PACIFIC CROSS

Application Form for
Individual Health and Accident Insurance

New Normal
Lifestyle Series

Pacific Cross Health Insurance PCL
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Section A : Details of the applicant

Type of Insured

- ◯ Spouse of Insured (Name of Main Insured) _____
- ◯ Child of Insured (Name of Main Insured) _____
- ◯ Spouse's child of Insured (Name of Main Insured) _____
- ◯ Insured

Title : ◯ Mr. ◯ Mrs. ◯ Miss ◯ Other: _____ Given name : _____ Family name : _____

Sex : ◯ Male ◯ Female Date of birth : _____ Nationality : _____ ID./ Passport No. : _____

Phone number : _____ Email address : _____

Height : _____ (in cm) Weight : _____ (in kg) Occupation : _____ (if retired, please state your last occupation) Marital status : _____

Current residential address : _____

Section B : Beneficiary's Details

Title : ◯ Mr. ◯ Mrs. ◯ Miss ◯ Other: _____ Given name : _____ Family name : _____

Sex : ◯ Male ◯ Female Date of birth : _____ Nationality : _____ ID./ Passport No. : _____

Phone number : _____ Email address : _____ Relationship to the applicant : _____

Section C : Insurance Plan Selection

Chosen Plan	◯ Standard ◯ Standard Extra ◯ Standard Plus	◯ Premier ◯ Premier Plus	◯ Maxima ◯ Maxima Plus	◯ Ultima ◯ Ultima Plus

Discount Option :

- ◯ Removal of outpatient benefits (-20%)
- ◯ Family Discount (-5%)

Deductible Per Policy Year:

◯ THB 20,000 (-15%) ◯ THB 40,000 (-25%) ◯ THB 100,000 (-32.5%)
◯ THB 200,000 (-40%) ◯ THB 300,000 (-50%)

remark: Deductible Options are not available for Standard and Standard Plus

Additional Benefits : Dental benefit : ◯ Cover ◯ Not Cover
Vision benefit : ◯ Cover ◯ Not Cover

remark: Dental and Vision benefits are not available for all types of Standard plans

◯ Buy More Personal Accident (PA) _____ Baht
(Additional Premium THB 145/ THB 100,000)

Expected effective date: _____

Section D : Health (Part 1)

Please truthfully provide thorough and precise responses to the following questions to aid us in accurately underwriting your policy. Detailed declarations of the questions you tick "Yes" to can be provided in Part 2 of the following Health Data section.

1		Do you have other health insurance policy(ies) with Pacific Cross Health Insurance PCL or other insurance company(ies)? If your answer is "YES", please state the company's name and provide a copy of the policy and benefits schedule if available.	◯ Yes ◯ No
2		Have you ever experienced a declined, postponed, rate adjusted, restricted, or cancelled medical insurance application or policy in the past?	◯ Yes ◯ No
3		Have you ever experienced symptoms, been diagnosed with, investigated, or received treatment for any of the following diseases or disorders? Please provide details, including organ, medical treatment history, diagnosis, date and nature of care received, date of last consultation, and any recent follow-ups?	◯ Yes ◯ No
	3.1	Psychological, psychiatric conditions, sleep disorders and substance use disorders, including drug or psychotropic substance addiction? E.g. Psychosis, depression, anxiety, stress, obsessive compulsive disorders, mood disorders, panic disorders, phobic disorder, insomnia, sleep apnea, self-harm ideas or attempted suicide, etc.	◯ Yes ◯ No
	3.2	Heart or blood circulatory system diseases or disorders? E.g. low blood pressure, high blood pressure, chest pains, palpitations, heart disorders, arrhythmias, ischemia, veins thrombosis, varicose veins, embolism, vascular anomalies, etc.	◯ Yes ◯ No
	3.3	Any cell abnormality, pre-cancerous, or any cancers? Egg: polyps, benign, cysts, growths, tumors, malignancy, lymphomas, etc.	◯ Yes ◯ No
	3.4	Brain, nervous, or cerebrovascular system diseases or disorders? E.g. Syncope, fainting or blackout spells, headaches, migraines, transient ischemic attack (TIA), stroke, seizure or epilepsy, multiple sclerosis, meningitis, neuritis, Parkinson's disease, aneurysm, etc.	◯ Yes ◯ No

Section D : Health (Part 1)

	3.5	Eyes, ears, nose, or throat diseases and disorders? E.g. glaucoma, cataracts, pinguecula, pterygium, cornea, retina, vitreous, visual loss, hearing difficulties/loss tonsil, sinus, etc.	◯ Yes ◯ No
	3.6	Diabetes, metabolic, any other endocrine system, hormone, lymph node or Blood system diseases or disorders? E.g. high blood sugar, diabetes type 1, diabetes type 2, insulin dependence, Impaired Fasting Plasma Glucose, thyroid, dyslipidemia, pituitary or adrenal problems, anemia, dengue etc.	◯ Yes ◯ No
	3.7	Breathing, Respiratory system or lung diseases or disorders? E.g. hemoptysis, respiratory allergies, pharyngitis, bronchitis, bronchial hyperresponsiveness, asthma, tuberculosis (TB), emphysema, pneumonia, chronic obstructive pulmonary disease (COPD), pneumothorax, Covid-19, etc..	◯ Yes ◯ No
	3.8	Urinary, kidney, ureter, bladder, urethral, prostate, or genital diseases or disorders? E.g. infections, stones, Benign Prostatic Hyperplasia (BPH)	◯ Yes ◯ No
	3.9	Digestive system or (Gastrointestinal) GI tract diseases or disorders? E.g. food allergies, gastritis, gastroesophageal reflux disease (GERD), hepatitis, cirrhosis, gallstones, pancreatitis, ascites, bile duct, jaundice, irritable bowels syndrome, diverticular disease, intestinal obstruction, ulcers, colitis, persistent diarrhea, Crohn's disease or Ulcerative colitis, chronic abdominal pain, bleeding, hernia, hemorrhoids/piles, perianal disorders, etc.	◯ Yes ◯ No
	3.10	Cartilage, tendon, ligaments or musculoskeletal diseases or disorders? E.g. neck, shoulder, upper back, lower back, joint disorders, sciatica, arthritis, rheumatoid arthritis, gout or high uric acid levels, any fracture, fibromyalgia, myofascial pain, bulging or herniated disc, etc.	◯ Yes ◯ No
	3.11	Auto-immune diseases or disorders? E.g. AIDS, AIDS-related complex, HIV, systemic lupus erythematosus (SLE), Immunodeficiency, Auto-Immune, etc.	◯ Yes ◯ No
	3.12	Skin disease or disorders? E.g. rashes, skin, skin tag, urticaria, eczema, dermatitis, scleroderma, psoriasis, cellulitis, moles that itch or bleed, keratosis nodules or lumps, cysts or lipomas, etc.	◯ Yes ◯ No
	3.13	Any conditions resulting from congenital abnormalities or incomplete organ formation, abnormality in the development of the body, or genetic diseases or disorders?	◯ Yes ◯ No
	3.14	Are you currently sick, experience any abnormal symptoms, or organ abnormality that has not been treated or consulted by a doctor	◯ Yes ◯ No
	3.15	Are you presently undergoing any medications or treatments that have been recommended or prescribed by a physician?	◯ Yes ◯ No
	3.16	Have you ever undergone or been suggested that you undergo any specialized medical examinations (such as ultrasound, CT scan, MRI, mammogram, Pap smear, etc.), health and physical check-ups, procedures for investigative purposes other than those mentioned, or any surgical procedures?	◯ Yes ◯ No
4		Have you ever been treated at a hospital, medical center, clinic, or sanitarium? If yes, please provide the name and address of the healthcare provider, the injury or illness, date of treatment, length of stay for hospitalization, and department of services (Inpatient/ Outpatient)	◯ Yes ◯ No

Treatment Date (DD/MM/YYYY)	IPD/OPD Please Specify	Length of Stay for hospitalization	Medical Provider Names	Diagnosis	Treatment	Latest Follow-up date

5	Are you currently using tobacco products such as pipes, cigars, or cigarettes, or any other forms of tobacco? If Yes, please specify _____ sticks per day, and the number of years _____ you have been smoking.	◯ Yes ◯ No
6	Do you consume alcohol? If yes, please specify the alcohol type _____ Average units per week consumed: _____	◯ Yes ◯ No
7	Are there any other conditions you may have had or suffered from which have not been mentioned above? If Yes, please specify _____	◯ Yes ◯ No
8	**For FEMALES ONLY**	
8.1	Are you currently pregnant? If yes, please specify number of weeks into the pregnancy: _____ Weeks.	◯ Yes ◯ No
8.2	Have you ever had a Surgical Delivery/C-Section? If yes, please specify the year of delivery: _____	◯ Yes ◯ No
8.3	Have you had any diseases or disorders of the breast, uterus, ovaries, fallopian tubes, cervix, menstruation, reproductive system, pregnancy, or childbirth, including complications, abortion or miscarriage or have been investigated, and/or treated for infertility?	◯ Yes ◯ No

Section D : Health (Part 2)

If your answer is "YES" to above questions in Part 1, please state the details: Section D | Health (Part 1)

Question No.	Details

Would you like to claim for personal income tax deduction with this health insurance premium?

◯ Yes, and I permit the insurer to send and reveal the information about this insurance premium to the Revenue Department.
If the applicant is a non-Thai resident, please enter the taxpayer ID number given by the Revenue Department: _____

◯ No

Remark

The Applicant hereby requests the Company to provide the insurance policy together with the terms and conditions according to their policy and the Application declares that the above statements are complete and true. The Applicant agrees to have this application form as part of the contract between the Applicant and the Company. Should there be any false statement, or any truth being concealed, the Applicant agrees to let the Company void and/or refuse to pay compensation according to this insurance policy under Section 865 of the CCC.

The Applicant, besides this, assigns the Company to request any kind of information regarding their personal health treatment or health condition records from any physician, hospital, clinic, or any other organization which has of their health information or records including the testing results of HIV for the payment of benefits and/or compensation.

The Company has the right to medically examine any Applicant who is claiming a benefit under this policy and has the right to conduct an autopsy, within the limits of the laws, in case of death, and the expense incurred will be paid by the Company.

If the Applicant does not allow the Company to investigate his/her claim or does not give permission to access his/her medical records or diagnosis, the Company reserves the right not to pay such claims.

The Applicant allows the Company to collect, use and reveal the truth about the Applicant's medical records and other information to the Office of Insurance (OIC) in order to regulate the insurance industry.

Would you like to receive the insurance which channel?

◯ Your e-policy will be emailed to you

◯ Your policy will send to you by your address

Applicant's Name and Signature	Guardian's Name and Signature (Applicant on behalf of a Minor)	Date/Month/Year
I hereby acknowledge that the signature provided above is my own and that I am voluntarily signing this application.	I hereby acknowledge that the signature provided above is my own and that I am voluntarily signing this application."	

WARNING BY OFFICE OF INSURANCE COMMISSION (OIC)

The applicant must truthfully answer all questions. Any concealment or misrepresentation of the truth may result in the Insurance contract becoming void and/or refusal to compensate under Clause 865 of the Civil and Commercial Code resulting in the cancellation of the policy.