Premier Care

APPLICATION FORM INDIVIDUAL HEALTH AND ACCIDENT

Please complete this form in **BLOCK LETTERS**, and tick in circle where applicable

1. Applicant's Personal Information

Name-Surname:..... Sex: ◯ Male ◯ Female

Date of Bith (DD/MM/YYYY):..... Weight (Kg)..... Height (Cm).....

◯ ID Card / ◯ Passport Number:..... Nationality:.....

◯ Office ◯ Home Address:.....

Office No:..... Mobile No:..... Email:.....

Occupation/Position:..... Salary/Wage (annual) THB.....

Brief description of your work:..... Other income(annual) THB.....

2. Beneficiary detail

Name-Surname:..... Relationaship to the applicant:.....

3. Period of insurance

From:..... Time:..... To: ..... at 24:00h

4. Choice of Plan.

Please select the insurance plan that you need

Plan 1: ◯IP ◯OP ◯PA

Plan 2: ◯IP ◯OP ◯PA

Plan 3: ◯IP ◯OP ◯PA

5. Premium payment

☐ Cash

☐ Bank Credit Card:..... Credit card No:.....

☐ Bank Account:..... Bank Name:..... Branch:.....

Net premium	THB	.....
10 %VAT	THB	.....
Registry Fee	THB	.....
Total premium	THB	.....

6. Within the past 5 years to present, have you ever been infected or have symtoms or have been treated or is currently receiving treatment or has been told by a doctor with the following diseases:
Cancer, tumors or cysts that have not yet been surgically removed or have been surgically removed less than 2 years before insurance, stroke, cirrhosis, hepatitis B, hepatitis C, AIDS or HIV positive, chronic kidney disease or renal failure, heart disease, tuberculosis, chest-pain, chronic pneumonia, chronic obstuctive pulmonary discase, emphysema SLE, diabetes, hypertension, severe blood disorder or need to receive blood regularly, liver disease, enlarged pancreas, ascites, parkinson's disorder, dementia and unable to take care of themselves, paralysis, disability, psychosis or addiction to drug ?

◯ No ◯ Yes, Please specify.....

7. Within the past 5 years have you received advice from a doctor for surgery or for further treatment and diagnosis from disease or illness which has not been done or still have abnormalities/illnesses/chronic conditions which have not been treated?

◯ No ◯ Yes, Please specify.....

8. Have you been denied an application for life insurance or health insurance or serious illness insurance or personal accident insurance or being denied a renewal of insurance policy or have you been charged an additional premium or changed the conditions for such insurance?

◯ No ◯ Yes, Please specify.....

9. Do you have other Health insurance, Critical Illness insurance, Life insurance or Personal Accident insurance with Forte Toko Lao Assurance Co., Ltd or with other insurance companies ?

◯ No ◯ Yes, Please specify.....

10. Do you currently use or have you ever used drugs or regularly drink alcohol or have you been treated with alcoholism or drugs addiction?

◯ No ◯ Yes, Please specify.....

11. Do you smoke?

In the past ◯ No ◯ Yes.....cigarette / day Long term smoking.....year(s)

Currently ◯ No ◯ Yes.....cigarette / day

12. Have the parents, spouse, brothers or sister of the applicant been diagnosed with illness or death due to tuberculosis, diabetes, heart disease, cancer, stroke, renal failure or HIV positive?

◯ No ◯ Yes, Please specify the person.....

Date of treatment:..... Cause of illness or death:.....

13. Are you currently recovering from illness or injury from an accident or hospitalization in a medical facility?

◯ No ◯ Yes, Please specify for cause.....

14. Do you take medications regularly or continuously or have underlying diseases or any chronic diseases?

◯ No ◯ Yes, Please specify the medicine or discase that you have.....

Declaration of the Applicant

It is agreed between the Applicant and the Forte Toko Lao Assurance Co., Ltd (hereinafter referred to as "the Company") that this insurance policy will not provide coverage for the Applicant in case of any injury or illness which directly occurred or as a consequence of or as a complication of any injury or illness that Applicant has declared in this insurance Application Form during the period of insurance. The Applicant has been informed and agreed with all conditions herein, which the Company will issue an endorsement excluding the coverage for specific injury or illness.

I intent to exercise my right of applying the insurance per the Company's terms and conditions of the policy, and I declare that the answer and particulars in this Application Form are true and complete and shall form the basis of the contract of insurance effected thereon. If my information thereby is falsified or concealed, I would allow the Company to terminate this insurance. In addition, I hereby authorize the company to obtain detail concerning medical history and my physical examination from doctors, hospital, medical facilities or any other information organization which have my medical record or my health condition.

Applicant's signature:..... .....

Name and Surname:..... Date (dd/mm/yy)