical Questions (Please ✓)

1 Have you ever had any Life, Health, Critical Illness or Personal Accident insurance application declined, postponed, rate adjusted, restricted or cancelled?

◯ No ◯ Yes, Please Specify .....

2 In the past 5 years, have you ever been diagnosed with, had or planning surgery, been or being treated or recovering or have ever consulted a doctor for or experienced any of the following diseases, symptoms and conditions:
(Please underline specific disease) .....

2.1 All types of Cancer
◯ No ◯ Yes, Please Specify .....

Stroke, Brain Disorders, Alzheimer's Disease, Parkinson's Disease or Seizures
◯ No ◯ Yes, Please Specify .....

Heart Disease, Vascular Disease, Chronic Obstructive Pulmonary Disease, Emphysema, Lung Disease, Tuberculosis
◯ No ◯ Yes, Please Specify .....

Chronic Kidney Disease or Kidney failure, Liver Disease or Splenomegaly, Cirrhosos, Hepatitis B or C virus, Alcoholism, Fatty Liver, Pancreatitis
◯ No ◯ Yes, Please Specify .....

AIDS, Positive HIV Test, Severe Blood Disease, require Regular Blood Transfusion, Ascites
◯ No ◯ Yes, Please Specify .....

SLE, Multiple Sclerosis, Crohn's Disease, Rheumatism
◯ No ◯ Yes, Please Specify .....

Paresis, Paralysis, Disability or Psychosis
◯ No ◯ Yes, Please Specify .....

2.2 Hypertension or High Blood Pressure (More than a 140 Systolic Measure)
◯ No ◯ Yes, Please Specify .....

2.3 Diabetes or High Blood Sugar
◯ No
◯ Yes, Please Specify
◯ Take Oral Medicine
◯ Take Insulin injections or Yes, I have been admitted in hospital with Diabetes or related symptoms
◯ Do not take Insulin and I never been admitted in hospital with Diabetes or related symptoms

2.4 Dyslipidemia or Cholesterol
◯ No
◯ Yes, Please Specify ◯ Medication ◯ Do not take medication but the doctor recommend exercise and diet control

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Medical Questions (Please ✓)

2.5 Anemia or any other Blood Disease
◯ No ◯ Yes, Please Specify .....

2.6 Tumors, Masses, Lumps, Cysts, Warts, Moles or Polyps
◯ No
◯ Yes (Please Specify) Type / Kind ..... Organ .....
◯ Currently have or being treated
◯ Removed / Cured Biopsy Result ◯ Normal ◯ Abnormal .....

2.7 Other Disease or other Chronic Diseases (than as noted above)
◯ No
◯ Yes (Please Specify)
Diagnosed / Caused / Symptoms / Examinations .....
Treated / Recommend by Doctor .....
Date of treatment .....
Results of treatment ◯ Normal ◯ Abnormal (Please Specify) .....

3 In the past 5 years, have you ever undergone tests such as CT Scan, MRI, Biopsy, Ultrasound, Electrocardiography (EKG) or Blood Test / Urine Test? (If Yes, Please specify the result of treatment, cause of examination, date of treatment and the name of hospital)
◯ No ◯ Yes .....

4 Have you ever received advice from a physician about surgical treatment or any other diagnosis tests for conditions which have never been treated? (If Yes, Please specify condition and the name of hospital)
◯ No ◯ Yes .....

Agreement Conditions

It is an agreement between the Applicant and the Company that this policy does not cover for injuries or illness that occured directly with the Applicant or as a result of complications of any injury or illness that the Applicant has declared in this application form or the Company exclusion that specifies an exclusion endorsement of a covered specific disease which the Applicant acknowledged and agreed to comply with this condition in all respects

The Applicant hereby requests the Company to provide the insurance policy together with the terms and conditions according to their standard policy and the Applicant declares that the above statements are complete and true. The Applicant agrees to have this application form included in the contract between the Applicant and the Company. Should there be any false statement or any truth being concealed, the Applicant agrees to let the Company void this insurance policy.

The Applicant, besides this, assigns the Company to request any kind of information regarding their personal health treatment or health condition records from any physician, hospital, clinic or any other organization which has any of their health information or records including the testing results of HIV for the payment of benefits and/or compensation.

The Company has the right to medically examine any Applicant who is claiming a benefit under this policy and has the right to conduct an autopsy, within the limits of the law, in case of death, and the expense incurred will be paid by the Company.

If the Applicant does not allow the Company to investigate his/her claim or does not give permission to access his/her medical records or diagnosis, the Company reserves the right not to pay such claims.

The Applicant allows the Company to collect, use and reveal the truth about the Applicant's medical records and other information to the Office of Insurance Commission (OIC) in order to regulate the insurance industry.

Your e - Policy will be emailed to you

Note: I understand and accept that Congenital or Pre-Existing Illnesses, Injuries and Conditions are not covered.
◯ (Please ✓ here as your Acknowledgement of these Terms,)

◯ Direct
◯ Agent
◯ Broker
License No. .....

Application's signature .....
(Full Name)
Date ..... / ..... / .....

Warning form the Office of Insurance Commission (OIC)

The applicant must truthfully answer all the questions. Any concealment or misrepresentation of the truth may result in the insurance company exercising its right to void this insurance contract as per Clause 865 of the Civil and Commercial Code.