**Bupa Health Insurance (Thailand) Public Company Limited**
98 Sathorn Square Office Tower, 14th-15th Floor, North Sathorn Road, Silom, Bangrak, Bangkok 10500
Tel : 0-2677-0000 Fax : 0-2230-6500

Bupa

# Application Form
# Health and Accident for General Group and Organizational Group

## Suggestion for Completing the Health Insurance Application Form

- Please complete the contents and give your information including medical record by yourself (please provide us your most information for your convenience when there is the consideration to accept your application for health insurance including the consideration on further approving the compensation to you)
- In case of minor, his/her guardian can give the statement of health on his/her behalf by mean of signing to certify that such statements are true.
- If you have any inquiry regarding the completing of this Health Insurance Application Form, please contact our Customers Relations Department, Tel.No. 02 232 8666 or E-Mail: csc@bupa.co.th

## After you have completed this Application Form, please return it to

Bupa Health Insurance (Thailand) Public Company Limited
No.98, Sathon Square Office Tower, 14-15 Floors, Sathon Nua Road, Silom Sub-district, Bangrak District, Bangkok 10500,
Tel.No. 02 677 0000, Telefax No. 02 230 6500

## Insured's Information

Company (Insurance Policy Holder) .....

Business Category ..... Position ..... Division.....

the first date working for the Company

Name title (for instance, Mr., Miss, Mrs., Mstr., Miss, M.R., Col.) ..... Gender : ☐ Male ☐ Female

Name (the Covered Person)..... Family name.....

Contact language ☐ Thai ☐ English

Convenient Contact Address .....

Postal code Telephone (Office) (Home)

(Mobile No.) E-mail.....

ID Card No. Date/Month/Year of Birth

Age years, Height (Cm.) Weight (Kg.) Home country .....

Current residence country .....

Relationship with the employee (in case of the Co-Covered Person not being the employee or officer of the Insurance Policy Holder. Please complete the details and specify the details of the employee or officer of the Insurance Policy Holder)

☐ Spouse ☐ Child

Name of Beneficiary (only the person who selects the benefit scheme with the accident)

Name-Family Name ..... Relationship.....

Address .....

Name-Family Name ..... Relationship.....

Address .....

1. Have you ever had health, life or accident insurance or other income compensation plan with Bupa or any other companies?

☐ Yes (please state the company name ..... and sum insured.....Baht) ☐ No

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

☐ Yes (please state the company name .....) ☐ No

3. During the past 5 years, have you ever been hospitalized?

☐ Yes ☐ No

4. Have you ever received treatment or ever diagnosed by physician that you had suffered from Hypertention (high blood pressure), Hyperlipidemia, Diabetes Mellitus (DM), Heart Disease, Epilepsy, Brain and Nervous System Disease, Paralysis, Celebral Atophy, Cerebral Hemorrhage, Tumor, Cyst or all kinds of Cancer, Kidney Disease, Liver Disease, Blood Disease, HIV (AIDS), Bone, Joint and Gouty Arthritis,Thyroid Disease, Lupus Erythematosus (SLE), Respiratory Disorders and Lung Disease, for instance, Asthma, Emphysema, Chronic Obstructive Pulmonary Disease, TB or any other Chronic Disease, or not?

☐ Yes ☐ No

5. Have you ever undergone a surgical procedure or ever diagnosed by physician to be undergone a sugical procedure?

☐ Yes ☐ No

In Case you declared **Yes** in Clause 3-5, please provide the details in the following schedule:-

| Disease | Date/Month/Year of treatment (please stipulate whether you received diagnosis or treatment or notice by physician) | Treatment and current symptom | Clinic/Medical Facility (if you can specify the name of physician, please do so) |
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I hereby certify that all the above statements in this Application Form are true in all aspects. If I give false statement or do not disclose any truth, I hereby consent to the Company to terminate the insurance contract.

I, do hereby, appoint Bupa Health Insurance (Thailand) Public Company Limited, as the Attorney-in-fact to request any kinds of information of my health record or health conditions from any physician or healthcare provider or any other organization (who has my health record or health conditions) on my behalf until completion. A photocopy of this statement of authorization shall be as effective and valid as the original.

The Applicant of insurance, in his/her name or on behalf of every Covered Person including every Beneficiary (according to the definition in the Insurance Policy), consents to the Company to store, use and disclose health facts and the information of the Insured Person (and Beneficiary) to the Office of the Insurance Commission for the purpose of the insurance business supervision.

Signed (Applicant)..... Date/Month/Year.....(Application Form Completing Date)

(and sign on behalf of the child of the Insured Person whose age in under full 20 years and not married)

| I hereby certify that the Applicant is a real employee of Company<br>(Employer's name and seal)<br>Employer.....<br>by .....(signature)<br>Title ..... | For Bupa's Officer : |
|---|---|

**Reminder of the Office of Insurance Commission, 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 Section 865 of the Civil and Commercial Code.