PACIFIC CROSS

Application Form for Health Insurance

Expat Care

実際のご記入はブランクフォームに英語で漏れずにご記入ください

SECTION A Applicant's Details

Mr.Mrs.Miss.

Title :	Surname : 苗字	First Name : お名前

Sex : ◯ Male ◯ Female	Date of birth :	Age :	ID/Passport No. :
Nationality :	Height (cm) :	Weight (kg) :	Smoker : ◯ No ◯ Yes please specified .....
Occupation : 職業。または Retired(最終職業)			
Residential address of the country where you are to be located :			
Address :			
Town / City :		Country :	
Post Code / Zip Code :		E-mail Address :	
Work Contact (Tel.) :		Home Contact (Tel.) :	

SECTION B Coverage Details

Coverage details (please tick one box only on each line) ご希望の丸にX印お願いします。	
Plan : ◯ Expat Care 1 ◯ Expat Care 2 ◯ Expat Care 3	Geographical area : ◯ Area 1 : Thailand ◯ Area 2 : Asia ◯ Area 3 : Worldwide excluding USA
Total Annual Premium (THB) :	

弊社内規定にて、齟齬防止の為下記の告知欄は和訳ご提供できません。

SECTION C Statement of Health 下記の該当Yes,No に X印ご記入ください。

Please truthfully provide thorough and precise responses to the following questions to aid us in accurately underwriting your policy.

1. Have you ever experienced symptoms, been diagnosed with, investigated, or received treatment for any of the following diseases or disorders? Please underline the specific conditions and provide details, including organ, diagnosis or name of diseases or disorders, symptoms and/or medical condition, When did the symptoms start? What treatment did you receive and when? (Please include dates and any medication prescribed), What was the outcome of the treatment? (e.g. ongoing, still under review, complete recovery, recurrent or likely recur), date of last consultation or follow-ups, etc. in section Medical details.

1.1	Have you ever had a past history of cancer or pre-cancer (including benign brain tumours), AIDS, AIDS-related complex, HIV, systemic lupus erythematosus (SLE), Immunodeficiency, Auto-Immune, alcoholism, substance abuse, diabetes type 1, insulin dependence, epilepsy, seizure, heart condition, stroke, chronic obstructive pulmonary disease (COPD), joint disorder, cirrhosis, paralysis, visual loss, blindness, pancreatitis, ascites, psychiatric or mental illness?	◯ Yes	◯ No
1.2	Do you have any long-term, ongoing or chronic condition for which you have regular appointments or need a review or treatment for? CHRONIC means an illness or injury which has one or more of the following characteristics: • It has no known recognized cure • It continues indefinitely • It recurs or is likely to recur • It is permanent • Requires palliative treatment • Requires long-term monitoring, consultations, check-ups, examinations, or tests • Requires rehabilitation or special training to cope with it.	◯ Yes	◯ No

Medical Details 過去の病歴は下記に英文でご記入ください。

Question Number 該当番号 1.1 または' 1.2	Organ 該当'の身体'部分 器官名	Diagnosis or name of diseases or disorders 診断名	Symptoms and/or medical condition 症状	When did the symptoms start? 症状'発生の年月日	What treatment did you receive and when? (Please include dates and any medication prescribed) 治療内容	What was the outcome of the treatment? (e.g. ongoing still under review, complete recovery, recurrent or likely recur) 治療後の経過簡下	Date of last consultation or follow-ups 最近直近'の検査結果' 現状	Etc.

SECTION C Statement of Health

2.	Have you ever undergone 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? **If your answer is yes, please specify the organ and procedure.** あなたは超音波、CT,MRIなど　検査'された事が有りますか'？ Yes,の場合は検査対象器官名と検査の内容	◯ Yes	◯ No

For WOMEN ONLY: 女性のみ

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? **If your answer is "YES", please specify diagnosis, treatment, and when?** 過去に乳房、子宮'など検査された事が有りますか？ Yesの場合は結果記載ください。	◯ Yes	◯ No

***** If the space provided is insufficient, please use a separate sheet. *****

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

保険料の所得税控除をご希望ですか？

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

_____

◯ No

Data protection :

Pacific Cross Health Insurance PCL assures you that all your personal and medical information will be held in strictest confidence and in accordance with applicable legislation. Personal date may be passed or given to third party providers in relation to services which we provide to you and may be transferred by electronic or other means. You have a right to know what information is held about you, and to amend or delete and date we hold which is inaccurate or out-of-date.

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 included in 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 this insurance policy.

The Applicant, besides this, assigns the Company to request any kind of information regarding their personal heath 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.

申込人サイン　　未成年者の場合は親のサイン(代筆ではない)

Applicant's Signature	Guardian's Signature
_____ (_____)	_____ (_____)

_____

Date / Month / Year

WARNING BY OFFICE OF INSURNACE COMMISSION (OIC)

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

PACIFIC CROSS
Pacific Cross Health Insurance PCL
152 Chartered Square Building, 21st Floor, North Sathorn Road, Silom, Bangrak, Bangkok 10500
T: +66 2 401 9189 | **F:** +66 2 401 9187 | **E:** contactus@th.pacificcrosshealth.com

OUR CONTACT INFORMATION