

Warning from the Office of Insurance Commissioner

The applicant must disclose all important information based on the fact. Any undisclosed information will motivate the insurer to deny the claim payment, which is in accordance with the 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

Application form for Insured **under 16 years old**



TOKIO MARINE
INSURANCE GROUP

☐ Non-medical examination ☐ Medical examination

Application no.....

Part 1 Child's personal data

1. Name and Surname of the child.....

Gender ☐ Male ☐ Female Race..... Nationality Age.....Year Date of Birth.....Month.....Year.....

Identity documents ☐ Identification card ☐ House registration ☐ Passport ☐ Others

ID. No. or Passport No _ _ - _ _ _ _ - _ _ _ _ _ Expired date.....

Currently ☐ Not Study ☐ Study Year..... Name of School.....

2. Father's Name and Surname..... ☐ Alive ☐ Dead

Mother's Name and Surname..... ☐ Alive ☐ Dead

3. Child's Address

A. Residence registration address no.	Village/ Building	Moo	Soi
Street/Road	Sub district	District	
Province	Postal code		
Telephone no.	Mobile no.		
B. Current address no.	Village/ Building	Moo	Soi
Street/Road	Sub district	District	
Province	Postal code		
Telephone no.	Mobile no.		

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
☐ Decrease the next due premium

Rider Sum Assured / Premium (Baht)

In case of apply PB rider, Sum assured of PB rider will be the same as premium of basic plan and riders that PB rider attached

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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

Payment with this application..... Baht

Payment by ☐ Cash ☐ Cheque ☐ Credit Card ☐ Transfer to Company's A/C no.....

A/C Name..... Bank..... Branch.....

Other..... CBR book number /running number

Name and Surname of the payer.....

Age.....Years Occupation..... Relationship.....

5. In the last five years, did your child

a) Take any physical checkup and/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	DD/MM/YY of Treatment	Place of treatment	Treatment and current condition
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.....

6. Does the child has currently healthy, no deformity or AIDS or any serious disease?

☐ Yes ☐ No If no, please specify the details.....

7. Has the child 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. Heightcm. Weight..... kg. Have you had any change in weight in the past six months?

☐ No ☐ Yes Please specify the details ☐ Increase.....kg. ☐ Decrease.....kg. Reason(s).....

9. Have the child's 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.....Age onset.....

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

Name and Surname of beneficiary	Relationship	Percentage
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.....
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Part 2 For Payer

11. Name and Surname **Gender** ☐ Male ☐ Female

Previous Name and Surname..... Race..... Nationality..... Name of Spouse.....

Marital Status ☐ Single ☐ Married ☐ Widow ☐ Divorced Age.....years Date of BirthMonth Year

Identity documents ☐ Identification card ☐ House registration ☐ Passport ☐ Others.....

ID. No. or Passport No. _____ - _____ - _____ - _____

Expiry Date Relationship with applicant.....

12. Address

A. Residence registration address no.		Village/ Building	Moo	Soi
Street/Road		Sub district	District	
Province		Postal code		
Telephone no.		Mobile no.	Email.	
B. Business address/ company name			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.	Email	
D. Contact address		<input type="checkbox"/> Residence registered address	<input type="checkbox"/> Business address	<input type="checkbox"/> Current address

13. Occupation..... Position.....Responsibility (s).....
 Type of businessAnnual income.....Baht
 Others occupation (if any).....Position..... Responsibility (s).....
 Type of business.....Annual income.....Baht

14. Has you ever been declined or postponed or requested to pay a higher premium, or changed the life insurance 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

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

16. Do you or have you ever taken any addictive drugs or substances ☐ No ☐ Yes, please specify types of drug.....
 Quantity per time Frequency.....times/week for.....years ☐ Abstain from any addictive drugs, please specify

17. Height..... cm. Weight.....kg. 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 3 In case to apply PB 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)

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

Disease	DD/MM/YY of Treatment	Treatment and current condition	Place of treatment
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19. 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)

<input type="checkbox"/> Abnormal eyesight	<input type="checkbox"/> Chest pain or tight	<input type="checkbox"/> Chronic abdominal pain	<input type="checkbox"/> Chronic joints pain
<input type="checkbox"/> Chronic Severe Headache	<input type="checkbox"/> Palpitation	<input type="checkbox"/> Abdominal Edema	<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Petachiac	<input type="checkbox"/> Hematemesis/ Melena	<input type="checkbox"/> Abnormal movement
<input type="checkbox"/> Hemoptysis	<input type="checkbox"/> Delay Development	<input type="checkbox"/> Chronic Diarrhea	<input type="checkbox"/> Loss of sensation
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Find out mass/tumor	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> 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
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20. 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
.....
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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)