BUPA Health Insurance (Thailand) Ltd
104/9 Unit M02-03 The Avenue Chaengwattana Moo 1 Chaengwattana
Tungsonghong Laksi Bangkok 10210
Tel. 02 573 8700 Fax 02 573 8711

Application Form

Suggestion for filling this application form

- Please provide your medical and health information as much as possible (It will be benefit for your underwriting and claim reimbursement)
- For person less than 18 years old, parents can declare medical and health information for and sign for approval.
- If you have any questions or need anymore information, you can contact customer service via "csc@bupa.co.th" or telephone 0-2632-1122

When you finish filling this form please send back to
BUPA Health Insurance (Thailand) Ltd Chaengewattana Branch
104/9 Unit M02-03 The Avenue Chaengwattana Moo 1 Chaengwattana Tungsonghong Laksi Bangkok 10210
Tel. 02 573 8700 Fax 02 573 8711

Company…Thai Expat Club……………………………………….Type of Business…Networking Association……..…………
Job Title ……………………………………..…. Department ……………………………….. Starting Date ………..……………..….
Personal Title (i.e. Mr., Mrs., Miss., Boy) ………..……………………………………………………….. Sex o Male o Female
Firstname……………………………….. Lastname…………………………..……………… Preferred language o Thai o Eng
Correspondence address …………………………………………………………………………………..……………..…………...
Postal code ……………….Tel (Work) …………………..……..(Home) ……………………………… (Mobile) ……………………….
Email………...
ID card no. / Passport No. ………………………………………………………………….. Date of Birth…..……………………………
Height…………….cm. Weight..………kg. Home country ………………………….. Country of residence ……..……………………..
Relationship with the employee (For dependent applicant) o Spouse o Child

NAME OF BENEFICIARY (FOR MEMBER WHO ALSO SELECTS PERSONAL ACCIDENT BENEFIT)

Name…………..……………………..……. Address ………………………………………………..Relationship ………………......
Name…………..……………………..……..Address ………………………………………………. Relationship ……………..……

1. Does the applicant or any of the persons covered have health, life or accident insurance with other insurance companies?
❑ No ❑ Yes If yes, please give details………………………………………………………………………………

2. Have the applicants or persons covered ever had an application rejected or a policy cancelled, rated and restricted by other insurance companies?
❑ No ❑ Yes If yes, please give details……………………………………………………………………………….

3. Has the applicant, spouse or child ever undergone a surgical procedure or investigative procedure or been hospitalized or had an accident? If yes, please give details including the nature of the diseases, disorder, condition or illness, the date of onset and the date of recovery, name of the doctor, the place of treatment and further treatment plan, if any.
❑ No ❑ Yes If yes, please give details………………………………………………………………………………

4. Has the applicant, spouse or child ever been advised to have a surgical operation or investigative procedure which has not yet been performed ? If yes, please give details including the name and address of the doctor making the recommendation.
❑ No ❑ Yes If yes, please give details………………………………………………………………………………

5. During the past 5 years, has the applicant, spouse or child ever consulted a doctor and/or been prescribed any drugs or medication? If yes, please give details of the reason for the consultation and the names of any drugs you or a member of your family have been or are currently taking.
❑ No ❑ Yes If yes, please give details………………………………………………………………………………

6. During the past 5 years, has the applicant, spouse or child ever had any tests done such as x-ray, ultrasound, CT scan, MRI scan, biopsy, electrocardiogram, blood or urine test? If yes, please give details including date(s), the reason for the tests and place where the tests took place.
❑ No ❑ Yes If yes, please give details………………………………………………………………………………

7. Is the applicant, spouse or child currently suffering from any symptoms (pain, lumps, bleeding etc) for which you have not yet consulted a doctor?
❑ No ❑ Yes If yes, please give details……………………………………………………………………

Please indicate below whether you have ever suffered from or had treatment for the following diseases, symptoms and conditions. It is important that you tell us about any known or suspected medical conditions and symptoms, even if you have not yet consulted a doctor about them. If you do not give us all the relevant information now, it could effect payment of your claims later on.

Systems / Diseases	Yes	No	Additional details
Chronic headache			
Migraine headache			
Numbness, paresthesis, weakness of extremities			
Eye disorder and abnormalities			
Ear disorder and abnormalities			
Nose disorder and abnormalities			
Allergy (exclude drug allergy, food allergy)			
Asthma			
Respiratory disorders			
Peptic ulcer			
Chronic abdominal pain			
Digestion abnormality and dyspeasia			
Abnormal stool ie: bloody stool, bowel habit change			
Hemorrhoids			
Gall bladder disorder ie: gall stones, cholecystitis			
Jaundice and cirrhosis			
Kidney and urinary tract disorder ie: stone, trouble passing water, bloody urine			
Prostate gland abnormalities (male only)			
Thyroid disorder			
Sex Hormonal abnormalities			
Cardiovascular and blood vessel disorder			
Blood disorder (including anemia, white blood cell and platelet)			
Hypertension			
Bone, joint and muscular disorder ie: chronic arthritis, gouty arthritis			
Chronic back pain or off and on back pain			
Non-malignant tumor, mass or cyst			
Malignant tumor or mass, cancer			
Bodily deformity			
Diabetes mellitus (DM)			
Hypercholesterol or hyperlipidemia			
Breast disorder and abnormalities			
Uterus, ovarian tubes and ovarian disorder (female only)			
Menstruation disorder (female only)			
Are you currently suffering from any other disease or injuries?			
Are you currently taking any medication or any treatment regularly?			

In the event that you have ticked yes to any of the above and you have received treatment, you are requested to provide more information below:

……

……

……

……

……

Please state the name of the physician, hospital or clinic together with the address which the applicant or persons covered use regularly.
(If you are a non-Thai national please give the name and address of the doctor at your last place of residence or your regular family doctor.)

……

……

……

……

……

All the above statements are true and complete to the best of my knowledge and belief and I understand that the Company, believing them to be such, will rely on them. I, do hereby, appoint BUPA Health Insurance (Thailand) Ltd as the Attorney-in-fact to request a photocopy or any kinds of information of my health record or health conditions from any physician or health care provider or any organisation on my behalf until completion. A photocopy of this statement shall be as effective and valid as the original.

Signature of Applicant……Date……
(and on behalf of children)

Signature of Spouse……Date……

WARNING BY INSURANCE DEPARTMENT, MINISTRY OF COMMERCE

The applicant must truthfully answer all questions. Any concealment or misrepresentation of the truth may result in the insurance company refusing to honor insurance claims, as per clause 865 of the Civil and Commercial Code. If you have any queries regarding this Insurance Policy, please contact **BUPA Health Insurance (Thailand) Ltd**, telephone 0-2632-1122 or **the Office of the Insurance Commissioner**, telephone 0-2547-4602-16

I hereby confirm that this applicant is the employee of the company. (Valid only upon Company Stamp and authorized signature)	**For BUPA Health Insurance Use Only :**
Employer……	
Authorised signature……	
Position ……	

Medical Confidentiality Note:

The confidentiality of your information is of the utmost importance to BUPA. Your medical information will only be discussed with those involved with your treatment and care, including your doctor and clinical persons involved in your treatment or called upon to give a second opinion, and if applicable to any person or organisation meeting your treatment expenses or their agents. If you have any concerns about the confidentiality of your information, please contact the Managing Director at 0-2234-7755 ext 501.

Dear Mr. / Ms. **Ref No.**

Additional information

This section applies if you have indicated "**Yes**". If you are unsure whether any details are relevant, you must include them.

Health Declaration No.	• The name of the illness or medical problem. • Where applicable, please state the area of the body affected (eg right leg, left eye).	• When did the symptoms start? • When was treatment completed?	What treatment did you receive and when (please include dates, names and details of medications)?	What was the outcome of the treatment? • ongoing • complete recovery • recurrent • likely to recur

Underwriter.

Yours truly,

All the above statements are true.

… ……. ……..

Signature Date

In case of you give your health information by telephone and Bupa staff fill this form, you agreed that all information are relevant. If there is no enough space, you can tick / in ( ) and use other paper to fill this form.

WARNING: By Insurance Department, Ministry of Commerce

The application must truthfully answer all questions. Any concealment or misrepresentation of the truth may result in the insurance company refusing to honor insurance claims, as per clause 865 of the Civil and Commercial Code.

CHOOSE YOUR PLAN (Please mark 'X')

❒ Plan 6	฿10,886	❒ Plan 7	฿12,952	❒ Plan 8	฿15,929

PLEASE COMPLETE & ATTACH (Please mark 'X')

❒ Copy of front page of Passport attached

Copy of your Social security card	❒ Yes or ❒ No
OR	
Copy of your work permit or social security	❒ Yes or ❒ No
OR	
If no work permit / social security card please indicate reason	❒ Spouse of permit holder ❒ Student ❒ Recently arrived in Thailand ❒ Recently joined the association ❒ Other……

Signature _____ Date (DD MM YYYY)_____/_____/_____