ทิพยประกันภัย
DHIPAYA INSURANCE
ภาครัฐเป็นผู้ถือหุ้นใหญ่

ห่วงใยทุกชีวิตในสังคม

Application Form Project Code:

Health TIP Premium & Accident Insurance Policy **Application No.……..……**

Personal Health and Accident Insurance (TIP Platinum Health Care (Covid-19))

1. APPLICANT INFORMATION

Name ☐ Mr. ☐Miss ☐Mrs. ……. Middle Name……. Surname ……

ID/Passport Number …….. Work Permit No. …….. Exp. Date of WP ……. (Please attach copy)

Visa Type …….. Visa No. …….. Exp. Date of Visa ……. (Please attach copy)

DD/MM/YR (Date of Birth.) …… Weight (Kgs.)…… Height (cm.)……Race……..…….… Nationality ……..……

Civil Status ☐Single ☐Married ☐Widowed ☐Divorced Current Address……

Tel. No. ……..……..…… E-mail ……..……..…….. Occupation…… Position……..…

Type of Business……..…… Monthly Salary THB ……..…. Other Income THB……..……

Company Name/Address ……. Tel. No. ……..……..…… Ext.……..

2. BENEFICIARY INFORMATION

1) Name ☐ Mr. ☐Miss ☐Mrs.…… Middle Name…… Surname …… Relationship to Insured ……..……

2) Name ☐ Mr. ☐Miss ☐Mrs.…… Middle Name…… Surname …… Relationship to Insured ……..……

3. Period of Insurance: From: …… at: ……hours To: …… at 24.00 hours

4. Please select plan of Insurance: Unit : THB

Age (Years)	Plan 1	Plan 2	Plan 3	Plan 4
16 - 30	☐ 38,196	☐ 32,616	☐ 23,249	☐ 17,669
31 - 40	☐ 36,076	☐ 31,038	☐ 20,986	☐ 15,950
41 - 50	☐ 49,042	☐ 41,982	☐ 29,415	☐ 22,355
51 - 60	☐ 62,494	☐ 53,346	☐ 38,116	☐ 28,968
61 - 70	☐ 78,840	☐ 67,111	☐ 48,898	☐ 37,164

5. Premium Payment Options: Total Premium THB _____ (Stamp Duty included)

☐ Cash payment

☐ Credit Card: Bank name: ……..……Card no. …….. Expiry date: ……../…….

☐ Bank Transfer: A/C Name Dhipaya Insurance Public Co., LTD.

KASIKORN Bank	A/C No : 001-1-10196-8 / Current A/C (Si Lom Branch)
BANGKOK Bank	A/C No : 215-3-02200-5 / Current A/C (Rama 9 Branch)
SCB Bank	A/C No : 001-3-11904-2 / Current A/C (Head Office Branch)
TMB Bank	A/C No : 002-2-19832-9 / Saving A/C (Ratchadamnoen Rd. Branch)
KRUNGTHAI Bank	A/C No : 056-1-05949-7 / Saving A/C (Asoke-dindaeng Rd. Branch)

Health & other health related questions:

6. Do you have or have proposed for Health Insurance, Critical Illness Insurance, Life Insurance or Personal Accident with the company or any other company?

○ No ○ Yes, Please explain: ……..……..……..

8. In the past 5 years, have you ever been admitted or diagnosed in a hospitalized or clinic for the following: any kind of Cancer, cyst, Cerebro-Vascular Disease (Stroke), Cardiac Arrest, Myocardial Infarction, Chronic Kidney Disease or Kidney failure, Systemic Lupus Erythematosus (SLE), Hypertension with admission, Diabetes (with insulin administration), Hyperlipidemia (Treated with Statins to lower cholesterol), Obesity (BMI more than 33 up), Chronic Obstructive Pulmonary Disease (COPD), Emphysema, AIDS or HIV, Thalassemia, Multiple Sclerosis, Crohn's Disease, Hepatitis B or C, Cirrhosis of the Liver, Alcoholism and Drug Abuse/Addiction, have any disabled part of your body, paralysis, psychologically impaired, taken narcotic drugs and other seriously illness?

○ No ○ Yes, Please explain: ……

9. In the past 5 years, have you ever been treated or been issued a prescription for any chronic disease or underlying disease by a physician for any pain or illness or surgical procedure? (If yes, please explain details of diagnosis and treatment provided for that incident).

○ No ○ Yes, Please explain: ……

10. Currently, are you recovering from any procedure or treatment for any illness, accident or substance abuse under the supervision of a physician?

○ No ○ Yes, Please explain: ……

11. In the past 5 years, have you ever been subjected to Radiographic exams, Nuclear Medicine evaluation as MRI and CT Scan, Ultrasound, Biopsy, EKG, Blood and Urine Test? (If, yes, please specify the doctor's order and diagnosis as to declare the reason of test and the place of hospitalized or clinic where test was done).

○ No ○ Yes, Please explain: ……

12. Have you ever been diagnosed and evaluated by a physician for a surgical procedure of any kind or instructed to undergo a major biopsy but have not proceeded to do so? (If yes, please specific the name of Physician and the hospitalized or clinic)

○ No ○ Yes, Please explain: ……

13. Are you currently in any abnormal state of health, (such as pain, tumor, abnormal bleeding, and presence of any cyst or any other condition that you have not seek medical advice or treatment?

○ No ○ Yes, Please explain: ……

14. Are you currently on regular prescription medications for a congenital disease or any chronic disease or not?

○ No ○ Yes, Please explain: ……

RATIFICATION OF THE INSURED

As agreed between the insured and the insurer, this policy does not provide coverage to the insured for injury or illness or any complication thereof obtained or acquired by the insured prior to the issuance of this policy as stated by the insured, except if indicated in any endorsement of identify disease-specific coverage issued. The insured acknowledges and agrees to these terms and conditions in all respects.

This is to certify that the above information are true and completely correct to my knowledge, and I authorize all medical institutions that have treated me to provide all and necessary information relating to my medical history and previous treatments and diagnosis, including any results of HIV virus testing as required by this application to DHIPAYA Insurance Co. (PLC). This document is not an insurance contract. The applicant will be protected once it has been verified by the Company. The Insured hereby authorize the Company to store, use and disclose the information relating to (my health and) information of the Insured to Office of Insurance Commission (OIC) for the benefits of insurance business governance.

According to the tax regulation, should the Insured wish to apply this insurance policy for the income tax reduction?

☐ Yes, I hereby authorize the Company to disclose and forward the information relating to insurance premium to the Revenue Department according to the government regulation.
In case the Insured are Non-Thai Residence who have duty to pay income tax, kindly specify your taxpayer identification No. ……

☐ No
The consent to disclose and forward the information to the Revenue Department will be in force until the Insured have an instruction of cancellation or any alterative.

Applicant Signature: …… Date of Application
(……) Day … Month.....……Yr……

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

REMINDER OF THE OFFICE OF INSURANCE COMMISSION

As stated by civil and commercial law clause 865, if any of the answers above are proven to be fictitious or not true then the insurance policy can be immediately terminated and any or all claims declined.

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