SMARTCARE EXECUTIVE APPLICATION FOR THE **PATTAYA EXPATS CLUB**

Insured Person : PARTICULARS OF THE INSURED PERSON

1.Applicant's Name………………………………………………………………………………………………………

Date of Birth………………………………………………………… Age (Years) …………………… Months……………………………

ID.Card No. /Passport No……………………………………………… Nationality…………………………………………………………..

Marital Status (please advise)……………………………………… Height (m) …………………….. …Weight (kg)……………………..

Address……..

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☎ Home…………………………………………………………… Mobile…………..………………………………………….

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Email………

Occupation (Position)……………………………………………… Job Responsibility……………………………………………………

Company Name ………………………………………………………… Type of Business…………………………………………………

Company address……

☎ Office………………………………………………………………… Fax…………………………………………………………………

Beneficiary Name…………………………………………………… Relationship to the applicant…………………………………………..

Please advise your Smoking And Drinking habits?	**Smoking**	☐ NO	☐ Yes…………….cigarettes/day, starting from age……………………..
	Drinking	☐ NO	☐ Yes……………bottles /day, starting from age………………………..

CHOICE OF PLAN

Please tick the appropriate box

1. Hospitalization and Surgery Care	☐ **PLAN 1**	☐ **PLAN 2**	☐ **PLAN 3**	☐ **PLAN 2+OPD.1,500**	☐ **PLAN 3+OPD.2,000**

QUESTIONS FOR THE INSURED PERSON **Please tick the appropriate box**	**Yes**	**NO**
1. Do you have health, life or accident insurance with other Insurers? (If yes, please provide more details)	☐	☐
2. Have you ever been declined or accepted on special terms for health, life or accident plan? (If yes, please provide more details)	☐	☐
3. Have you ever undergone a surgical procedure of investigative nature or hospitalized or had a major accident in the last 5 years? (If yes, please provide more details)	☐	☐
4. Have you ever been advised to have a surgical operation or investigative procedure which has not been performed? (If yes, please provide more details)	☐	☐
5. Have you had special treatment with X-Ray, Ultrasound, CT scan, MRI Scan, Biopsy, and Electrocardiogram? (If yes, please provide more details)	☐	☐

Remark: If your answer is "Yes" please provide more details such as name of insurer, reason of decline, special terms, nature of surgical, procedure, etc

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HEALTH DECLARATION OF THE INSURED PERSON

Please tick the appropriate box and Fill in the information

Item	NO	YES	Note for illness	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 Diabetes Tuberculosis S.L.E Thalassemia Dwarfish Renal or Heart Problem					
14. Are you currently taking any medication or undergoing any treatment regularly?					

Remark If your answer is "Yes", please give more details of the above treatment received such as the hospitals or clinics providing the medical treatment: ……………………………………………………………………………………………………

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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 for health insurance handling, both underwriting and claims process, 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.

……………………………………………………………… ……………………………………………

Signature of Applicant (dd/ mm/ yyyy)

for and on behalf of my child/ children (if proposed to be insured in this policy)

WARNING: OFFICE OF INSURANCE COMMISSION

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

Note: Kindly provide to us your Photocopy of ID Card, and Passport. Thank you.

2011-11-08