Application form group (Employers) health and accident insurance
InternationalExclusive

1. DETAILS OF THE APPLICANT (PLEASE TICK THE REQUIRED BOX)

The Company		Tax ID No.
Address		
Nature of Business		
Telephone	FAX	Email :
Total Employees or All Members, at present _____ Persons		Business has been in operations for _____ years

This insurance is arranged for
- ☐ All Employees
- ☐ Employees of some positions
- ☐ All Employees including "Dependents"
- ☐ Employees of some positions including "Dependents"

Premium payment
- ☐ Employer pays total premium
- ☐ Employer pays partial premium, i.e., Employer pays _____ % and Employee pays _____%

2. PERIOD OF INSURANCE

Commencing Date, as required (DD/MM/YYYY)	Expiry Date (DD/MM/YYYY) at 24.00 hours

3. YOUR CHOICE OF INSURANCE PLAN (PLEASE TICK THE REQUIRED BOX)

PLAN ☐ PLAN 1 ☐ PLAN 2 ☐ PLAN 3 ☐ PLAN 4	Area of Cover ☐ Asia ☐ Worldwide excluding USA ☐ Worldwide
Deductible / Year	

4. INSURING AGREEMENTS / COVERAGE EXTENSIONS BY ENDORSEMENT (SUBJECT TO ADDITIONAL PREMIUM)

PLAN	INSURING AGREEMENTS / COVERAGE EXTENSIONS BY ENDORSEMENT

5. QUALIFICATIONS OF EMPLOYEES OR APPLICANT'S MEMBERS (PLEASE TICK THE REQUIRED BOX)

5.1 Employees or Applicant's members
- ☐ On date requested for insurance to commence
- ☐ Coverage to commence right after working for _____ months

5.2 Employees or Applicant's members during policy year
- ☐ On date when start working
- ☐ Coverage to commence right after working for _____ months

6. OTHER HEALTH INSURANCE POLICY(IES)

Have the Applicants ever been covered under any group insurance policy(ies) with the Company or other insurance company(ies) ?	☐ YES ☐ NO
Have the Applicants ever been declined for insurance or accepted with special conditions or refused for insurance renewal by the insurance company(ies) t?	☐ YES ☐ NO

If your answer is "YES" to above questions, please give details (including Company's name, insurance plan, period of insurance, and policy number, if any)

_____

_____

_____

บริษัท แอกซ่าประกันภัย จำกัด (มหาชน)
AXA Insurance Public Company Limited

1168/67 อาคารลุมพินีทาวเวอร์ ชั้น 23 ถนนพระรามสี่ แขวงทุ่งมหาเมฆ เขตสาทร กรุงเทพฯ 10120
1168/67 Lumpini Tower 23rd Fl., Rama 4 Rd., Thung Mahamek, Sathorn, Bangkok 10120
Tel. +66 2118 8111 Fax: +66 2285 6383 Email: axathai@axa.co.th - **axa.co.th**

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7. HEALTH DATA OF EMPLOYEES OR APPLICANT'S MEMBERS (Please separately fill up the application form of each employee or each application's member)

Part 1: Please truthfully declare health data by ticking the appropriate "YES" or "NO" box to the following questions

1. Have you ever been hospitalized as an inpatient in the past 5 years ?	☐ YES	☐ NO
2. Have you ever consulted with a physician or a medical specialist in the past 5 years ?	☐ YES	☐ NO
3. Have you ever or had symptom of physical abnormalities which has yet to consult with a physician in the past 5 years ?	☐ YES	☐ NO
4. Have you visited a physician in the past 2 years ?	☐ YES	☐ NO
5. Do you have any pre-existing chronic diseases or receiving continuing treatments or having any physical abnormalities or recurring diseases in the past 5 years ?	☐ YES	☐ NO
6. Must you consult with a physician in the future ?	☐ YES	☐ NO

Part 2: If the Applicant or any member's answer is "YES" to the above questions, please give details, as follows:

1. Name	2. Question No.	3. Cause of Injury or Sickness	4. Onset Date	5. Duration	6. Continuing treatment needed or not?	7. Present status of the Disease

If there are more than 1 diseases or injuries, please give details separately.

In the name of the authorized person acting for and on behalf all Applicants, I warrant that the above statements are truthfully provided. If any statement is misrepresented or omitted of any relevant facts, I agree for the Company to cancel the contract. In addition, I authorize AXA Insurance Public Company Limited or its representative to have access to details of health data, news related to medical treatment record and physical conditions of my employees or members (including "Dependents" of employees or members if the Applicant has requested them to be included) from physicians, hospitals or any organizations where medical record is kept or has knowledge about me or health conditions of my employees or members (including "Dependents" of employees or members if the Applicant has requested them to be included). The copy of this "Power of Attorney" is valid and complete in same manner as an original copy. I understand and know thoroughly that this insurance will be effective upon receiving confirmation from the Company.

In the name of the authorized person acting for and on behalf all Applicants, I warrant that I agree for AXA Insurance Public Company Limited to keep, use and disclose health facts as well as details of covered persons to the Office of Insurance Commission (OIC) for the benefits in supervising insurance business.

In the name of the authorized person acting for and on behalf all Applicants, I warrant that I wish to insure with the Company in accordance with the Policy's conditions applicable to this insurance and I also warrant that all details given above are correct and complete. I agree that the Application Form shall be the basis of the insurance contract between I and the Company.

This document is not the insurance contract. You will be covered upon receiving confirmation from the Company.

_____ _____ / _____ / _____

Signature
(The Applicant – Authorized Person)

Applying Date (DD/MM/YYYY)

_____

Company's stamp affixed

REMINDER FROM THE OFFICE OF INSURANCE COMMISSION (OIC)
Please give answers to all questions truthfully otherwise the Company may have cause to deny liability under the Policy in accordance with Section 865 of the Civil and Commercial Code.

ADDITIONAL INFORMATION

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