Allianz AYUDHYA

UltraCare plan

Individual application

Moratorium

Need help completing this application?
Please contact either your advisor or us directly. You can find our contact details on our website at allianz.co.th/health

You must tell us about all material facts before we accept an application or renew the plan. A material fact is information likely to influence us in assessing and accepting the insurance. If you do not tell us all material facts or if you misrepresent any material facts, this may render the insurance voidable from inception (the start of the contract) and enable us to repudiate liability (entitle us not to pay your claims). If there is any doubt about whether a fact is material, for your own protection, you must tell us.

If any of the details that you give on this application are different from the details that you gave when you received your quotation, your premium may be different.

Please read your policy and its conditions carefully and if you find any error or omission, please return your documents for immediate correction.

Reminder of The Office of Insurance Commission.

The Insured must answer all questions truthfully otherwise we may have cause to deny liability under the policy in accordance with section 865 of the Civil Commercial Code.

Please complete this application clearly in BLOCK CAPITALS.

If you have received a quotation from us, please write the quotation number and option number if you have one:

Quotation number:	Option number:

A Your personal details (the planholder)

Title: ☐ Mr ☐ Mrs ■ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Country where you live[1]:	How long have you lived there?
Home country:	Nationality on passport:
Occupation[2]:	Date of birth (dd/mm/yyyy): Sex: ☐ M ☐ F
ID or Passport number:	

[1] The amount of insurance premium tax and any other relevant taxes you will have to pay will depend on the country where you live. Please speak to your advisor or contact us if you are unsure whether your premium will be affected. Please make sure that your plan meets the requirements of the country where you live.

[2] Some occupations may have an increased premium. Please contact us for more information.

Your address[3]

[3] We will send all correspondence to this address unless you have completed the details below for a correspondence address. You must tell us immediately about any changes to your contact or personal details. A change in circumstances may affect your cover.

Address:	
Town:	City:
Postcode:	Country:
Phone:	Mobile:
Email:	

A Your personal details (the planholder) (continued)

Correspondence address – if different from your address above

Address:	
Town:	City:
Postcode:	Country:
Phone:	Mobile:
Email:	

Workplace address

Address:	
Town:	City:
Postcode:	Country:
Phone:	Mobile:
Email:	

B Dependants to be covered

Spouse/Partner

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Country where you live[1]:	How long have you lived there?
Home country:	Nationality on passport:
Occupation[2]:	Date of birth (dd/mm/yyyy): Sex: ☐ M ☐ F
ID or Passport number:	Relationship to planholder:

Workplace address

Address:	
Town:	City:
Postcode:	Country:
Phone:	Mobile:
Email:	

I am applying to be covered under the Ultracare plan and any add-on plans I have chosen, which is subject to terms and conditions of the relevant Plan Documentation.

I confirm that I have read this application in full, understand it, have followed its instruction and agree to all of its terms.

I declare that I will inform the insurer if the answers to the question set out in this application or in the questionnaires, or any other information I provide to the insurer in response to its questions, as applicable, change between the date of signing of this declaration and the date the cover commence.

I confirm that my information stated in this application is true and correct to the best of my knowledge.

I give consent to the insurer for my personal data, including medical information that may be collected and/or processed.

B Dependants to be covered (continued)

I authorize the doctor(s) named in section G or any other medical establishment, including any other health professional who has treated me under this plan, to give you any information you may need in connection with this application or any claim made under this plan.

Spouse/Partner signature (if 20+):	Date (dd/mm/yyyy):

Dependant 1

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Country where you live[1]:	How long have you lived there?
Home country:	Nationality on passport:
Occupation[2]:	Date of birth (dd/mm/yyyy): Sex: ☐ M ☐ F
ID or Passport number:	Relationship to planholder:

Workplace address

Address:	
Town:	City:
Postcode:	Country:
Phone:	Mobile:
Email:	

I am applying to be covered under the Ultracare plan and any add-on plans I have chosen, which is subject to terms and conditions of the relevant Plan Documentation.

I confirm that I have read this application in full, understand it, have followed its instruction and agree to all of its terms.

I declare that I will inform the insurer if the answers to the question set out in this application or in the questionnaires, or any other information I provide to the insurer in response to its questions, as applicable, change between the date of signing of this declaration and the date the cover commence.

I confirm that my information stated in this application is true and correct to the best of my knowledge.

I give consent to the insurer for my personal data, including medical information that may be collected and/or processed.

I authorize the doctor(s) named in section G or any other medical establishment, including any other health professional who has treated me under this plan, to give you any information you may need in connection with this application or any claim made under this plan.

Dependent 1 signature (if 20+):	Date (dd/mm/yyyy):

Dependant 2

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Country where you live[1]:	How long have you lived there?
Home country:	Nationality on passport:
Occupation[2]:	Date of birth (dd/mm/yyyy): Sex: ☐ M ☐ F
ID or Passport number:	Relationship to planholder:

B Dependants to be covered (continued)

Workplace address

Address:	
Town:	City:
Postcode:	Country:
Phone:	Mobile:
Email:	

I am applying to be covered under the Ultracare plan and any add-on plans I have chosen, which is subject to terms and conditions of the relevant Plan Documentation.

I confirm that I have read this application in full, understand it, have followed its instruction and agree to all of its terms.

I declare that I will inform the insurer if the answers to the question set out in this application or in the questionnaires, or any other information I provide to the insurer in response to its questions, as applicable, change between the date of signing of this declaration and the date the cover commence.

I confirm that my information stated in this application is true and correct to the best of my knowledge.

I give consent to the insurer for my personal data, including medical information that may be collected and/or processed.

I authorize the doctor(s) named in section G or any other medical establishment, including any other health professional who has treated me under this plan, to give you any information you may need in connection with this application or any claim made under this plan.

Dependent 2 signature (if 20+):	Date (dd/mm/yyyy):

Dependant 3

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Country where you live[1]:	How long have you lived there?
Home country:	Nationality on passport:
Occupation[2]:	Date of birth (dd/mm/yyyy): Sex: ☐ M ☐ F
ID or Passport number:	Relationship to planholder:

Workplace address

Address:	
Town:	City:
Postcode:	Country:
Phone:	Mobile:
Email:	

I am applying to be covered under the Ultracare plan and any add-on plans I have chosen, which is subject to terms and conditions of the relevant Plan Documentation.

I confirm that I have read this application in full, understand it, have followed its instruction and agree to all of its terms.

I declare that I will inform the insurer if the answers to the question set out in this application or in the questionnaires, or any other information I provide to in response to the insurer its questions, as applicable, change between the date of signing of this declaration and the date the cover commence.

I confirm that my information stated in this application is true and correct to the best of my knowledge.

B Dependants to be covered (continued)

I give consent to the insurer for my personal data, including medical information that may be collected and/or processed.

I authorize the doctor(s) named in section G or any other medical establishment, including any other health professional who has treated me under this plan, to give you any information you may need in connection with this application or any claim made under this plan.

Dependent 3 signature (if 20+):	Date (dd/mm/yyyy):

If you have any more dependants to be covered, please give us details on a separate sheet of paper and send it to us with this application.

C Cover start date

The plan is a yearly contract. Your cover will begin on the date when we confirm acceptance of your application in writing. If you want your cover to start at a later date, please tell us below. This date can be no more than 30 days after the date you complete this application.

We cannot backdate cover under any circumstances.

Date you want cover to start (dd/mm/yyyy):

D Your cover options

Level of cover and type of plan

Please tell us the type of UltraCare plan that you need. Please make sure that you have read the Table of benefits before making your choice. You must make sure the plan meets your needs. Please contact us if you need a copy of this document.

☐ Standard	☐ Select	☐ Comprehensive	☐ Elite	☐ Thailand UltraCare

Area of cover

Your area of cover will be **Area 2** Worldwide, not including the USA.

Excess options (deductibles)

If you want to change the excess from the standard excess shown, please tick the appropriate box below.

Excess options	Standard	Select	Comprehensive	Elite	Thailand UltraCare
No excess (Refer to Premium Table B)	N/A	☐ 10% premium increase	☐ 10% premium increase	Standard	N/A
THB 1,800 (Refer to Premium Table A)	Standard	Standard	Standard	N/A	N/A
THB 3,400	N/A	☐ 5% premium discount	☐ 5% premium discount	N/A	N/A
THB 6,800	N/A	☐ 10% premium discount	☐ 10% premium discount	N/A	N/A
THB 17,000	N/A	☐ 15% premium discount	☐ 15% premium discount	N/A	N/A
THB 34,000	☐ 10% premium discount	☐ 20% premium discount	☐ 20% premium discount	N/A	N/A
THB 68,000	☐ 20% premium discount	☐ 25% premium discount	☐ 25% premium discount	N/A	N/A
THB 170,000	☐ 30% premium discount	☐ 30% premium discount	☐ 30% premium discount	N/A	N/A
THB 340,000	☐ 40% premium discount	☐ 40% premium discount	☐ 40% premium discount	N/A	N/A
THB 68,000 (In-patient and daycare treatment received outside Thailand)	N/A	N/A	N/A	N/A	Standard

D Your cover options (continued)

UltraCare Standard plan
You must pay a standard excess amount of THB 1,800 for each medical condition in each plan year for all out-patient treatment claims.
If you choose a voluntary excess, this will apply for each medical condition in each plan year for all in-patient, daycare and out-patient treatment, including organ transplants.

UltraCare Select plan
You must pay a standard excess amount of THB 1,800 for each medical condition in each plan year for all out-patient treatment claims, including HIV or AIDS and maintenance of chronic medical conditions.
If you choose a voluntary excess, this will apply for each medical condition in each plan year for all in-patient, daycare and out-patient treatment, including organ transplants, HIV or AIDS, emergency treatment outside your area of cover and maintenance of chronic medical conditions.

UltraCare Comprehensive plan
You must pay a standard excess amount of THB 1,800 for each medical condition in each plan year for all out-patient treatment claims, including congenital abnormalities, HIV or AIDS and maintenance of chronic medical conditions.
If you choose a voluntary excess, this will apply for each medical condition in each plan year for all in-patient, daycare and out-patient treatment, including congenital abnormalities, organ transplants, HIV or AIDS, emergency treatment outside your area of cover and maintenance of chronic medical conditions.

UltraCare Elite plan
You do not have to pay a standard excess on this plan. If you choose a voluntary excess, this will apply for each medical condition in each plan year for all in-patient, daycare and out-patient treatment, including congenital abnormalities, organ transplants, HIV or AIDS, emergency treatment outside your area of cover and maintenance of chronic medical conditions.

Thailand UltraCare

Excess (deductibles)
There is no excess to pay for all out-patient medical treatment claims. There is no excess to pay for in-patient and daycare treatment received in Thailand. You must pay a standard amount of THB 68,000 for each medical condition in each plan year for all in-patient and daycare medical treatment received outside of Thailand, including organ transplants, HIV or AIDS and maintenance of chronic medical conditions.

Co-insurance (deductibles)

UltraCare Comprehensive plan
You must pay 25% of all out-patient dental treatment claims. The maximum amount we will pay to you for out-patient dental treatment will be 75% of each eligible claim. The total amount we will pay to you for an eligible claim for out-patient dental treatment will be 75% of the limit shown on your Table of benefits. You cannot remove this co-insurance.

E Add-on plans and benefits

Do you want to add any of the following?

Maternity add-on plan	☐ Yes ☐ No

If yes, please tell us which level of co-insurance you have chosen for each person:
☐ No co-insurance ☐ 10% ☐ 20%

The Maternity add-on plan is only available for female members. The minimum age at entry for this plan is 18. The maximum age at entry is 44. Cover only becomes available for treatment received 12 months after the start date of this add-on plan.

Personal accident add-on plan	☐ Yes ☐ No

If yes, please circle the number of Personal accident units you need for each person as set out in the Personal accident add-on plan Table of benefits. You must be aged 0 to 74 when joining this plan.

Planholder: 1 2 3 4 5	Dependant 1: 1 unit only	Dependant 2: 1 unit only
Spouse/Partner: 1 2 3 4 5	Dependant 3: 1 unit only	

If you have any more dependants to be covered, please give us details on a separate sheet of paper and send it to us with this application.

The Personal accident add-on plan provides cover for managerial, clerical and administrative

occupations only. The plan does not cover claims arising from engaging in manual or dangerous occupations or hazardous pursuits. If you or any dependants on this application engage in any hazardous pursuit or occupation which puts you at greater risk of a bodily injury caused by an accident, please give full details on a separate sheet and include it with this application. If you are in any doubt as to whether an occupation is manual or dangerous or a pursuit is a hazardous one, please tell us. If we agree to provide cover, extra premiums may apply.

F Paying your premiums

To enjoy the full benefit of the plan, you must make sure the premiums are paid on or before the premium due date. You must tell us about any changes to your payment details to make sure that we can continue to collect any premiums due.

You can find full payment details and information on unpaid or late payments in the Plan guide.

Currency

Your premiums must be paid in Thai baht (THB).

Payment options

You can pay yearly, every three months or every month. Please choose how often you want to pay your premiums and tick the relevant method applicable to it. We cannot accept payment by bank transfer or cheque if you are paying by instalments. Due to administration costs, the total premiums you pay every month or every three months will be higher than if you pay the premiums every year (about 7.5% more if you pay every month and 5% if you pay every three months).

	Card	Bank transfer	Cheque
Yearly	☐	☐	☐
Every three months	☐	N/A	N/A
Every month	☐	N/A	N/A

Add-on plans and benefits

Personal accident and Maternity add-on plan premiums can only be paid yearly.

Payment details

Card

We can accept card payments by Visa or MasterCard. Please complete the Credit card authority attached to this application. Please make sure that your card is valid for at least three months from the start date of your plan.

Bank transfers

Bank transfers must be in the currency of your plan. Please make sure that you give your full name and quotation or plan number as the reference for your bank transfer.

Account Name: Please refer to payment form **Account Type:** Please refer to payment form **Currency:** THB	
Bank:	Please refer to payment form
Account No:	Please refer to payment form
Swift Code:	Please refer to payment form

To ensure that the full amount of your payment is received by us, please mark your bank transfer: 'PAY FULL AMOUNT' or 'Bank Charges Debit Account'.

Cheque or banker's draft

Cheques must be in the currency of your plan and payable to the insurer Please make sure that your full name and quotation or plan number is clearly shown on the back of the cheque in case your payment becomes separated from this application.

G Doctor's or medical practitioner's details

Please give the contact details of any family doctor or medical practitioner who has treated you or your dependants in the last two years. If you do not provide this information, it may result in a delay in processing any claims and/or your claim may be rejected.

Name:	Name:
Hospital, clinic or practice:	Hospital, clinic or practice:
Phone:	Phone:
Fax:	Fax:
Email:	Email:
Address:	Address:
Postcode:	Postcode:

H Medical questionnaire

Please answer the following questions:

1. Have you or any of your dependants ever had a past history of cancer (including benign brain tumours), a heart condition or stroke, joint disorder, psychiatric or mental illness?	☐ Yes	☐ No
2. Do you or any of your dependants have any long-term, ongoing or chronic condition for which you have regular appointments or need a review or treatment for?	☐ Yes	☐ No

If you answer yes to either of the above questions, please provide details in section M Medical details.

I Pre-existing medical conditions

Please read benefit exclusion BE1 carefully before applying for this plan. You can find this in the Plan guide and below.

You must sign this section to show that you understand and accept our 24-month moratorium. We will not process your application unless you have signed this section as well as the declaration section in this application.

It is important that you read, understand and accept all of the paragraphs in the following declaration for your UltraCare plan.

This declaration applies to you and to any eligible dependants you have included in this application.

The 24-month moratorium is a waiting period of 24 months from your date of joining, or the date shown on the special terms section of your Certificate of insurance, that must have passed before claims for pre-existing medical conditions may be eligible under the plan. Please read benefit exclusion BE1 in the Plan guide. The moratorium also applies to the Maternity add-on plan.

Any medical condition or related medical condition which has one or more of the following characteristics:

- clearly showed itself;
- you had signs or symptoms of;
- you asked for advice about;
- you received treatment for;
- to the best of your knowledge, you were aware you had.

A medical condition or related medical condition that is pre-existing within the 24-month period before the date of joining or the date shown on the special terms section of your Certificate of insurance.

Pre-existing medical conditions or related medical conditions may be covered after you have had 24 months' continuous cover under the plan and within that time you have not:

- experienced symptoms;
- asked for advice; or
- needed or received treatment, medication or a special diet.

If you have:

- experienced symptoms;
- asked for advice; or
- needed or received treatment, medication or a special diet;

then you will have to wait until you have completed a continuous 24-month period when none of these apply to you. Pre-existing medical conditions or related medical conditions may then be covered. This is the rolling part of the moratorium.

I confirm that I have read, understood and accept this moratorium underwriting clause about pre-existing medical conditions and that it applies to any eligible dependants included in this application.

Signature:	Date (dd/mm/yyyy):

J Data Protection

We are committed to protecting your personal data and privacy. Any personal information that we collect from you will be kept confidential and will be processed in accordance with relevant legislation and our own strict internal policy.

We will use any personal data to process your claims, administer your plan, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

Your information may also be used for fraud prevention and audit purposes. If you give us false or inaccurate information and we suspect fraud, we will record this. We may pass such information to law enforcement or other legal agencies, governmental or judicial bodies, or to regulators.

Your medical information will only be disclosed to those involved with your treatment or care, including your medical practitioner, or their agents. If you ask us to, we will also send your medical information to any person or organisation that may be responsible for meeting your treatment expenses, or their agents. Your information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information.

We will not disclose your medical information to any other individual without your explicit consent. If you want us to disclose your medical information to another individual or next of kin, you must tell us. In exceptional emergency situations, and in accordance with medical confidentiality guidelines and relevant law, we may be required to disclose such information to relatives, family members or other third parties.

To help us ensure that your personal information remains accurate and up to date, please inform us of any changes.

You have the right to see personal information about you held by us. There may be a charge for this.

K Declaration

I am applying to be covered under the UltraCare plan or plans I have chosen together with the dependants listed in this application.

I have read, understood and agree to keep to the terms and conditions shown in the Plan guide, along with all eligible dependants included in this application or any dependants I enrol in the future after the start date of the plan. I confirm that I have authority to give the insurer information about my family members referred to in this application.

By agreeing to the UltraCare terms and conditions I consent to any personal data, including medical information, that you may collect about myself and my family members and dependants, being processed by the insurer.

I authorise the doctor named in section G or any other medical establishment, including any other health professional who has treated me and any of my dependants included under this plan, to give you any information you may need in connection with any claim made under this plan.

I understand that if I do not provide the information asked for in sections G and H, and I or any of my dependants included under this plan make a claim, which you view as being treatment for a pre-existing medical or related medical condition, my claim may be rejected.

I understand that should I or one of my dependants attend a hospital, clinic or medical facility where direct billing or cashless arrangements are in place and the claim is subsequently found to be ineligible, the insurer has the right to recover the full amount of the ineligible claim from me or one of my dependants.

I understand and agree that this declaration and the information in this application will form the basis of the contract between me, my dependants and the insurer. After reading all the terms and conditions and documents you have given me, I am satisfied that the product I have chosen meets my needs at this time.

If you would like to exercise your right regarding tax exemption by law:

☐ I would like to exercise, and hereby declare my intention and give consent to the insurer to deliver and disclose my information pertaining to insurance premium to the Revenue Department regarding rules and methods specified by the Revenue Department.n-Thai Resident who is not obliged to pay tax in Thailand, please specify your tax identical

If you are Non-Thai Resident who is not obliged to pay tax in Thailand, please specify your tax identification number received from the Revenue Department:

☐ I have no desire to exercise the right.

For your own benefit and protection, you should read the terms and conditions shown in the Plan guide carefully before signing this declaration. If you do not understand any point, please ask for more information. You can find our full terms and conditions and details of our privacy policy at allianz.co.th/health

Signature:	Date (dd/mm/yyyy):

Cancellation

If you feel this plan does not meet your needs, you may cancel it. You must tell us in writing by letter, fax or email and return all membership cards and Certificates of insurance within 30 days of the date of joining or receiving the plan documents, whichever is later.

L Broker details

Broker's or advisor's details if applicable:
Thai Expat Club (Nutcha Paijak) - 6304006903

M Medical details

Name	Question number	Symptom 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 to recur?)

If you require more space, please give us details on a separaate sheet of paper and send it to us with this application.

N Contact details

Please return your completed application to your advisor or send it to us using the contact details below:

Allianz Ayudhya General Insurance Public Company Limited.
898 Ploenchit Tower
Ploenchit Road
Khwang Lumpini
Khet Pathumwan
Bangkok 10330
Thailand

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