

## SECTION A

### Applicant's Details

Title :  Surname :  First Name :

Sex : <input type="radio"/> Male <input type="radio"/> Female	Date of birth :	Age :	ID/Passport No. :
Nationality :	Height (cm) :	Weight (kg) :	Smoker : <input type="radio"/> No <input type="radio"/> Yes please specified .....
Occupation :			Effective date : ___ / ___ / _____
Residential address of the country where you are to be located :			
Address :			
Town / City :		Country :	
Post Code / Zip Code :		E-mail Address :	
Work Contact (Tel.) :		Home Contact (Tel.) :	

## SECTION B

### Coverage Details

Coverage details (please tick one box only on each line)	
Plan : <input type="radio"/> Expat Care 1 <input type="radio"/> Expat Care 2 <input type="radio"/> Expat Care 3	Geographical area : <input type="radio"/> Area 1 : Thailand <input type="radio"/> Area 2 : Asia <input type="radio"/> Area 3 : Worldwide excluding USA
Total Annual Premium (THB) :	

## SECTION C Statement of Health

Please truthfully provide thorough and precise responses to the following questions to aid us in accurately underwriting your policy.

- Have you ever experienced symptoms, been diagnosed with, investigated, or received treatment for any of the following diseases or disorders? Please underline the specific conditions and provide details, including organ, diagnosis or name of diseases or disorders, symptoms and/or medical condition, When did the symptoms start? What treatment did you receive and when? (Please include dates and any medication prescribed), What was the outcome of the treatment? (e.g. ongoing, still under review, complete recovery, recurrent or likely recur), date of last consultation or follow-ups, etc. in section Medical details.

1.1	Have you ever had a past history of cancer or pre-cancer (including benign brain tumours), AIDS, AIDS-related complex, HIV, systemic lupus erythematosus (SLE), Immunodeficiency, Auto-Immune, alcoholism, substance abuse, diabetes type 1, insulin dependence, epilepsy, seizure, heart condition, stroke, chronic obstructive pulmonary disease (COPD), joint disorder, cirrhosis, paralysis, visual loss, blindness, pancreatitis, ascites, psychiatric or mental illness?	<input type="radio"/> Yes	<input type="radio"/> No
1.2	Do you have any long-term, ongoing or chronic condition for which you have regular appointments or need a review or treatment for? CHRONIC means an illness or injury which has one or more of the following characteristics: <ul style="list-style-type: none"> <li>• It has no known recognized cure</li> <li>• It continues indefinitely</li> <li>• It recurs or is likely to recur</li> <li>• It is permanent</li> <li>• Requires palliative treatment</li> <li>• Requires long-term monitoring, consultations, check-ups, examinations, or tests</li> <li>• Requires rehabilitation or special training to cope with it.</li> </ul>	<input type="radio"/> Yes	<input type="radio"/> No

### Medical Details

Question Number	Organ	Diagnosis or name of diseases or disorders	Symptoms and/or medical condition	When did the symptoms start?	What treatment did you receive and when? (Please include dates and any medication prescribed)	What was the outcome of the treatment? (e.g. ongoing still under review, complete recovery, recurrent or likely recur)	Date of last consultation or follow-ups	Etc.

## SECTION C

## Statement of Health

2.	<p>Have you ever undergone any specialized medical examinations (such as ultrasound, CT scan, MRI, mammogram, Pap smear, etc.), health and physical check-ups, procedures for investigative purposes other than those mentioned, or any surgical procedures?</p> <p><b>If your answer is yes, please specify the organ and procedure.</b></p> <p>_____</p> <p>_____</p>	<input type="radio"/> Yes	<input type="radio"/> No
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<b>For WOMEN ONLY:</b>			
	<p>Have you had any diseases or disorders of the breast, uterus, ovaries, fallopian tubes, cervix, menstruation, reproductive system, pregnancy, or childbirth, including complications, abortion or miscarriage or have been investigated, and/or treated for infertility?</p> <p><b>If your answer is "YES", please specify diagnosis, treatment, and when?</b></p> <p>_____</p> <p>_____</p>	<input type="radio"/> Yes	<input type="radio"/> No

**\*\*\* If the space provided is insufficient, please use a separate sheet. \*\*\***

<b>Would you like to claim for personal income tax deduction with this health insurance premium?</b>	
<input type="radio"/>	<p>Yes, and I permit the insurer to send and reveal the information about this insurance premium to Revenue Department. If the applicant is a non-Thai resident, please enter the taxpayer ID number given by the Revenue Department:</p> <p>_____</p>
<input type="radio"/>	<p>No</p>

### Data protection :

Pacific Cross Health Insurance PCL assures you that all your personal and medical information will be held in strictest confidence and in accordance with applicable legislation. Personal data may be passed or given to third party providers in relation to services which we provide to you and may be transferred by electronic or other means. You have a right to know what information is held about you, and to amend or delete and data we hold which is inaccurate or out-of-date.

**Remark :**

The Applicant hereby requests the Company to provide the insurance policy together with the terms and conditions according to their policy and the Application 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 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 laws, 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 (OIC) in order to regulate the insurance industry.

Applicant's Signature	Guardian's Signature
<p>_____</p> <p>( _____ )</p>	<p>_____</p> <p>( _____ )</p>

\_\_\_\_\_  
Date / Month / Year

**WARNING BY OFFICE OF INSURANCE COMMISSION (OIC)**

The applicant must truthfully answer all questions. Any concealment or misrepresentation of the truth may result in the Insurance contract becoming void under Clause 865 of the Civil and Commercial Code resulting in the cancellation of the policy.



**Pacific Cross Health Insurance PCL**

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OUR CONTACT  
INFORMATION