Broker/Agent: Kanokwan Dabbs

Code: 4904003427

BUPA HEALTH INSURANCE

APPLICATION FORM AND HEALTH DECLARATION FOR INDIVIDUALS AND FAMILIES

- The policy -holder should complete and sign the joining application on behalf of all covered persons. The choice of plan should be the same for both the applicant and all family members.
- Each covered person should then complete the medical history. Additional sheets are provided for dependents. It is important that each person reads, signs and dates the health declaration. A parent may complete and sign the form on behalf of a child aged under 18 years.
- If you have any questions concerning the completion of the form please contact our **Customer Service Centre** on 0-2632-1122 or e mail them at "csc@bupa.co.th"

Once the application form and health declarations have been completed and signed, please return them together with a copy of your national ID card or passport, to the address below :

BUPA Health Insurance (Thailand) Ltd.

CHAENGWATTANA : 104/9 UNIT M02-03 THE AVENUE CHAENGWATTANA, MOO1 CHAENGWATTANA RD., TUNGSONGHONG, LAKSI, BANGKOK 10210

TEL. 02 573 8700 FAX 02 573 8711 Email : Chaengwattana@bupa.co.th

Thank you

JOINING APPLICATION

To be completed by the Policy holder

Applicant's Name**Mr./Mrs./Ms./Master**.....

Nationality:..... Birth Country.....Place of Residence.....

Applicant' s Address .....Moo.....Soi.....Mooban.....Road.....

District.....Amphur..... Province .....Zip code.....

Address for correspondence (if different) .....

Telephone No : (Home).....(Office).....(Mobile).....(Fax).....

E mail address: (Home).....(Office).....

Language for documents and correspondence:

☐ Thai ☐ English

Personal Accident Cover (in the event of accidental death):

Name of first beneficiary.....Relationship to the insured.....

Address.....

Telephone number.....

Name of second beneficiary.....Relationship to the insured.....

Address.....

Telephone number.....

For additional PA only:

Applicant's occupation: .....

Please describe nature of work.....

Plan selected:

Name of plan.....

Optional benefits: ☐ Outpatient..... ☐ Maternity.....

☐ Personal accident.....

☐ Other .....

Policy commencement date: .....

(Your coverage cannot be started before the date we receive your completed application form)

Details of all persons to be covered:

Name of covered persons Surname-Given Name	Sex	ID Card / Passport No.	Date of Birth	Age (years)	Weight (kg.)	Height (cm.)	Subscription Amount	For Staff Use Only
							Total subscription amount	Baht

Signed: .....X..... Date: .....X..... (Apply date)

1.If you are buying this policy for your parent and you are a tax payer, please tick here so we can issue your tax reduction certificate ☐ Yes ☐ No

2.Please select the type of policy ☐ CD ROM ☐ Hard Copy ☐ E- Mail

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HEALTH AND OTHER DECLARATIONS

TO BE COMPLETED BY EACH COVERED PERSON

A parent should complete the form on behalf of a child

Please answer each of the following questions fully and accurately. If you are uncertain about any of the medical terms please contact our medical underwriter at chaegwattana@bupa.co.th" or telephone 02 573 8700

NAME OF COVERED PERSON : Mr / Mrs / Ms./Master:……..……..

Tel no: ……Fax no: ……E Mail: ……..

1. Do you currently have or have you ever had Health, life or accident insurance with Bupa or any other insurance company?

☐ No ☐ Yes (If yes, please give details)

……

2. Have you ever had an application rejected, a policy cancelled or restricted by other insurance companies?

Have you also ever had your premium adjusted?

☐ No ☐ Yes (If yes , please give details)

……

3. Have you ever undergone a surgical procedure or investigative procedure or been hospitalized or had an accident? If yes, please give details including the nature of the diseases, disorder, condition or illness, the date of onset and the date of recovery, name of the doctor, the place of treatment and further treatment plan, if any.

☐ No ☐ Yes (If yes , please give details)

……..

4. Have you ever been advised to have a surgical operation or investigative procedure which has not yet been performed? If yes, please give details and the place of treatment.

☐ No ☐ Yes (If yes, please give details)

……

5. During the past 5 years, have you ever consulted a doctor and/or been prescribed any drugs or medication?

☐ No ☐ Yes (If yes, please give details including names of drugs)

……

6. During the past 5 years have you ever had any tests done such as x-ray, ultrasound, CT scan, MRI scan, biopsy, electrocardiogram, blood or urine test?

☐ No ☐ Yes

(If yes, please give details including date(s), the reason for the tests and place where the tests took place)

……

7. Are you currently suffering from any symptoms: (pain, lumps, bleeding etc) for which you have not yet consulted a doctor?

☐ No ☐ Yes (If yes, please describe)

……

Please indicate below whether you have ever suffered from or had treatment for the following diseases, symptoms and conditions. It is important that you tell us about any known or suspected medical conditions and symptoms, even if you have not yet consulted a doctor about them. If you do not give us all the relevant information now, it could effect payment of your claims later on.

Please tick "Yes" or "No" If yes, please give details of the treatment given, medical practitioner and the hospitals or clinics providing the medical treatment at the end of the question table.

Disease, symptom, condition	Yes	No	Please give details
1.Chronic headache			
2.Migraine headache			
3.Numbness, weakness of extremities			
4.Eye disorder and abnormalities			
5.Ear disorder and abnormalities			
6.Nose disorder and abnormalities			
7.Allergy (exclude drug allergy, food allergy)			
8.Asthma			
9.Respiratory disorders			
10.Cardiovascular and blood vessel disorder			
11.Hypertension (high blood pressure)			
12.Diabetes mellitus (DM)			
13.Hypercholesterol or hyperlipidemia			
14.Blood disorder (including anemia, white blood cell and platelet)			
15.Thyroid disorders			
16.Sex hormone abnormalities			
17.Breast disorder and abnormalities (Male and Female)			
18.Uterus, ovarian tubes and ovarian disorder (female only)			
19.Menstruation disorder (female only)			
20.Peptic ulcer, gastritis			
21.Chronic abdominal pain			
22.Digestive Abnormality and dyspepsia			
23.Gall bladder disorder ie: gall stones, cholecystitis			
24.Jaundice and cirrhosis			
25.Abnormal stool ie: bloody stool, bowel habit change			
26.Hemorrhoids			
27.Kidney and urinary tract disorder ie: stone, trouble passing water, bloody urine			
28.Prostate gland abnormalities (male only)			
29. Bone, joint and muscular disorder ie: chronic arthritis, gouty arthritis			
30.Chronic back pain or off and on back pain			
31.Non-malignant tumor, mass or cyst			
32.Malignant tumor or mass, cancer			
33.Skin disorders			
34.Bodily deformity, disability			
35.Are you currently suffering from any other disease or injuries?			
36.Are you currently taking any medication or any treatment regularly?			

In the event that you have ticked yes to any of the above and you have received treatment, you are requested to provide more information below:

……

……

……

Please state the name of the physician, hospital or clinic together with addresses which you use regularly.

(If you are a non-Thai national, please also give the name and address of the doctor at your last place of residence.)

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All the above statements are true and complete to the best of my knowledge and belief and I understand that the Company, believing them to be such, will rely on them. I, do hereby, appoint **BUPA Health Insurance (Thailand) Ltd** as the Attorney-in-fact to request a photocopy or any kinds of information of my health record or health conditions from any physician or health care provider or any organisation on my behalf until completion. A photocopy of this statement shall be as effective and valid as the original.

Claim payment method

1. ☐ CQ-Cheque
2. ☐ AT-Autopay

Please specify your bank account details for claim reimbursement……

Branch……..Account no……..Account name……

Signature of Covered Person……..……**Date**……..……(Apply date)

(and on behalf of your child who is under 18 years old)

Insurance payer name……Remark :Application is valid within 30 days

WARNING

By Insurance Department, 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 clause 865 of the Civil and Commercial Code. If you have any queries regarding this Insurance Policy, please contact **BUPA Health Insurance (Thailand) Ltd**, Telephone 0-2632-1122 or **the Office of the Insurance Commissioner**,Telephone 0-2547-4602-16

Medical Confidentiality Note;

The confidentiality of your information is of the utmost importance to BUPA. Your medical information will only be discussed with those involved with your treatment and care, including your doctor and clinical persons involved in your treatment or called upon to give a second opinion, and if applicable to any person or organisation meeting your treatment expenses or their agents. If you have any concerns about the confidentiality of your information, please contact the Managing Director at 0-2234-7755 ext 501

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