



# APPLICATION FORM

YOUR PERSONAL DETAILS																	
Title				Surname													
Sex	M	F	First Name														
Nationality						Passport No.				Date of birth	D	D	M	M	Y	Y	Y
Height (cm)						Weight (kg)				Age last birthday							
Occupation													Smoker	Y	N		

YOUR CONTACT DETAILS			
Residential address of the the country where you are to be located			
Address			
Town/ City		Country	
PostCode/ Zip Code		Email Address	
Home Country		Country of Residence	
Work Contact (Tel.)		Home Contact (Tel.)	

YOUR CHOICE OF MEDICAL COVER			
Coverage details (please tick one box only on each line)			
Programme	Lite 1 <input type="checkbox"/>	Lite 2 <input type="checkbox"/>	
Deductible	Nil <input type="checkbox"/>	THB 40,000 <input type="checkbox"/>	THB 100,000 <input type="checkbox"/>
			THB 200,000 <input type="checkbox"/>
Additional cover available (please tick for a quotation)			
	Travel Insurance <input type="checkbox"/>	Life Cover <input type="checkbox"/>	PA <input type="checkbox"/>

TOTAL ANNUAL PREMIUM THB

## ELIGIBLE DEPENDANTS TO BE INSURED

Title				Surname													
Sex	M	F	First Name														
Passport No.										Date of birth	D	D	M	M	Y	Y	Y
Address										Age last birthday							
Town/City						Country of Residence											
Nationality						Occupation											
Height (cm)						Weight (kg)											
Relationship to you, eg son, daughter, wife/spouse												Smoker	Y	N			

Title				Surname													
Sex	M	F	First Name														
Passport No.										Date of birth	D	D	M	M	Y	Y	Y
Address										Age last birthday							
Town/City						Country of Residence											
Nationality						Occupation											
Height (cm)						Weight (kg)											
Relationship to you, eg son, daughter, wife/spouse												Smoker	Y	N			

\* If you have more than two dependants please request a ' Additional Dependants Form ' .

### MEDICAL QUESTIONNAIRE

Kindly answer the questions below in respect of each proposes insured for each "Yes" answer please provide all necessary details include hospital and doctor/surgeon's name address/pho

	Yes	No
1.a. Are you currently covered by any medical policy? (Include a copy of the policy and benefit schedule)	<input type="checkbox"/>	<input type="checkbox"/>
b. Has any medical of life insurance application been declined, rated, restricted, or cancelled?	<input type="checkbox"/>	<input type="checkbox"/>
c. Are you currently applying for health, life or accident insurance with any other company?	<input type="checkbox"/>	<input type="checkbox"/>
2. <b>In the past 10 years</b> have you had symptoms of or been diagnosed or treated for any of the following:		
a. Speech defect, hearing loss, sight loss, congenital or chronic condition or illness related to your sight, hearing, or speech?	<input type="checkbox"/>	<input type="checkbox"/>
b. Respiratory or allergic condition, asthma, emphysema, COPD, pneumonia or bronchitis or other breathing problems or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>
c. Psychiatric or mental disorder, fainting, blackout, mood change, drug alcohol addiction, seizure or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
d. High blood pressure/hypertension, chest pain, cholesterol problem, dizziness, lung, heart or circulatory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
e. Kidney stone, venereal disease, or disorder of the bladder, prostate, kidney or genito-urinary tract?	<input type="checkbox"/>	<input type="checkbox"/>
f. Gall stone, pancreatitis, ulcer, hemorrhoid, colitis or stomach, liver or bowel disorders?	<input type="checkbox"/>	<input type="checkbox"/>
g. Sciatica, back pain, joint pain or rheumatic, arthritis, muscle, joint or bone disease or condition?	<input type="checkbox"/>	<input type="checkbox"/>
h. HIV, AIDS, AIDS Related Complex, or any blood or immune system disease of condition?	<input type="checkbox"/>	<input type="checkbox"/>
i. Skin, hormone, gland disease or condition, diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
j. Injury, illness, disease, or birth defect, or condition other than as note above?	<input type="checkbox"/>	<input type="checkbox"/>
3. Within the past 15 years have you had cancer, tumor or cyst, or been treated for suspected cancer or tumor? If so, please specify _____	<input type="checkbox"/>	<input type="checkbox"/>
4. 4.1) Are you currently taking or have any medications or treatments been recommended or prescribed? (please list) _____	<input type="checkbox"/>	<input type="checkbox"/>
4.2) Do you take:		
a. Insulin, or other Blood sugar lowering medicines	<input type="checkbox"/>	<input type="checkbox"/>
b. Blood pressure medicines	<input type="checkbox"/>	<input type="checkbox"/>
c. Blood thinning medicines (Anticoagulants), heart medicines	<input type="checkbox"/>	<input type="checkbox"/>
d. Nitroglycerin or other heart medications	<input type="checkbox"/>	<input type="checkbox"/>
e. Cholesterol lowering medicines	<input type="checkbox"/>	<input type="checkbox"/>
f. Prednisone or breathing medicines (i.e. inhalers or nebulizers)	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you been admitted to a hospital, medical centre, clinic or sanitarium in the past 15 years? If so, for what? And for how long? _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>FOR WOMEN ONLY:-</b> Have you in the past 10 years had breast disorder, disease of uterus, ovaries, tubes or cervix, menstruation disorder, gynecological disorder or pregnancy-related disease or complication? If so, for what? _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you been advised to have any medical test or procedure other than as noted above? If so, please specify _____	<input type="checkbox"/>	<input type="checkbox"/>
7. 7.1) Do you currently smoke pipes, cigars or cigarettes and how many packs do you smoke per day? <input type="text"/> Packs		
7.2) Have you ever smoked? If so, for how many years? <input type="text"/> Years And when did you quit? <input type="text"/> Years		
7.3) How many drinks do you have per week? <input type="text"/>		
8. Are you diabetic, have you ever had elevated blood sugar levels, have you ever taken insulin or other blood sugar lowering medicine? If so, for how long? _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had a heart attack, any heart problems, chest pains or angina, irregular heart rate, treadmill stress test, cardiac Catheterization, If so, when? _____	<input type="checkbox"/>	<input type="checkbox"/>

(continued)

	Yes	No
10. Have you ever had any trouble breathing, asthma, emphysema, pneumonia, bronchitis in the past 10 years?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had problems with the veins <input type="checkbox"/> arteries <input type="checkbox"/> or nerves <input type="checkbox"/> in your legs?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have high blood pressure and have you been treated for high blood pressure within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever had a stroke, mini-stroke (TIA) or dizzy spells, lost consciousness within the past 10 years? If so, please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever had any surgical operations? If so, for what? And when? _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
15. Did your parents or siblings (brothers/sisters) die at less than 60 years of age? If so, please list age and cause of death. _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
When you answered "Yes" to any of the questions on the above page of this form please give details in the space below or on additional papers required. _____ _____ _____		

#### DECLARATION

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 further understand that the premiums quoted above, or elsewhere, unless otherwise advised by LMG Pacific Healthcare, are quote in respect of me and my family being resident in Thailand. I do hereby appoint LMG Insurance Company Limited as the Attorney-in-face to request copies or any kind of information regarding my health records or health condition from any physician, 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.

APPLICANT'S SIGNATURE

DATE

#### WARNING BY THE OFFICE OF INSURANCE COMMISSION (OIC), MINISTRY OF FINANCE

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.