SMARTCARE EXECUTIVE APPLICATION (Page 1/2)

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

APPLICANT NO.1: PARTICULARS OF PERSON TO BE INSURED		
Applicant's Name		
Date of Birth		Age (Years) /Months
ID.Card No./Passport No		Nationality
Marital Status (please advise)		Height(m) /Weight(kg)
Address		
Home	Mobile	EMAIL
Occupation (Position)		Job Responsibility
Company Name		
Company address		
Office		FAX
Beneficiary Name		Relationship to the applicant

APPLICANT NO.2: PARTICULARS OF SPOUSE TO BE INSURED		
Spouse's Name :		
Date of Birth		Age (Years) /Months
ID.Card No./Passport No		Nationality
Marital Status (please advise)		Height(m) /Weight(kg)
Occupation (Position)		Job Responsibility
Company Name		
Company address		
Office	Mobile	EMAIL
Beneficiary Name		Relationship to the applicant

APPLICANT NO. 3-4: PARTICULARS OF CHILD/CHILDREN TO BE INSURED	
3. Child' s Name	
Date of Birth	Age (Years) /Months
ID.Card No./Passport No	Height(m) /Weight(kg)
Beneficiary Name	Relationship to the applicant
4. Child' s Name	
Date of Birth	Age (Years) /Months
ID.Card No./Passport No	Height(m) /Weight(kg)
Beneficiary Name	Relationship to the applicant

QUESTIONS FOR ALL APPLICANTS PROPOSED FOR INSURANCE (Please tick the appropriate box)	YES	NO
1. Does any one of the applicants proposed for insurance have health, life or accident insurance with other insurers?		
2. Has any one of the applicants proposed for insurance ever been declined or accepted on special terms for health, life or accident 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 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 had special treatment with X-Ray, Ultrasound, CT Scan, MRI Scan, Biopsy, Electrocardiogram?		

Remark:If your answer is "YES" please provide details;e.g, Insurer Name, reason of decline or details of special terms, nature of surgical

For Authorized Staffs:	☐ **To confirm the cover with effective from date:**
Name:	☐ **To hold cover for the exclusion acceptance form until date: :12:00**
Date:	☐ **Not Cover-more information are required.** ☐ **Not Cover**

PLEASE TICK CHOICE OF PLAN					
I. INPATIENT HOSPITALISATION & SURGERY CARE	☐ Plus 1	☐ Plus 2	☐ Plus 3	☐ Plus 4	☐ Plus 5
II. OUTPATIENT CARE	☐ 800.-	☐ 1,000.-	☐ 1,500.-	☐ 2,000.-	☐ 2,500.-

HEALTH DECLARATION OF ALL APPLICANTS PROPOSED FOR INSURANCE

Please tick the appropriate box and fill in the information

Item	YES	NO	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, nervous system disorders and cerebrovascular					
13.Are you currently suffering or ever been following disease? Blind Autistic Epilepsy Diabetes Tuberculosis S.L.E Thalassemia Dwarfism Renal or Heart problem					
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

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.

Signature of Applicant *Application Date*

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