

(continued)

	Lead Applicant		Dependant 1		Dependant 2		Dependant 3	
	Yes	No	Yes	No	Yes	No	Yes	No
Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental/Nervous Disorder/Nervous System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reproductive System Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/Blood Pressure/Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgical Operation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tumour /Growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION E : STATEMENT OF ORAL HEALTH
(ONLY COMPLETE THIS SECTION IF YOU HAVE SELECTED PROGRAMME 3)**

Please indicate if there is an oral/dental condition needing treatment by any individual requesting coverage.

	Lead Applicant		Dependant 1		Dependant 2		Dependant 3	
	Yes	No	Yes	No	Yes	No	Yes	No
Routine dental examination in the last year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any fillings needed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any crowns needed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any denture/bridgework/implant needed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Missing teeth needing replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged teeth needing repair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gum problem needing treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Root canal treatment needed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any teeth needing extraction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal disease needing treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontic treatment needed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Use this space to complete extra information required for Section D and E. Continue on a separate sheet of paper if there is insufficient space.



SECTION F : DATA PROTECTION

LAMP Insurance Company Limited assures you that all your personal and medical information will be held in strictest confidence and in accordance with applicable legislation. Personal data may be passed to other companies with the LAMP Group 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 any data we hold which is inaccurate or out-of-date.

SECTION G : DECLARATION

- I hereby apply for membership to the Premier International Healthcare Plan.
- I accept the benefits terms conditions and limits provided for in the terms of the insurance company Ltd.
- I understand that this Application is subject to written acceptance by LAMP Insurance Company Ltd.
- I confirm the correctness of the statements and information contained in this application. This clause will constitute a condition precedent to the payment of the benefit provided for in terms of the Plan. We accept that LAMP Insurance Company Ltd will be relying on such statements and information when agreeing to accept this application. LAMP Insurance Company Ltd reserves the right to investigate where uncertainty exists about the validity of information provided.
- I, the applicant and the listed dependents, agree to being called upon to submit such medical examinations and tests as LAMP Insurance Company Ltd deems concerned.
- I acknowledge that LAMP Insurance Company Ltd reserves the right to cancel the membership of this plan if any amount due is not paid by or on the due date concerned.
- I agree to give LAMP Insurance Company Ltd immediate written notice should any changes material to the assessment of this application occur before the date upon which LAMP Insurance Company Ltd the opportunity to reconsider the terms of acceptance. This will give LAMP Insurance Ltd the opportunity to reconsider the terms of acceptance.

AUTHORISATION: To all physicians/hospitals/healthcare institutions/insurers/medical or hospital service providers/employers: You are authorized to provide LAMP Insurance Company Limited information concerning healthcare, advice, treatment, supplies, absence (including those related to mental illness and/or AIDS/ARC/HIV) relating to me or any members of my family for whom coverage has been requested. This information will be used to determine eligibility for coverage. This authorization will be valid for twenty four months from the date of signature of this form.

SIGNATURE

DATE

NAME

Please return this questionnaire to:

Premier International Healthcare Ltd.: Asia Pacific Office

5th Floor, M Thai Tower, All Seasons Place,

87 Wireless Road, Lumpini, Pathumwan,

Bangkok 10330

Tel: +66 2 654 1150

Fax: +66 2 654 1151

Email: sales@premier-ih.com