AXA Insurance Public Company Limited
Lumpini Tower-23 Fl., 1168/67 Rama 4 Road,
Thungmahamek, Sathorn, Bangkok 10120
Tel: 0-2679-7600, 0-2285-6385 Fax : 0-2624-9111

SmartCare Optimum

HEALTH INSURANCE APPLICATION FORM

WARNING: Department of insurance. The applicant should disclose all the facts you know. Any nondisclosure shall make the policy issued hereunder void able. The company has the right to void the contract and refuse claims according the Civil Commercial Code Section 865

PARTICULARS OF PERSON TO BE INSURED

Applicant's Name		Nationality
Date of Birth		AGE YEARS MONTH
ID. Card No./Passport No		Height(m) Weight(kg)
Marital Status ☐ Married ☐ Single ☐ Others (please advise)		
Address		
☐ HOME	☐ MOBILE	☐ EMAIL
Occupation/Position	Company Name	
Company address		
☐ OFFICE	☐ FAX	
Corresponding address ☐ Home ☐ Office ☐ Others (please advise)		
Beneficiary		
Relationship to the applicant	Effective Date (1 Year) : From	

PARTICULARS OF SPOUSE TO BE INSURED (APPLICANT 2)

Spouse's Name :		Nationality
Date of Birth		AGE YEARS MONTH
ID. Card No./Passport No		Height(m) Weight(kg)
Occupation/Position	Company Name	
Company address		
☐ OFFICE	☐ MOBILE	☐ FAX
Spouse's Beneficiary		
Relationship		

PARTICULARS OF CHILD TO BE INSURED (APPLICANT 3.1-3.3)

3.1. Child' s Name	AGE YEARS MONTH
Date of Birth	Height(m) Weight(kg)
ID. Card No./Passport No	Class
3.2. Child' s Name	AGE YEARS MONTH
Date of Birth	Height(m) Weight(kg)
ID. Card No./Passport No	Class
3.3. Child' s Name	AGE YEARS MONTH
Date of Birth	Height(m) Weight(kg)
ID. Card No./Passport No	Class

QUESTIONS FOR ALL APPLICANTS PROPOSED FOR INSURANCE (Please tick the appropriate box)

	NO	YES
1. Does any one of the applicants proposed for insurance hereunder have health, life or accident insurance with other Insurance companies?	☐	☐
2. Has any one of the applicants proposed for insurance hereunder ever been declined or accepted on special terms other medical / life insurance plan?	☐	☐
3. Has any one of the applicants proposed for insurance hereunder ever undergone a surgical procedure of investigative nature or hospitalized or had a major accident in the last 5 years?	☐	☐
4. Has any one of the applicants proposed for insurance hereunder ever been advised to have a surgical operation or investigative procedure which has not been performed?	☐	☐
5. Has any one of the applicants proposed for insurance hereunder had special treatment with x-ray, Ultrasound, CT Scan, MRI Scan, Biopsy, Electrocardiogram?	☐	☐

Remark: If your answer is "Yes" to any of the above questions, please provide details such as name of insurance company, reason of decline or acceptance on special terms, nature of surgical procedure etc.....

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HEALTH DECLARATION OF ALL APPLICANTS PROPOSED FOR INSURANCE(Please tick Yes or No and fill in the box)					
Item	NO	YES	Name	Date of Onset	Date of Recovery
1. any respiratory disorders, lung trouble, asthma, allergy?					
2. any heart, myocardial or cardiovascular disease?					
3. any skeletal - muscular system disorders, joint disorders, rheumatism, arthritis, gout or back trouble?					
4. any digestive disorders?					
5. any enlarged glands or any form of cancer, tumor non-malignant tumor or mass or cyst?					
6. any eye, ear, nose or throat disorders and abnormalities?					
7. any liver and gall bladder disorder i.e. hepatitis cholecystitis, gallstones?					
8. any reproductive disorders and sexually transmitted diseases?					
9. any urinary system disorders?					
10. any circulatory and blood disorders?					
11. any thyroid gland disorders i.e. hypothyroid, thyrotoxicosis?					
12. any brain and nervous system disorders and cerebrovascular disease?					
13. Are you currently suffering or ever been following disease?					
Autistic Epilepsy Renal disease/left with one kidney					
Diabetes Tuberculosis S.L.E Thalassemia Dwarfism					
14. Except item 13 are you suffering or injuries?					
15. Are you currently taking any medication or undergoing any treatment regularly?					

Remark If your answer is "Yes", please give details of the treatment received, name of medical practitioner and the hospitals or clinics providing the medical treatment hereunder :

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We declare that the above answers are full, complete and true and agree that they shall form part of my/our application which shall be the basis of the contract of insurance. We also agree that in case of any claims we authorize any hospital, physician or other person who has attended to us, or examined us or is authorized to maintain medical records, to disclose when requested to do so by AXA Insurance PCL, any and all information with respect to any illness or injury, medical history or treatment. A photocopy of this authorization shall be considered as effective and valid as the original. We understand that this insurance will not commence until the company has approved my application.

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Signature of Applicant (Application Date : ddmmyyyy)

(for and on behalf of all persons to be insured)

Agent / Broker .....