

Application Form

Health and Accident Special Insurance Policy

Aetna Health Insurance (Thailand) Public Company Limited

98, Sathorn Square Office Tower, 14th-15th Floor, North Sathorn Road, Silom, Bangrak, Bangkok 10500

Tel. 0 2677 0000 Fax. 0 2230 6500 Aetna Call Center 0 2232 8666 (Service 24/7 hours)

Insured's Information

- Applicant's Name Mr. / Mrs. / Ms.
Applicant's address / Address for correspondence.....
..... Zip code
Telephone No. : (Home) (Office) ext.....
(Mobile) (Fax) Email.....
- ID Card No. Date of Birth Age Year
Weight (kg) Height (cm) Nationality.....
- Applicant's occupation..... Position..... Place of work.....
- Please describe nature of work.....
- Name of first beneficiary..... Relationship with the insured.....
Address.....
..... Telephone No.
Name of second beneficiary..... Relationship with the insured.....
Address.....
..... Telephone No.
- Required Period of Insurance : starting from to
(the policy will be valid when the Company has already considered and approved the insurance and the premium has already been paid).
- Name of your selected plan.....
Additional coverage : Maternity Personal Accident Others (please specify).....
- You select the insurance payment by : monthly annually by
 Credit card (Bank's name).....
Credit card No. Expiry date
Credit card type : Visa Master Card holder's name :..... Telephone No.
 Direct debit (Bank's name)..... Branch..... Account No.
Premium..... Baht Duty Stamp..... Baht Tax Baht
Total..... Baht
- Auto Renew
 I wish to renew the term of the policy upon every expiration date by having the Company charge the insurance premium via credit card or bank deposit as provided in the aforementioned.
- Claim payment method : CQ-Cheque Bank Transfer
Please specify your bank account details for claim reimbursement
Bank's name..... Branch..... Account No.
- Do you have health, life or accident insurance or other income compensation plan with Aetna and/or any other companies?
 No Yes (please state the company name..... and sum insured..... Baht)
- Have you ever had an application rejected or a policy cancelled, rated or restricted by Aetna and/or other companies?
 No Yes (please state the company name.....

(English translation for the convenience of foreigner applicant only)



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13. During the past 5 years, have you ever been hospitalized?

No Yes

14. Have you ever received treatment or ever diagnosed by physician that you had suffered from Hypertension (high blood pressure), Hyperlipidemia, Diabetes Mellitus (DM), Heart Disease, Epilepsy, Brain and Nervous System Disease, Paralysis, Cerebral Atrophy, Cerebral Hemorrhage, Tumor, Cyst or all kinds of Cancer, Kidney Disease, Liver Disease, Blood Disease, HIV (AIDS), Bone, Joint and Gouty Arthritis, Thyroid Disease, Lupus Erythematosus (SLE), Respiratory Disorders and Lung Disease, for instance, Asthma, Emphysema, Chronic Obstructive Pulmonary Disease, TB or any other Chronic Disease, or not?

No Yes

15. Have you ever undergone a surgical procedure or ever diagnosed by physician to be undergone a surgical procedure?

No Yes

In case you declared Yes in Clause 13 to 15, please provide the details in the following schedule:-

Disease	Date/Month/Year of treatment (please stipulate whether you received diagnosis or treatment or notice by physician)	Treatment and current symptom	Clinic/Medical Facility (if you can specify the name of physician, please do so)

I hereby consent to the company's keeping, use, and disclose of the facts about my health and information to the OIC for the benefits of supervision of the insurance business.

Would you like to claim for personal income tax deduction with this health insurance premium?

Yes. and I permit the insurer to send and reveal the information about this insurance premium to the Revenue Department. If the applicant is a Non-Thai Resident, please enter the taxpayer ID number given by the Revenue Department.....

No

I hereby certify that all the above statements in this Application Form are true in all aspects. If I give false statement or do not disclose any truth, I hereby consent to the Company to terminate the insurance contract.

I, do hereby, appoint Aetna Health Insurance (Thailand) Public Company Limited, as the Attorney-in-fact to request any kinds of information of my health record or health conditions from any physician or healthcare provider or any other organization (who has my health record or health conditions) on my behalf until completion. A photocopy of this statement of authorization shall be as effective and valid as the original.

.....
Applicant's Signature

.....
Signature of Lawful Representative
(a person, on completion of 20 years of age)

.....
Apply date (Date/Month/Year)

Agent

Broker

License No. **6304006903**.....

In case where the Insured does not wish to apply for the insurance, please contact the Company and provide relevant documents requesting the termination of the Insurance Application Form or the policy (as the case may be) within 15 days upon receiving such documents. If the Insured did not comply with the aforementioned, the Company shall deem that the Insured accepts all the aforementioned details and conditions and that the Insurance Contract shall be in effect until the Company is provided with your written notice of any change.

Reminder of the Office of Insurance Commission, 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 Section 865 of the Civil and Commercial Code.

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