



## Application form health and personal accident insurance SmartCare Executive

### 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 to the Applicant	
About your cigarette smoking and alcohol drinking habits?				
Cigarette Smoking <input type="checkbox"/> No <input type="checkbox"/> Yes, Quantity _____ Cigarette(s) / Day, for approximately _____ Year(s)				
Alcohol Drinking <input type="checkbox"/> No <input type="checkbox"/> 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 to the Applicant	
About your cigarette smoking and alcohol drinking habits?				
Cigarette Smoking <input type="checkbox"/> No <input type="checkbox"/> Yes, Quantity _____ Cigarette(s) / Day, for approximately _____ Year(s)				
Alcohol Drinking <input type="checkbox"/> No <input type="checkbox"/> 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 to the Applicant		
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 to the Applicant		
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 to the Applicant		



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

<b>At present, the Applicant and Dependent(s) of the Applicant</b>	<b>NO</b>	<b>YES</b>
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.

**YOUR CHOICE OF INSURANCE PLAN**

**1. INPATIENT HOSPITALIZATION AND SURGERY CARE (IPD)**

SmartCare Executive  Plan 1  Plan 2  Plan 3  Plan 4  
 SmartCare Executive Plus  Plus 1  Plus 2  Plus 3  Plus 4

**2. OUTPATIENT CARE (OPD)  800 Baht  1,000 Baht  1,500 Baht  2,000 Baht**

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

<b>At present, the Applicant and Dependent(s) of the Applicant</b>	<b>YES</b>	<b>NO</b>	<b>Name of Applicant</b>	<b>Onset Date</b>	<b>Recovery Date</b>
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 AXA Insurance (Public) Company Limited 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 AXA Insurance (Public) Company Limited 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 AXA Insurance (Public) Company Limited.

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.**

\_\_\_\_\_  
Signature - The Applicant  
(and as representative of spouse and children)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Applying Date (DD/MM/YYYY)

- Direct Insurance       Agent       Broker License No. \_\_\_\_\_

**REMINDER 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.

Please attach following documents:	
<b>The Applicant</b> 1. Copy of ID Card 2. Copy of House Registration	<b>The Beneficiary</b> 1. Copy of ID Card 2. Copy of House Registration