

## HEALTH INSURANCE APPLICATION AND DECLARATION FORM

1. NAME OF APPLICANT (FIRST NAME / LAST NAME) ..... SEX ☐ MALE ☐ FEMALE  
 OCCUPATION ..... POSITION ..... HEIGHT ..... CM. WEIGHT ..... KG.  
 CONTACT ADDRESS:  
 FACULTY .....  
 MAJOR .....  
 TEL. .... FAX. .... E-MAIL ADDRESS: .....  
 ADVISOR (FIRST NAME / LAST NAME) ..... TEL. .... FAX. ....
2. DATE OF BIRTH ..... AGE ..... ☐ SINGLE ☐ MARRIED ☐ WIDOW ☐ DIVORCE
3. ☐ IDENTIFICATION CARD ☐ OFFICIAL IDENTIFICATION CARD ☐ FOREIGN NATIONAL IDENTIFICATION CARD ☐ PASSPORT  
 NO. .... ISSUE AT DISTRICT ..... PROVINCE ..... COUNTRY .....  
 DATE OF ISSUE ..... EXPIRED DATE .....  
 NATIONALITY ..... RACE ..... RELIGION .....
4. THE BENEFICIARY : NAME ..... AGE ..... RELATIONSHIP TO THE INSURED .....
5. POLICY PERIOD EFFECTIVE FROM ..... AT 12.00 P.M.  
 EXPIRY DATE ..... AT 12.00 P.M.

### HEALTH DECLARATION AND OTHER CONDITIONS

6. PLEASE COMPLETE NAME OF ANY OTHER INSURED (IF ANY)  
☐ ACCIDENTAL INSURANCE ☐ HEALTH INSURANCE ☐ LIFE INSURANCE  
 NAME OF COMPANY ..... SUM INSURED .....
7. HAVE YOU {APPLICANT AND/OR DEPENDENT (S)} BEEN DENIED OF LIFE INSURANCE, ACCIDENTAL INSURANCE, OR HEALTH INSURANCE ?  
☐ NO ☐ YES  
 IF YES, PLEASE GIVE DETAILS .....
8. HAVE YOU {APPLICANT AND/OR DEPENDENT (S)} BEEN TREATED IN THE LAST 5 YEARS.

(8.1) MEDICAL DECLARATION

	<u>YES</u>	<u>NO</u>	<u>NAME</u>	<u>WHEN</u>	<u>DETAILS</u>
- HAVE YOU EVER HAD ANY OPERATION ?	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- HAVE YOUR DOCTOR EVER RECOMMEND ANY OPERATION FOR YOU ?	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- HAVE YOU EVER ADMIT TO HOSPITAL MORE THAN 1 DAY ?	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- PSYCHIATRIC OR MENTAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- BRAIN OR NERVE DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- DISEASE OF EYE	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- EAR / NOSE / THROAT / SINUSES DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- BREAST PROBLEM IN WOMAN	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- LUNG / BRONCHEAL LARYNX PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- STOMACH AND SMALL INTESTINE DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....

	YES	NO	NAME	WHEN	DETAILS
- LARGE OR SMALL INTESTINE DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- LIVER / GALL BLADDER / PANCREAS	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- SEXUAL TRANSMITTED DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- ALLERGIC REACTION FROM FOOD, DRUG, ENVIRONMENT	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- HEART CONDITIONS	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- HIGH / LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- VEIN / ARTERY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- BLOOD DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- JOINTS / MUSCLES PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- BONE DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- KIDNEY OR URINARY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- SKIN PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- TUMORS	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- CANCER	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- PHYSICAL DISABILITY OR IMPAIRMENT (CONGENITAL / ACCIDENT)	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- THYROID DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....
- DIABETES OR ENDOCRINE DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	.....	.....	.....

(8.2) HAVE YOU {APPLICANT AND/OR DEPENDENT (S)} HAD ANY OTHER PROBLEM OR CONDITION AS MENTIONED ABOVE ?

☐ NO ☐ YES IF YES, PLEASE GIVE DETAILS .....

(8.3) FOR WOMAN, WHEN IS YOUR MENSES IN LAST PERIOD ? .....

(8.4) HAVE YOU {APPLICANT AND/OR DEPENDENT (S)} TAKE ANY MEDICATION REGULARLY ?

☐ NO ☐ YES IF YES, PLEASE GIVE DETAILS .....

(8.5) NAME OF DOCTOR, HOSPITAL OR CLINIC THAT YOU VISIT REGULARLY .....  
.....

I DECLARE TO BEST OF MY KNOWLEDGE AND BELIEF THE STATEMENTS CONTAINED IN THIS DISCLARATION ARE TRUE CORRECT AND THAT I HAVE NOT OMITTED ANY RELEVANT INFORMATION. THE EFFECT OF ANY NON-DISCLOSURE OF INFORMATION COULD BE THAT THE INSURER MAY BE ENTITLED TO REDUCE ITS LIABILITY UNDER THIS CONTRACT IN RESPECT OF A CLAIM OR MAY CANCEL THE CONTRACT IF THIS NON-DISCLOSURE. IF FRAUDULENT THE INSURER ALSO HAS THE RIGHT OF AVOIDING THE CONTRACT FROM ITS BEGINING.

I HEREBY AUTHORISE THE SIAM CITY INSURANCE CO., LTD. TO HAVE ACCESS TO ALL MEDICAL RECORDS AND HOSPITAL OR PHYSICIAN RECORDS RELATING TO THE DIAGNOSIS TREATMENT PROVIDED TO ME OR A COVERED DEPENDENT IN ORDER TO CONSIDER THIS APPLICATION AND TO ADMINISTER HEALTH INSURANCE IF ACCEPTED FOR COVERAGE.

SIGNATURE OF APPLICANT .....

(.....)

DATE ...../...../.....