บมจ. นวกิจประกันภัย
The Navakij Insurance Public Company Limited

Personal Health Insurance (File and use)

Application Form and Health Declaration for Individuals

Long Stay Visa Scheme

A) Do you apply for Authorization for Certain Groups of Aliens to Enter the Kingdom of Thailand on an exceptional case on Long-Stay Purpose in accordance with the Cabinet Resolution, dated 22 November B.E. 2559 (2016)?

❒ **Yes** ❒ **No**

Applicant's detail

1. Given name Mr./Mrs./Ms./Master……Family name……..

Nationality……..……Place of Birth……...……Place of Resident…….……...

❒ Passport No……..... (Please attach copy passport) Sex ❒ Male ❒ Female

Date of birth...../...../..... Age .....years Height.....cm. Weight.....kg.

Marital Status ❒ Single ❒ Married ❒ Widowed ❒ Divorced ❒ Other No. of children..... persons

2. (Present) Home Address No.....Moo.....Moobaan ……..…….Soi.....Road.....

District.....Amphur.....Province..... Post code.....

Telephone No (Home)..... Mobile..... Fax..... E-mail address ……..

3. Occupation..... Type of work .....Position.....

Office location..... Telephone No. ..... Average Income ❒ /month ❒ / year ..... Baht

Office Address No..... Moobaan / Building……....Soi.....Road.....

District.....Amphur.....Province..... Post code.....

4. Address for correspondence ❒ Home Address ❒ Office Address

Important notice

Please mark "✓" in the appropriate boxes, as well as ensure a thorough and truthful declaration. Failure to do so, or false declaration, may free The Navakij Insurance Public Company Limited ("The Company") from any/all responsibilities stated in your policy.

1. Please indicate below whether you have ever suffered from or had treatment for the following diseases, symptoms and conditions.

Disease /Disorder/Symptom	Yes	No	Time of onset or finding	Additional details	Recover (cured)	On going
- Brain and spinal cord disorders, Convulsion/ Epilepsy, chronic headache						
- Peripheral neuropathy : Numbness, weakness of extremities, paralysis						
- Eye, Ear, Throat, Nose disorders and abnormalities						
- Respiratory disorder: lung disease, sinusitis, asthma, allergy						
- Heart disease, cardiovascular and blood vessel disorder						
- Hypertension (high blood pressure)						
- Diabetes mellitus (DM)						
- Hypercholesterol or Hyperlipidemia						

Disease /Disorder/Symptom	Yes	No	Time of onset or finding	Additional details	Recover (cured)	On going
- Blood disease, Immune disorder, AIDS or HIV+						
- Endocrine disorder, Thyroid disease (Please identify)						
- Digestive disorders: esophagus, stomach, bowel						
- Disease/disorder of liver, gall bladder, pancreas						
- Defecation disorders ie : bloody stool, irritable bowel syndrome, rectum disease, Hemorrhoids						
- Disease/disorder of kidney and urinary tract ie: stone, trouble passing water, bloody urine, infection						
- Breast disorder and abnormalities (male and female)						
- Disease/disorder of uterus, ovarian tubes, ovaries menstruation disorder, vagina (female only)						
- Disease/disorder of prostate gland ,testis (male only)						
- Bone, joint and muscular disorder ie: chronic arthritis, gout, gouty arthritis etc.						
- Skin disease, allergic dermatitis, food and drug allergy						
- Non-malignant tumor, mass or cyst						
- Cancer						
- Mental disorders, Psychosis, Neurosis						
- Bodily deformity, disability(congenital / accident)						
- Have you ever suffered from another disease or injuries which are not stated as above?						

*** (Additional information may be attached) ***

2. According to / Related to the above declaration with yes or have, please provide details.

- How did the doctor treat you? (please specified the organ or side of organ which was/were treated or got surgery)

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- Time of onset treatment ……..…… Type of patient ❒ IPD ❒ OPD Duration of treatment …….
- Place of treatment or Hospital name …….. Doctor's name …….

3. Are you currently recovering from an accident/illness/other form of health related anomalies?

❒ No ❒ Yes, if so, please provide details (additional information may be attached) ……

……

4. During the pass 5 years have you ever had any tests done such as blood, urine, x-ray, MRI, EKG, ultrasound, biopsy exercise stress test etc.?

❒ No ❒ Yes, if so, please provide details (additional information may be attached) ……..

……..

5. Have you ever been advised by the doctor/physician to do any treatment, surgery, investigated procedure, test which have not been done yet?

❒ No ❒ Yes, if so, please provide details (additional information may be attached) ……..

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6. Are you taking any medication regularly? ❒ No ❒ Yes, (please specified the name of medication and the reason or disease)

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7. Are you currently pregnant ❒ No ❒ Yes ……month

8. Are you drink alcohol or beverages containing alcohol ❒ No ❒ Occasionally ❒ Regularly

9. Are you a smoker (cigarettes, cigars, pipes etc.) ❒ No ❒ Yes Amount per day ……..

10. Have you ever had a serious substance abuse is to blame (drug addict) ❒ No ❒ Yes

11. Have you ever been refused coverage, revoked coverage, increased premium, or endorsed exclusion clauses, for Health / Life / PA Insurance by Any Insurance Company? ❒ No ❒ Yes, if so, please provide details (additional information may be attached)

Details ……..…….. Company ……..

Details ……..…….. Company ……..

12. Do you currently hold a policy with some other company? ❒ No ❒ Yes, if so, please provide details(additional information may be attached)

Health Insurance Company ……..……..... Sum Insured …….

Personal Accident Company ……..……..... Sum Insured …….

Life Insurance Company ……..……..... Sum Insured …….

<u>Plan Selected</u> **(Your coverage cannot be started before the date we receive your completed application form)**

1. Name of Plan ❒ Plan 1 ❒ Plan2

2. Policy commencement date : ……..……Time ……..…….. Expiry date ……..…..…….. Time …….

All the above statements are true and complete to the best of my knowledge and belief and I understand that the Company, believing them to be such, will rely on them. I, do hereby, appoint The Navakij Insurance Public Company Limited as the Attorney-in-face to request a photocopy or any kinds of information of my health record or health conditions from any physician or health care provider or any organization on my behalf until completion. A photocopy of this statement shall be as effective and valid as the original.

Signature of Covered Person……

(…..……...)

Remark: Application form is valid within 30 days **Date……..…/…….…… /……. (Apply date)**

WARNING

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 clauses 865 of the Civil and Commercial Code. If you have any queries regarding this Insurance Policy, please contact The Navakij Insurance Public Company Limited Tel. 02-636-7900, 02-664-7777

Effective 11/8/2017