Application form health and personal accident insurance

SmartCare Executive (Long-Stay Visa)

(For Groups of Aliens to Enter the Kingdom on an exceptional case on Long-Stay Purpose in accordance with the Cabinet Resolution)

DETAILS OF THE APPLICANT (APPLICANT # 1)			
1. Name–Surname (Mr. / Mrs. / Ms.)			Age Years Months
Date of Birth (DD/MM/YYYY)			Height (cm) Weight (kg)
ID Card No. / Passport No.			Marital Status (Married / Single / Others, if other please specify)
Present Address			
Telephone No.	Mobile No.		Email
Occupation (Position)		Nature of Work	
Company Name		Type of Business	
Office Address		Office phone No.	Fax
Name – Surname of the Beneficiary (Mr. / Mrs. / Ms.)			Relationship

About your cigarette smoking and alcohol drinking habits?

Cigarette Smoking ☐ No ☐ Yes, Quantity _____ Cigarette(s) / Day, for approximately _____ Year(s)

Alcohol Drinking ☐ No ☐ Yes, Quantity _____ Bottle(s) / Day, for approximately _____ Year(s)

DETAILS OF "DEPENDENT" (SPOUSE) (APPLICANT # 2) - OPTIONAL			
2. Name – Surname (Mr. / Mrs. / Ms.)			Age Years Months
Date of Birth (DD/MM/YYYY)			Height (cm) Weight (kg)
ID Card No. / Passport No.			
Occupation (Position)		Nature of Work	
Company Name		Type of Business	
Office Address		Office phone No.	Fax
Name – Surname of the Beneficiary (Mr. / Mrs. / Ms.)			Relationship

About your cigarette smoking and alcohol drinking habits?

Cigarette Smoking ☐ No ☐ Yes, Quantity _____ Cigarette(s) / Day, for approximately _____ Year(s)

Alcohol Drinking ☐ No ☐ Yes, Quantity _____ Bottle(s) / Day, for approximately _____ Year(s)

DETAILS OF "DEPENDENTS" (SON/DAUGHTER) (APPLICANT # 3, #4, & #5) - OPTIONAL			
3. Name–Surname (Mr. / Mrs. / Ms.)			Age Years Months
Date of Birth (DD/MM/YYYY)	ID Card No. / Passport No.		Height (cm) Weight (kg)
Name – Surname of the Beneficiary (Mr. / Mrs. / Ms.)			Relationship
4. Name–Surname (Mr. / Mrs. / Ms.)			Age Years Months
Date of Birth (DD/MM/YYYY)	ID Card No. / Passport No.		Height (cm) Weight (kg)
Name – Surname of the Beneficiary (Mr. / Mrs. / Ms.)			Relationship
5. Name–Surname (Mr. / Mrs. / Ms.)			Age Years Months
Date of Birth (DD/MM/YYYY)	ID Card No. / Passport No.		Height (cm) Weight (kg)
Name – Surname of the Beneficiary (Mr. / Mrs. / Ms.)			Relationship

YOUR CHOICE OF INSURANCE PLAN

☐ Plan 1 ☐ Plan 2 ☐ Plan 3

PLEASE GIVE TRUTHFUL INFORMATION AND TICK THE APPROPRIATE BOX TO THE FOLLOWING QUESTIONS

At present, the Applicant and Dependent(s) of the Applicant	NO	YES
1. Have taken out health, life or accident insurance with other insurance companies ?		
2. Have ever been declined for insurance or cancelled policy or charged additional premium or imposed special exclusions by the insurance company ?		
3. Have ever undergone a surgery, diagnosis, inpatient hospitalization or having an accident during the past 5 years ?		
4. Have received physician's advice for medical treatment by way of surgery or for additional diagnosis which has yet to be performed ?		
5. Have ever been diagnosed, i.e., CT Scan, MRI Scan, Biopsy, Ultrasound, Electrocardiogram in the past 5 years or ?		

Remarks: If your answer is "YES", please give details, i.e., name of insurance company with reasons for declining insurance or imposing special exclusions, causes for medical treatment in a hospital, name of disease, name of physician and name of the hospital providing treatment to you.

PLEASE GIVE TRUTHFUL INFORMATION AND TICK THE APPROPRIATE "YES" OR "NO" BOX TO THE FOLLOWING QUESTIONS

At present, the Applicant and Dependent(s) of the Applicant	YES	NO	Name of Applicant	Onset Date	Recovery Date
1. Have any respiratory disorders, i.e., lung trouble, asthma, allergy ?					
2. Have any heart diseases, cardiomyopathy, myocardial disorders or cardiovascular disease or experienced any sign/ symptom of any heart condition ?					
3. Have any skeletal – muscular system disorders, joint disorders, rheumatism, arthritis, gout, spine or back trouble ?					
4. Have any digestive disorders, i.e., intestine, stomach, and chronic abdominal pain ?					
5. Have any tumor, cancer, mass or cyst ?					
6. Have any eye, ear, throat, nose disorders ?					
7. Have any liver and gall bladder diseases, i.e., liver inflammation, cirrhosis, gallstones ?					
8. Have any reproductive disorders and sexually transmitted diseases ?					
9. Have any urinary system disorders, i.e., stones, bladder inflammation ?					
10. Have any circulatory and blood disorders, i.e., high blood pressure, Anemia, hemophilia ?					
11. Have any thyroid gland disorders, i.e., goiter, thyrotoxicosis, hypothyroid ?					
12. Have any nervous system and brain disorders and cerebrovascular disease ?					
13. Are you presently suffering or have ever suffered the following diseases, i.e., autistic, epilepsy, kidney disease (with only one remaining kidney), diabetes, tuberculosis, SLE, thalassemia, dwarfism ?					
14. Apart from item 13, are you presently sick or injured ?					
15. Are you presently taking any medication or any routine injection for treatments of chronic disease ?					

Remarks: If your answer is "YES", please give details of disease, treatment, name of physician and name of the hospital providing treatment to you.

The Applicant authorizes company to keep, use and disclose health facts as well as details of the Applicant to the Office of Insurance Commission (OIC) for the benefits in supervising insurance business.

I wish to apply for the insurance with company in accordance with the conditions of the Policy related to this insurance and I declare that the information given above is correct and complete. I agree that the information given in my application shall be the basis of the insurance contract between I and company.

Do you wish to exercise your right for income tax exemption pertinent to Revenue Code or not?

☐ Yes, I do and I authorize the general insurance company to submit and disclose details of insurance premium to the Revenue Department pertinent to relevant guidelines and procedures. If the Applicant is a Non-Thai Resident and is required by the Revenue Code to pay income tax, please also provide your Tax ID Number as received from the Revenue Department _____ .

☐ No, I do not.

This document is not the insurance contract. You will be covered upon receiving confirmation from the Company.

_____ / _____ / _____
Applying Date (DD/MM/YYYY)

_____
( )
Applicant's Signature
Or Authorized Person with Company's stamp affixed

☐ Direct Insurance ☐ Agent ☐ Broker License No. _____

WARNING FROM THE OFFICE OF INSURANCE COMMISSION (OIC)
Please give answers to all questions truthfully otherwise the Company may have cause to deny liability under the Policy in accordance with Section 865 of the Civil and Commercial Code.