PREMIER INTERNATIONAL HEALTHCARE

APPLICATION FORM

Your personal details

Title		Surname	
Sex	M / F	First Name	

Nationality		Passport No.		Date of birth	D D M M Y Y Y Y
Height (cm)		Weight (kg)		Age last birthday	
Occupation				Smoker	Y / N

Your contact details

Residential address of the the country where you are to be located

Address			
Town/ City		Country	
PostCode/ Zip Code		Email Address	
Home Country		Country of Residence	
Work Contact (Tel.)		Home Contact (Tel.)	

Your choice of medical cover

Coverage details (please tick one box only on each line)

Programme	In-patient only ☐	Programme 2 ☐	Programme 3 ☐		
Geographical area	Area 1 Europe only ☐	Area 2 Worldwide excluding USA, Canada & Caribbean ☐	Area 3 Worldwide ☐		
Deductible	Nil ☐	THB 2,700 ☐	THB 9,000 ☐	THB 18,000 ☐	THB 36,000 ☐

Total Annual Premium THB

Eligible dependants to be insured

Title		Surname	
Sex	M / F	First Name	
Passport No.		Date of birth	D D M M Y Y Y Y
Address		Age last birthday	
Town/City		Country of Residence	
Nationality		Occupation	
Relationship to you, eg son, daughter, wife/spouse		Smoker	Y / N

Title		Surname	
Sex	M / F	First Name	
Passport No.		Date of birth	D D M M Y Y Y Y
Address		Age last birthday	
Town/City		Country of Residence	
Nationality		Occupation	
Relationship to you, eg son, daughter, wife/spouse		Smoker	Y / N

Title		Surname	
Sex	M / F	First Name	
Passport No.		Date of birth	D D M M Y Y Y Y
Address		Age last birthday	
Town/City		Country of Residence	
Nationality		Occupation	
Relationship to you, eg son, daughter, wife/spouse		Smoker	Y / N

* If you have more than three dependants please request a ‘ Additional Dependants Form ’ .

Underwritten By

Insured By

(continued)

Confidential medical history

	Main Applicant		Spouse/ Partner		1st Child		2nd Child		3rd Child	
Name										
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
a) Has any person named in this form been admitted to hospital or nursing home or had any medical tests done in the last 4 years?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
b) Has any specialist been consulted and/or provided prescriptions for any drugs or medication in the last 4 years?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
c) Has any application for life, accident, health or any other insurance been refused or had special terms applied?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
d) Does any person named in this form anticipate the need or has been recommended to undergo any medical tests or investigations in the foreseeable future?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
e) Has any person named in this form ever suffered from or are suffering from any disease stated in Note* below?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Note: * Heart Trouble, Chest pain, blood pressure problems or circulatory disorders; Fainting blackout, dizziness, seizures, fits, stroke or paralysis, Asthma, persistent cough, breathlessness or other respiratory disorders; Stomach ulcer, liver, hepatitis, gall bladder, intestinal or bowel disorders; Kidney bladder, prostate or genitor-urinary disorder; Gynecological or hormonal disorders or irregularity; Diabetes, cholesterol problems or diseases or disorders of the blood; cyst, growth, tumour , cancer or glandular diseases or abnormalities; Diseases or disorders of the eyes, ears, nose or throat; Diseases or disorders of the back, bones, joints, muscles or skin; Mental or nervous disorders; AIDS, HIV or venereal disease; Any diseases, disorders or conditions which are long lasting or recurrent; Treatment for drug and alcohol addiction or abuse; Any other illness, disabilities or defects present that have not already been disclosed.

If you have answered "Yes" to any of the above questions, please provide more details below by indication the question number, the condition, dates of consultation, the treatment received and the name and address of doctor. Please attach a copy of all medical reports if applicable. If you need to use a separate sheet of paper, attach to this form and indicate you have done so by ticking this box: ☐

Declaration

Benefits may not be payable if you do not fully disclose any material facts which could influence our assessment and acceptance of this applications and, if you are in any doubts as to any facts are material, you should disclose them.

I/We declare that all the information on this Application Form is true and complete. I /We am/are unaware of the existence of any medical condition or circumstance foreseeably requiring my/our hospitalisation in the future, and understand that benefits will not apply to treatment or expense arising from medical conditions originated or were known to exist or for which treatment, medication, advice or diagnosis was sought or received prior to my/our enrolment in the Policy unless such conditions are fully disclosed to and accepted by Aviva Ltd prior to the inception of the Policy.

I/We authorise any medical source, insurance office, or organisation to release to Aviva Ltd and similarly Aviva Ltd to release to any of the prior mentioned organisation, relevant information concerning me at any time, regardless of whether the application is accepted by Aviva Ltd. A photographic copy of this authorisation shall be as valid as the original. I/We further authorise Aviva Ltd to give such information obtained or information contained herein for the purpose of obtaining insurance cover under this Application to my insurance representative. I/We understand that Aviva may require further medical information from my doctor and I/ We am/are aware that I /We am/are responsible for obtaining and paying for such information should I /We wish to continue my/our application.

I/We am/are aware that I/We can seek advice from a qualified adviser before I /We sign this application form. Should I/We choose not to, I /We take sole responsibility to ensure that this product is appropriate to my/our financial needs and insurance objectives. I/We have received Your Guide to Health Insurance, Fact Find and the Product summary and they have been explained to my/our satisfaction.

I further declare that I am not an undischarged bankrupt and that I have committed to no act of bankruptcy within the last twelve months and no receiving order of adjudication order in bankruptcy has been made against me during that period.

I/We agree that any cover which I/We may purchase for the USA & Canada shall terminate upon informing Aviva Ltd that I /We have become a resident of the USA/Canada. I /We agree that this application shall be the basis of the contract of insurance between me/us and Aviva Ltd. I/We understand that the insurance shall not become effective until it is accepted and confirmed in writing by Aviva Ltd.

Signature of Main Applicant	**Date**
Signature of Spouse/ Partner	**Date**

Underwritten By

Insured By