



## Application Form Health and Accident Special Insurance Policy

### Insured's Information

1. Applicant's Name Mr. / Mrs. / Ms. ....  
Applicant's address / Address for correspondence .....  
..... Zip code
- Telephone No. : (Home)  (Office)  ext. ....  
(Mobile)  (Fax)  Email Address .....
2. ID Card No.  Date of Birth  Age  Year  
Weight ..... (kg) Height ..... (cm) Nationality .....
3. Applicant's occupation ..... Position ..... Place of work .....
4. Please describe nature of work .....
5. Name of first beneficiary ..... Relationship with the insured .....  
Address .....  
..... Telephone No.
- Name of second beneficiary ..... Relationship with the insured .....  
Address .....  
..... Telephone No.
6. 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).*
7. Name of your selected plan .....  
Additional coverage:  Maternity  Personal Accident  Others (please specify) .....
8. You select the insurance payment by:  annually  monthly 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) ..... Bank Branch ..... Account No.   
Premium ..... Baht Duty Stamp ..... Baht Tax ..... Baht  
Total ..... Baht
9. 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.
10. Claim payment method :  CQ-Cheque  Bank Transfer  
Please specify your bank account details for claim reimbursement  
Bank's name ..... Branch ..... Account No.

11. Do you have health, life or accident insurance or other income compensation plan with Bupa or any other companies?  
 No  Yes (please state the company name.....and sum insured..... Baht)
12. Have you ever had an application rejected or a policy cancelled, rated or restricted by other companies?  
 Yes (please state the company name.....)  No
13. During the past 5 years, have you ever been hospitalized?  
 Yes  No
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, Lupus Erythematosus (SLE), Respiratory Disorders and Lung Disease, for instance, Asthma, Emphysema, Chronic Obstructive Pulmonary Disease, TB or any other Chronic Disease, or not?  
 Yes  No
15. Have you ever undergone a surgical procedure or ever diagnosed by physician to be undergone a surgical procedure?  
 Yes  No

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 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 Bupa 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  
(in case where the Applicant is a minor)

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

Agent

Broker

License No.....

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.