บมจ. นวกิจประกันภัย
The Navakij Insurance Public Company Limited

Personal Health Insurance (File and use)

Application Form For Long-Stay Visa Plan

Type of Visa :	**Plan Selected :**
☐ **Non-Immigrant Visa "O-A" (Long Stay: 1 year)**	☐ Essential (Plan1) ☐ Essential+ (Plan2)
☐ **Non-Immigrant Visa "O-X" (Long Stay: 10 year)**	☐ Plan 1 ☐ Plan 2
☐ **Not apply Long Stay Visa**	☐ Essential (Plan1) ☐ Essential+ (Plan2) ☐ Plan 1 ☐ Plan 2

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 ……month Height.....cm. Weight.....kg.

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

2. Registered address No. .....Moo..... Village /Moobaan .....Soi.....Road.....

Subdistrict/Tambon.....District/Amphur.....Province..... Post code.....

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

3. Current address No. .....Moo..... Village /Moobaan .....Soi.....Road.....

Subdistrict/Tambon.....District/Amphur.....Province..... Post code.....

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

4. Occupation..... Type of work .....Position.....

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

Office Address No. ..... Building.....Soi.....Road.....

Subdistrict/Tambon.....District/Amphur.....Province..... Post code.....

5. Address for correspondence ☐ Registered address ☐ Current address ☐ Office address

Important notice

Please mark "✓" in the appropriate boxes, as well as ensure a thorough and truthful declaration, if the statement of the applicant is found to befalse or concealing the truth, The Navakij Insurance Public Company Limited willreject the responsibilities stated in your policy.

1. Please indicate in the item 1.1 below whether you have ever suffered from or had treatment for the following diseases, symptoms and conditions in the past 10 years. For the applicant's age is under 15 years old, please indicate additional health history in item 1.2

(1.1) Disease /Disorder/Symptom	**Yes**	**No**
- Brain, cerebrovascular and spinal cord ie : cerebrovascular accident, convulsion/epilepsy, amnesia , Alzheimer, Parkinsn, chronic headache, migraine etc.		
- Peripheral neuropathy ie : numbness, weakness of extremities, paralysis, hemiparesia, abnormal movement etc.		
- Eye, Ear, Nose, Throat ie : retinal detachment, cataract, glaucoma,hearing loss, otitis media, perforated ear drum etc.		
- Respiratory tract (lung, larynx, bronchus, nasal cavity, sinus) ie: asthma, allergy rhinitis, hemoptysis, nosebleeds regularly, tuberculosis (including Disseminated tuberculosis) etc.		
- Heart disease and blood vessel system ie : cardiovascular disease, heart valve disease, cardio-septum defect,chest pain, // artritis, thrombophlebitis, varicose vein etc.		
- Hypertension (high blood pressure)		
- Diabetes mellitus (DM), hyperglycemia (high blood sugar), pancreatitis		
- Hyperlipidemia ie. hypercholesterol, hypertriglyceride		
- Blood and Immune diseases (red blood cell, white blood cell, platelets) ie: anemia, blood clotting disorders, HIV+ or AIDS,SLE etc.		
- Endocrine/Hormone disorder, thyroid disease (Please identify), hormonal disorders etc.		

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(1.1) Disease /Disorder/Symptom	Yes	No
- Digestive system and abdomen (esophagus, stomach, bowel) ie : haematemesis, gastritis, peptic ulcer, gastro-esophageal reflux disease, strictured of esophagus, esophageal varices hernia, intussusception etc.		
- Liver and Biliary system ie : hepatitis, fatty liver, cholecystitis, gall stone, jaundice etc.		
- Defecation system ie : bloody stool, irritable bowel syndrome, rectum disease, hemorrhoids, fistula in ano etc.		
- Kidney and urinary tract ie: nephritis, cystitis, urethritis, stones, trouble passing water, bloody urine etc.		
- Breast disorder and abnormalities (male and female)		
- Female reproductive organs and genitalia (uterus, ovarian tubes, ovaries, vagina) ie : menstruation disorder, endometriosis, abnormal cell of cervix etc.		
- Male reproductive organs and genitalia (prostate gland ,testis, testicular tube) ie : proatatitis, enlarged prostate, undescended testis, phimosis etc.		
- Musculoskeletal system (spine,bone, joint, muscle, ligament, cartilage) ie : spine and disc disorders, arthritis, osteoarthritis, tear of ligament, fracture bone, carpal tunnel syndrome, trigger finger, gout, gouty arthritis etc.		
- Skin disease ie : allergic dermatitis, psoriasis etc.		
- Food and drug allergy		
- Non-malignant tumor, mass, polyp,lipoma, cyst		
- Cancer		
- Mental disorders, Psychosis, Neurosis ie : Depression, schizophrenia, bipolar, self-harming etc.		
- Congenital or genetic disorder, Bodily deformity, disability (congenital/accident) ie : blindness, deaf, Polio, autism, Abnormal of growth and development and slow learning etc.		
- Have you ever suffered from another disease or injuries which are not stated as above.		

(1.2) For the applicant's age under 15 years old, please indicate additional health history below	Yes	No
- RSV (Respiratory Syncytial Virus)		
- Convulsion ● In the event that you have answered that you have / had symptoms, please specify the number……. times Age/when…… ● Are you having an abnormal condition after a convulsion? ☐ No. ☐ Yes (if yes, please indicate the symptoms. ……..…… …….. ● Treatment ……..……..… ● Current symptoms ……..……..……..		

(1.3) When you answered "Yes" to any question in the item 1.1 and 1.2 as above and the event that you got a treatment or surgery(please indentify the organ and the side of the illness/ injury /treatmented) please give details in the table as following.

Month/Year of symptom	Symptom	The symptom have been treated?		Name of Healthcare Provider	Diagnosis	Treatment method or medical advice	OPD / IPD	Latest Follow-up date	Next appointment	
		No	Yes						Date	Additional treatment

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2. At present, Are you undergoing rehabilitation due to injury or illness?

☐No ☐ Yes, if so, please provide details (If any, please attached additional information) ………………………………………………………

………

………

3. During the past 5 years, Have you been diagnosed with blood , urine, x-ray, MRI, EKG, ultrasound, biopsy exercise stress test etc?

☐No ☐ Yes, if so, please provide details (if any, please attached additional information) ………………………………………………

………

4. During the past 3 years, Have you been a health check-up? ☐ No ☐ Yes, if so, please specify the latest time.

Month/Years………/……………/………… Place of treatment or Hospital name ……………………………………………………………

- Health examination results (Hypertension test, blood test such as blood sugar level, cholesterol, triglyceride, liver or kidney function tests and urinetest)……

……………………………………………………………………………………………………(if you have a record please attached)

- How have you received advice and additional treatment from your health care provider? ………………………………………………

……………………………………………………………………………………………… (if any, please attached additional information)

5.Have you ever seek treatment by alternative medicine or medical specialist such as Thai traditional medicine, Folk medicine, Traditional chinese medicine or western alternative medicine acupuncture massage, Herbal medicine, bone alignment, etc.

☐ No/Never ☐ Yes/Have (If yes, please provide details.)……………………………………………………………………………………

…………………………………………………………………………………………….(if any, please attached additional information)

6. Please specify symptom or disease do you have treatment on the last time………………………………………………………………

………

- Month/Years…………/………../………….
- Place of treatment or Hospital name……………………………………………………………………………………………………

………………………………………………………………………………………………… (if any, please attached additional information)

7. Are you currently taking medicine or injections regularly? ☐ No ☐ Yes, (please specified the medicine name and the reason or disease)

………

………

8. For female, Are you currently pregnant ☐ No ☐ Yes ………………………………month

9. Your alcohol consumption.

☐No☐Yes Type…….. Amount..……..…Bottle/Time. Average units …..…Time/Week. Duration of Alcohol Consumption …..….. Years.

10. Do you have smoked (cigarettes, cigars, pipes etc.) ☐ No ☐ Yes Amount per day ………………………………………

11. Have you ever had a serious substance abuse.☐ No ☐Yes

12. Have you ever been refused coverage, revoked coverage,denied policy renewal, 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 ………………………………………………………………

13. 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 ………………………………………
Reimbursement Income Insurance	Company ………………………………………	Sum Insured ………………………………………
Critical illness Insurance	Company ………………………………………	Sum Insured ………………………………………

Cancer InsuranceCompany ……………………………………………… Sum Insured ………………………………………………

(attached additional information)

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I hereby request the Company to provide the Insurance Policy with your terms and conditions and I confirm that the above statements are complete and true. I agree to have this Application Form included in the contract between I and the Company. If there are any false statements or any truth concealed, I agree to let the Company cancel this Insurance Policy. In addition, I also authorized The Navakij Insurance Public Co.,Ltd. to request for any information regarding to my personal health treatment or health condition records from any physician, hospital, clinic or any other organization which has any my health information or record including blood test for HIV testing.

The Company has the right to examine the insured's medical treatment history and diagnosis as needed in accordance with this policy, and have an autopsy performed as necessary and without a violation of law, at the cost of the company.

In the event that the insured does not allow the company to check the medical history and the diagnosis of the insured in order to consideration of compensation payment, the company may deny coverage under this insurance policy to the insured.

I hereby consent to the Company to maintain, utilize and disclose my personal factual information to Office of Insurance Commission for regulatory purpose of the Insurance Industry.

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

☐ No

☐ 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: …………...………………

This document is not an insurance contract. The coverage will be effective when confirmed by the company.

Applicant's Signature …………………………......……..…… (……………..…...…………….…….…....)

Date ......…../…..……/…..…... (Apply date)

Signature of Lawful Representative ……………………...…….………… (…………………………….….…......)

Date ......…../…..……/…..…... (Apply date)

In case of act on behalf of the applicant must be only father/mother or parent.

(In case of the applicant is a minor). Please specified the relationship...

Remark: Application form is valid within 30 days

☐ **Direct** ☐ **Agent** ☐ **Broker** **License No.** ………………………………………………

WARNING

The applicant should disclose all the facts you know. Any nondisclosure shall make the policy issued hereunder voidable. The company has the right to void the contract and refuse the claims according the Civil Commercial Code Section 865.

Please attached the documents for underwriting as follows :

1. Copy of passport
2. Physician Examination Report (For the applicant's age is over 65 years old**)**

หมายเหตุ: เอกสารนี้ถือเป็นคำแปลเท่านั้น

Remark: The English language is merely a translation of the Thai version

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Attaching to and forming a part of Personal Health Insurance

Application Form For Long-Stay Visa Plan

Additional Agreement of Chronic Disease Declaration

I would like to inform the company that I have the pre-existing disease(s) as follows:

(Please mark "✓" in the appropriate boxes)

- ☐ Epilepsy
- ☐ Cerebrovascular disease
- ☐ Brain death – Stroke
- ☐ Dementia
- ☐ Parkinson's disease
- ☐ COMA (unconscious)
- ☐ Respiratory failure
- ☐ Brain tumor with complications
- ☐ Ataxia
- ☐ HIV positive, AIDS
- ☐ SLE
- ☐ Crohn's disease
- ☐ Multiple Sclerosis (MS)
- ☐ Paralysis
- ☐ Weakness
- ☐ Myasthenia gravis
- ☐ Cirrhosis-Liver failure
- ☐ Chronic renal failure
- ☐ Myocardial infarction
- ☐ Severe blood disease
- ☐ Thalassemia (except carrier)
- ☐ Alcoholism
- ☐ Psychosis
- ☐ Alzheimer
- ☐ Drug addict
- ☐ Disability
- ☐ Severe illness
- ☐ Cancer
- ☐ No disease above

I hereby acknowledge that the above diseases are not covered under the Personal Health Insurance Long-Stay Visa Plan and I confirm that I will not make a claim with the aforementioned diseases.

Insured's signature……

(full name)……

Date……

In case of the applicant is a minor. Please specify the relationship……

Father/Mother or parent's signature……

(full name)……

Date……