PROTECTA Insurance Solutions www.protecta-thai.com
Official Customer Adviser ; La Cascade 8A, 1/7 Soi Charoenmitr (Ekamai 10), Sukhumvit Soi 63 Road ; Bangkok 10110
Tel : 02 714 4177 ; Fax : 02 714 4179 ; e-mail : info@protecta-thai.com

NSI MAXI / ULTRA MEDICAL PLAN APPLICATION

Name of Policy Holder _____

Residential Address _____ Mailing Address _____

Contact No: Home Tel _____ Mobile _____ Office Tel _____ Fax _____

E-mail _____ E-mail _____

Insured (s) Name	Date of Birth	Policy Holder Relationship	PREMIUM CALCULATION					Additional Personal Accident	Additional "P.A." Premium (6)
			MAXI CARE (1)	ULTRA CARE (2)	Dental (3)	Vision (4)	Travel (5)		
1.									
2.									
3.									
4.									
		Total							

(Note: Maximum "PA" for children is ฿ 500,000 to age 18) Total (Column 1 – 5)

Treatment Area Limitation: tick one please

Required ( ) Not Required ( )

Less: Deductible discount (per sickness)

( ) 25% ฿ 40,000.- **( ) 32.5% ฿ 100,000.-** **( ) 40% ฿ 200,000.-**

Less: Treatment area limitation Discount 20%

Semi Annual Payment (x 54%)

Net Subtotal

Grand total (add "PA" premium)

MEDICAL QUESTIONAIRE

Kindly answer the questions below in respect of each proposed insured for each "Yes" answer please provide all necessary details including hospital and doctor/surgeon's name/address/phone/fax, condition, nature/date of treatment, current status, and other relevant information.

		YES	NO
1.	a) Are you currently covered by any medical policy? (Include a copy of the policy and benefit schedule)	( )	( )
	b) Has any medical of life insurance application been declined, rated, restricted, or cancelled?	( )	( )
	c) Are you currently applying for health, life or accident insurance with any other company?	( )	( )
2.	In the past 5 year 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?	( )	( )
	b) respiratory or allergic condition or disorder of the eyes, ears, nose or throat	( )	( )
	c) psychiatric or mental disorder, fainting, blackout, mood change, drug alcohol addiction, seizure of fit or epilepsy?	( )	( )
	d) high blood pressure/hypertension, chest pain, cholesterol problem, dizziness, lung, heart or circulatory disorder?	( )	( )
	e) gall/kidney stone, venereal disease, or disorder of the bladder, prostate, kidney or genito-urinary tract?	( )	( )
	f) ulcer, hemorrhoid, colitis or stomach, liver or bowel disorders?	( )	( )
	g) sciatica, back pain, joint pain or rheumatic, arthritis, muscle, joint or bone disease or condition?	( )	( )
	h) HIV, AIDS, AIDS Related Complex, or any blood or immune system disease or condition?	( )	( )
	i) skin, hormone, gland disease or condition, diabetes?	( )	( )
	j) injury, illness, disease, or birth defect, or condition other than as noted above?	( )	( )
3.	Within the past 7 years have you had cancer, tumor or cyst, or been treated for suspected cancer or tumor?	( )	( )
4.	Are you currently taking or have any medications or treatment been recommended or prescribed? (list with dosage)	( )	( )
5.	Have you been a patient in a hospital, clinic or sanitarium in the past 5 years?		
	FOR WOMEN ONLY :- Have you in the past 5 years had breast disorder, disease of uterus, ovaries, tubes or cervix, menstruation disorder, gynecological disorder or pregnancy-related disease or complication?	( )	( )

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6. Have you been advised to have any medical test or procedure other than as noted above? ( ) ( )

When you answered "Yes" to any of the questions on the above or obverse page of this form please give details in the space below or on additional paper as required.

I hereby apply for insurance designated. I hereby further state that all information provided herein is accurate and complete in respect of all proposed insured to the best of my knowledge. I further understand that the premiums quoted above, or elsewhere, unless otherwise advised by Nam Seng Insurance Public Co., Ltd. are quoted in respect of my and my family being resident in Thailand.

Policy Holder's Signature ..... Date: ..... Agent: Gerber Th.

Send completed **Medical Application** together with **Passport Copy** (page with Name, birth date and nationality information) to:

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Sukhumvit 63 Road, Bangkok 10110.
Tel: 02 714 4177 Fax: 02 714 4179
E-mail: info@protecta-thai.com

Send payment to :

Account Name: Nam Seng Insurance Public Co. Ltd.
Account Nr.: 082-2-50333-0
Bank: Thai Farmers Bank, Langsuan Branch, Saving Account

Send Pay-in slip to: Fax 02 714 4179

I hereby give my permission to Nam Seng Insurance Public Co., Ltd. or their duty appointed agents to make any inquiry into details of my and my family's health, and I kindly request that any doctor, specialist, clinic, hospital or other insurance company assist Nam Seng Insurance Public Co., Ltd. in their enquiries thereof.

Policy Holder Signature: .....

WARNING BY Insurance Department, Ministry of Commerce 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.	Broker/Agent Name/Code: "Thomas" / Insurance Solutions