Policy no ………………
Application no. ……….
Certificate no.………….

Generali Life Assurance (Thailand) Public Co., Ltd.

Reminder of the Department of Insurance, Ministry of Commerce. The insured must give all questions below truthfully; concealment may cause the Company to deny the indemnity under this policy in accordance with section 865 of the Civil and Commercial Code.

Insured's Application Form

Written date. ……………………

1. Name-Surname (Mr. /Mrs. /Ms./)..……………………………………………………………………………
   (In case applicant is [ ] Spouse [ ] Child [ ] Father [ ] Mother of employee / member name…………………)
2. Policyholder Name (Corporate / Company Name) ……………………………………………………………
3. Date of Birth (Day / Month / B.E.)…………… Age……….. Height. ……… cms. Weight ……………. kgs.
   Status [ ] Single [ ] Married [ ] Divorce [ ] Widow Numbers of children ………. Male……….Female……..
4. Current Address………. Moo………. Trok / Soi……….. Road……….. Tumbol / Kwang ……………………
   Ampur / District.………………Province …………………. Zip Code….……..Telephone……………………
5. Occupation ………………………Responsibility………………………..Years of Service.…….yrs..……. mths.
   Annual Income.……………. Baht Are you using motorcycle as your vehicle? [ ] Yes [ ] No
6. Name-Surname of Beneficiary …………………………………Relationship.……………...…………………
   Name-Surname of Beneficiary …………………………………Relationship.…………..……..………………
   Name-Surname of Beneficiary ……………………………..……. Relationship.……………..…….………..….
   (**Suggestion:** To accelerate the underwriting process, please nominate the beneficiaries who are parents, husband, wife or children)
7. During the past 2 years, were you sick or got injury or got medical consultation or had been admitted in Hospital? [ ] Yes [ ] No
8. Have you ever been cured or informed by physician of the related diseases; Heart Disease, Hypertension, Diabetes, Liver Disease, Renal Disease, Cancer, Pneumonia, AIDS, Brain related Disease, Nervous System Disease, Disease of joint or muscle impairment? [ ] Yes [ ] No
9. Have you ever been operated or instructed by physician to operate? [ ] Yes [ ] No
10. Have your health declaration form or application form been rejected, postponed, rated up, reduce sum assured or change of coverage type? [ ] Yes [ ] No
11. Currently, are you sick or injury or be instructed by physician to be cured or to be operated? [ ] Yes [ ] No
12. Do you have any underlying diseases or any parts of your body disabled?
    If yes, please specify……………………………………………………………
    (if any of your answer for the question no. 7 – 12 is " Yes" , please give more detail(the disease, time period of symptom or cure, results of the cure, Hospital that provide medical treatment).
    ………..
    ………..
    ……………………………………………………………………………………….…………………
    I declare and accept by myself that all answers and information given above are true and complete. Besides, I give authorization to any other insurers, physicians, medical providers, hospitals, persons or organizations who has my medical history record or the record that will be incurred in the future to disclose my medical record including the result of diagnosis, x-ray lab test, blood or saliva test or physical exam. This disclosure also includes all medical expenses incurred. This is for the purpose of insurance underwriting or the claim settlement. A photocopy of this authorization shall be effective and valid as the original.

I certify that the applicant is our member/employee.
Policyholder……………………………………………..
Signature…………………………………..Certifier
Position…………………………………………….
(Seal of company / employer / corporate)

Signature …………………………..Applicant
(……………………………..)