

BLUE CROSS INSURANCE LIMITED

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GROUP HEALTH & ACCIDENT INSURANCE APPLICATION (G1826)

Please complete this form as clearly as you can. If you have any questions concerning completion of this form please contact your Human Resources Manager. (Father or mother must complete the form on behalf of child below 15 years old)

Please note that one form should be used for each enrollee.

Company **Thai-Chinese International School** Starting Date _____ Job Title _____
 Department _____ Personal Title (i.e Mr., Mrs., Miss., Boy) _____ Date of Birth _____
 Firstname _____ Lastname _____ Sex Male Female Preferred language Thai Eng
 Correspondence address _____
 Postal code _____ Tel (Work) _____ (Home) _____ (Mobile) _____ (Email) _____
 ID card no. / Passport No. _____ Home country _____ Country of residence _____
 Relationship with the employee (For dependent applicant) Spouse Child
NAME OF BENEFICIARY (FOR MEMBER WHO ALSO SELECTS PERSONAL ACCIDENT BENEFIT)
 _____ Address _____ Relationship _____

1. Do you have health, life or accident insurance with other insurance companies?
 No Yes If yes, please give details.....

2. Have you ever had a request for life insurance rejected or a policy cancelled, rated or restricted by other insurance companies?
 No Yes If yes, please give details.....

3. Have you ever undergone an operation or been diagnosed or been hospitalised or had an accident?
 No Yes If yes, please give details including the nature of the disease, disorder, condition or illness, the date of onset and the date of recovery, name of the doctor, the place of treatment and further treatment plan, if any.....

4. Have you ever been advised to have a surgical operation or investigative procedure which has not yet been performed?
 No Yes If yes, please give details including the name and address of the doctor making the recommendation.....

5. During the past 5 years, has the applicant, spouse or child ever had any tests done such as x-ray, ultrasound, CT scan, MRI scan, biopsy, electrocardiogram, blood or urine test?
 No Yes If yes, please give details including date(s), the reason for the tests and place where the tests took place.....

The followings are the questions regarding to your illnesses, injuries, physical impairment, deformity or condition requiring in-patient treatment, operation or consultation with a medical practitioner, which the applicant or the persons covered may have suffered from. *Please tick "Yes" or "No" If yes, please give details of the treatment given, medical practitioner and the hospitals or clinics providing the medical treatment at the end of the question table.*

Systems / Diseases	Yes	No	Systems / Diseases	Yes	No
Nervous system ie: chronic headache, Blurred vision, abnormal gait , dizziness			Thyroid gland ie: goiter,thyroid enlargement, hypothyroid, thyrotoxicosis		
Migraine headache , tension headache			Other endocrine disorders ie: sex hormone abnormality		
Psychiatric problems, stress and anxiety			High or low blood pressure		

Numbness, paresthesia, weakness of extremities		Cardiovascular disorder and blood vessel disorder		
Eye disorders		Disorders of blood (anemia, white blood cells & platelets)		
Ear, nose and throat disorders		Bodily deformity		
Allergies , asthma		Disorders of bone, muscle and joints (Musculoskeletal system)		
Respiratory disorders		Joint pain ie: Gouty arthritis , chronic arthritis		
Stomach disorder or abdominal discomfort ie: Peptic ulcers,chronic abdominal pain		Chronic back pain or off and on symptoms		
Digestion abnormality and dyspepsia		Chronic pain		
Chronic constipation or abnormal stool ie: bloody stool, bowel habit changes		Loss or increase body weight about 4-5 kgs. in the last 2-3 months		
Intestinal or bowel disorders (small&large bowel)		Sleep disorder		
Liver and gall bladder disorder ie: hepatitis, gallstone, cholecystitis		DM (Diabetes mellitus)		
Jaundice		Hyperlipidemia or hypercholesterol conditions		
Kidney and urinary tract disorders ie: hematuria, turbid urine, passing stone		Abnormal urination ie: dysuria, stress incontinence, prostate gland enlargement (BPH)		
Breast disorder ie: mass, pain, or abnormal secretion.		Female genital disorders ie: uterus, ovary, or ovarian tubes		
Cancer or malignant tumor		Chronic pelvic pain		
Non malignant lump or Benign tumor		Menstruation disorder		
Sexual trasmitted disease		Skin, hair or nail disorder		
Urogenital disorder		Are you currently suffering from any diseases or injuries?		

Remarks _____

Please state the name of the physician, hospital or clinic together with the address which the applicant or persons covered use regularly.

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 Blue Cross Insurance Ltd. as the Attorney-in-fact 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 the applicant Date

WARNING BY INSURANCE DEPARTMENT, MINISTRY OF COMMERCE

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 clause 865 of the Civil and Commercial Code. If you have any queries regarding this Insurance Policy, please contact the office of the Insurance Commissioner, Telephone 0-2547-4602-16

I hereby confirm that this applicant is the employee of the company. (Valid only upon Company Stamp and authorized signature) Employer..... Authorised signature..... Position	For BUPA Blue Cross Use Only :
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