Note: This translation is for understanding and for information purpose only, the official application must be in Thai version.

Warning the Office of Insurance Commissioner
The applicant must disclose all important information based on the fact. Any undisclosed information will give right to the insurer to deny the claim payment, which is in accordance with section 865 of the Civil and Commercial Code

Tokio Marine Life Insurance (Thailand) Public Company Limited
1 Empire Tower Building, 26th Floor, South Sathorn Road,
Yannawa, Sathorn, Bangkok 10120
Tel. 02 650 1400 tokiomarine.com
Company Registration No. 0107540000103

TOKIO MARINE INSURANCE GROUP

Application form for Insured above 16 years old

☐ **Non-medical examination** ☐ **Medical examination**

Agent name.....**License No**.....
Agent Code.....**Unit Name**.....
Unit.....**Branch** .....

Part 1 Applicant's personal data and details of insured matter

1. Name and Surname of the applicant..... Gender ☐ Male ☐ Female
Previous Name and Surname..... Race..... Nationality..... Name of Spouse.....
Marital Status ☐Single ☐ Married ☐ Widow ☐ Divorced The age at last birthday.....years old Date of Birth ..... Month.....Year.....
Identity documents ☐ Identification card ☐ House registration ☐ Others.....
ID.No. or Passport No. __ - __ __ __ __ -__ __ __ __ __ - __ __ -__ Expiry Date.....

2. Address

A. Residence registered address no.	Village/ Building	Moo Soi
Street/Road	Sub district	District
Province	Postal code	
Telephone no	Mobile no	E-Mail
B. Business address / Company		Address no. Moo
Soi	Street/Road	Sub district
District	Province	Postal code Telephone no
C. Current address no.	Village/ Building	Moo Soi
Street/Road	Sub district	District
Province	Postal code	
Telephone no	Mobile no	E-Mail
D. Contact address	☐ Residence registered address	☐ Business address ☐ Current address

3. Occupation.....Position..... Responsibility(s).....
Type of business.....Annual Income .....
Others occupation (if any)..... Position..... Responsibility(s).....
Type of business.....Annual Income .....

Do you ride a motorcycle in your day to day work? ☐ No ☐ Yes

4. Type of basic plan..... Sum assured ..... Baht
Cover Period ..... years Payment Period ..... years Premium ..... Baht.
Type ☐ with dividend ☐ without dividend Dividend option (If any), ☐ Receive in cash / cheque
☐ Deduction with the next due premium

Rider	Sum Assured / Premium (Baht)
Company will reserve to separate policy automatically in order to make sum assured of WP to be the same as premium of basic plan and reserve to separate sum assured of basic plan without WP to be another policy by using the same application	
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

Mode of payment

- ☐ Annually
- ☐ Semi-annually
- ☐ Quarterly
- ☐ Monthly
- ☐ Single premium

Warning: The insured must receive the conditioning binding receipt (CBR) for every time that premium is paid

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Payment with this application..... Baht by ☐ Cash ☐ Cheque ☐Credit Card ☐Transfer to Company's A/C No.....A/C Name..... Bank..... Branch..... Other.....
Name and Surname of the payer..... Age……years Occupation……Relationship.....

5. Beneficiary(s) (The Sum Assured will be equally proportionate if it is not specified otherwise in below)

Name and Surname of beneficiary(s)	Age	Relationship	Address (if it differs from the application)	Percentage
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....
.....	.....	.....	.....	.....

6. Have you hold or being applied for life or accident or health insurance policy with this company or another company?

☐ No ☐ Yes, please specify

Company name	Sum Insured (Baht)			Hospital Benefits (per day)	In-forced policy?
	Life	Accident	Critical Illness		

7. Have you ever been declined or postponed or loaded for extra premium, or changed the underwriting term and condition by this company or others in case of apply for new policy or request for reinstatement? ☐ No ☐ Yes If yes, please specify the details.

Company	Reason	When

8. Have you ever been involved with narcotic selling or convicted of narcotic criminal? ☐ No ☐ Yes

9. Do you or have you ever taken any addictive drugs or substances?

☐ No
☐ Yes, please specify types of drug……Quantity per time ……..Frequency……..……times/wk. for…..……years
☐ Abstain from any addictive drugs or substances, please specify the details……

10. Do you or have you constantly consume alcoholic beverages?

☐ No
☐ Yes, please specify types of beverages ……Consumption per time ……Frequency……..……per wk. for…….years
☐ Abstain from alcoholic beverages, please specify the details……

11. Do you or have you ever smoke cigarette or other type of tobacco?

☐ No ☐ Yes /Use to, please specify quantity……stick/day for How long?.....years ☐ When did you abstain from smoking.....

12. Height..... cms. Weight ..... kgs. Have you had any change in weight in the past six months? ☐ No ☐ Yes
Please specify the details ☐ Increase..... kg. ☐ Decrease..... kg. Reason(s).....

Part 2 Insured life's family history

13. Have your parents or siblings ever diagnosed from doctors or suffered from: Heart diseases, Blood vessel diseases, Cancer, Diabetes Mellitus, Kidney diseases, High blood pressure, Commit suicide or Mental disorder, Blood diseases or Viral Hepatitis?

☐ No ☐ Yes If yes, please specify the details Who..... Disease(s).....Age onset.....

14. Does your spouse has suffered from AIDS (HIV) or Viral Hepatitis?

☐ No ☐ Yes If yes, please mark in ( ) AIDS (HIV) ( ) Hepatitis

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Part 3 Illness or medical treatment history of the applicant

15. Have you ever diagnosed or got treatment or suspected by doctors these following symptom or disease(s)?

☐ No ☐ Yes If yes, please mark in ☐ and specify disease(s) and details of treatment below (can be more than 1)

☐ Abnormal eyesight	☐ Parkinson	☐ Gastrointestinal Ulcer	☐ KidneyDisease	☐ Gout
☐ Glaucoma	☐ Stroke	☐ Liver or Bile duct Disease	☐ Enlarge Spleen	☐ SLE
☐ Retina Disorder	☐ Paralysis	☐ Alcoholism	☐ Pancreatitis	☐ Thyroid Disorder
☐ Amnesia	☐ Epilepsy	☐ Arthritis	☐ Asthma	☐ Scleroderma
☐ Tuberculosis	☐ Lung Disease or Pneumonia	☐ Enlarge Lymph node	☐ Heart Disease	☐ Blood vessel Disease
☐ Blood Disease	☐ Sleep Apnea	☐ Tumor Mass or Cyst	☐ Cancer	☐ Down's Syndrome
☐ Hypertension	☐ COPD	☐ Venereal disease (within 2 years)	☐ Jaundice	☐ Depression
☐ Disability	☐ Emphysema		☐ Diabetes Mellitus	☐ Mental Disorder
☐ AIDS	☐ Coronary heart Disease			☐ Nervous Disorder

Disease	DD/MM/YY of Treatment	Treatment and current condition	Place of treatment
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

16. A. Do you have or have you ever had these following symptoms? ☐ No ☐ Yes

If yes, please mark in ☐ and specify disease(s) and details of treatment below (can be more than 1)

☐ Abnormal eyesight	☐ Chest pain or tight	☐ Chronic abdominal pain	☐ Chronic joints pain
☐ Chronic Severe Headache	☐ Palpitation	☐ Abdominal Edema	☐ Muscle weakness
☐ Chronic Cough	☐ Petachiac	☐ Hematemesis/ Melena	☐ Abnormal movement
☐ Hemoptysis	☐ Delay Development	☐ Chronic Diarrhea	☐ Loss of sensation
☐ Fatigue	☐ Find out mass/tumor	☐ Blood in urine	☐ Suicidal idea

B. Symptom within last 6 months ☐ Fatigue ☐ Chronic Diarrhea ☐ Weight loss ☐ Chronic skin Disease ☐ Prolong Fever

C. For female applicant only ☐ Are you now pregnant? ……months ☐Complication during pregnant and/or delivery ☐Bleeding per vagina

Symptom	DD/MM/YY Onset of Symptom	Current Symptom
.....	.....	.....
.....	.....	.....

17. In the last 5 years, did you

A. Take any physical checkup, biopsy or examination for diagnosis purpose such as, X-Ray, ECG, Blood testing or others investigation

☐ No ☐ Yes If yes, please specify the details

Test	When	Where	Resulted	Notice by doctor

B. Have any medical treatment for accident/ injury/ sickness/ operation, doctor's consultation, doctor's recommendation or other treatment not mentioned in the above item? ☐ No ☐ Yes If yes, please specify the details

Disease/ Symptom	DD/MM/YY of Treatment	Place of treatment	Treatment and current condition
.....	.....	.....	.....
.....	.....	.....	.....

Question number 18 for apply health or Dread Disease Rider

18. Have you ever diagnosed or got treatment or suspected by doctors these following symptom or disease(s)?

☐ No ☐ Yes If yes, please mark in ☐ and specify disease(s) and details of treatment below (can be more than 1)

☐ Otitis Media	☐ GERD	☐ Spondylosis	☐ Endometriosis
☐ Chronic Tonsillitis	☐ Stone	☐ Herniated disk	☐ Neuritis
☐ Sinusitis	☐ Cholecystitis	☐ Osteoarthritis	☐ Autistic
☐ Migraine	☐ Hernia	☐ ChronicTendinitis	☐ Attention Deficit
☐ Allergy	☐ Hemorrhoid		
☐ Chronic Bronchitis	☐ Anal Fistula		

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Disease	DD/MM/YY of Treatment	Treatment and current condition	Place of treatment
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

19. For applicant's in case of additional information provided

.....

.....

PART 4: Consent and Verification of Status for Compliance with the US Foreign Account Tax Compliance Act (FATCA)

Consent and Verification of Status

A. I hereby give my consent and agree that if I am considered a U.S. indicia such as: born in the U.S.; am/ used to be a U.S. citizen, no matter how; having permanent address / current address / contact address or temporary address in the U.S.; or reside in the U.S. for longer than 183 days in the past calendar year, I shall provide additional information in item B and comply with all requirements stated below.

B. I hereby provide additional information supplemental to my statement made in item A as I am considered a U.S indicia as described in item A that;

☐ 1. I am not required to pay US Tax to US. IRS and attach herewith (1) W – 8 BEN form and (2) additional supplementary / clarification

☐ 2. I am required to pay US Tax to US. IRS and attach herewith (1) W-9 form or (2) Tax payment confirmation document (/Tax Return Form).

Consent given for providing information / notifying information and Acknowledgment of consequence from failure to provide information / notify information.

1. I hereby consent and agree: (1) to notify the Company in case that there is any change in respect of my previous U.S. indicia related FATCA declaration statement, including statement given in item A or B, previously given to the Company, within 30 days upon any such change; (2) to provide additional information within 30 days upon receipt of written request from the Company; and (3) that the Company may disclose any information that the Company is legally bound to do so, to any Thai or Foreign government agencies that monitor / supervise FATCA Compliance.

2. In the event that I fail to provide / notify any information, I hereby consent and agree that the Company has the right to decline the application (prior to underwriting the same). In such event, the Company shall provide written notice therefor, not later than 30 days from the day of my receipt (or should have received) the message requiring me to provide additional information, sent by registered mail, return receipt requested, for my acknowledgment or allowing me to provide any evidence countering the same.

Part 5 Declarations, Delegation of authority and Permission

1. I hereby declare that the answers in this application including the declarations to the examination physician are true. I understand that In the case of non-disclosed information, my life insurance policy can be voidable and denounced.
2. I hereby give consent to the physician or other insurance companies or other parties to disclose my pass and the further health information to Tokio Marine Life Insurance (Thailand) PCL or company's representative for the purpose of underwriting or indemnification in accordance with the policy coverage.
3. I hereby authorize to Tokio Marine Life Insurance (Thailand) PCL to gather, use and disclose my health information to other insurance Companies or the reinsurer or lawful authority institute or paramedic for purpose of underwriting or indemnification in accordance with the policy coverage or medical benefit.
4. I hereby authorize to Tokio Marine Life Insurance (Thailand) PCL to gather, use and disclose my health information to the Office of Insurance Commissioner for purpose of regulating the insurance industry.

Written at..... Date.....

1. If you cancel your insurance policy before maturity due, benefit stipulated in a surrender value table that may be lessen than the determined sum assured shall be applied to your insurance policy benefit (if any).
2. To ensure of insurance contract validation, please recheck the correction of all of your answer(s) before affix your signature.

Statement of witness / Life insurance agent

I hereby declare that the identity, statement and signature of insured are true

Signature.....

(.....)

Witness / Life insurance agent

Signature.....

(.....)

Applicant

Signature.....

(.....)

Consented by ☐ Parents

☐ Lawful Representative

(In case the applicant is not attain legal age yet)