Please completely fill out and sign by an identical pen.
In case of any change, your endorsement is required.

American International Assurance Company, Limited

181 AI Tower Surawong Bangrak Bangkok 10500

Health Declaration Form

Policyholder (Company / Organization Name) ..... Policy No.....

Employee Name (Mr./Mrs./Miss) ..... Last Name ..... Gender ..... Age .....

Date of birth (dd/mm/yy) ☐☐ ☐☐ ☐☐☐☐ ◯ ID Card / ◯ Government ID Card No .....

Height ..... Weight ..... Occupation/Position ..... Section (Unit/Company) .....

Division / Department ..... District ..... Province .....

Beneficiary ..... Relationship .....

Beneficiary ..... Relationship .....

Address ..... Telephone No .....

1 Have you ever been treated for or told you have heart disease, high blood pressure, diabetes, liver disease, cancer or any other serious diseases? ☐ Yes ☐ No

2 Have you ever suffered from a sustained illness or had a serious injury, received consultation, or been treated in a hospital or clinic, or been advised about any treatment during the past 2 years ? ☐ Yes ☐ No

3 Have you ever had, or been advised to have, any surgical operation? ☐ Yes ☐ No

4 Have you ever had any life insurance application or application for reinstatement declined, postponed, rated up or modified of its conditions? ☐ Yes ☐ No

5 Has any member of your immediate family ever had tuberculosis, diabetes, heart disease or mental disease, or has your spouse suffered from AIDS or had a positive HIV blood test? ☐ Yes ☐ No

Remark : If any of the answers to question 1 though 5 is "Yes" or injury as a result of accident , please provide full details below, by noting the question number.

.....

All the above statements are true and complete to the best of my knowledge and belief. Furthermore, I hereby authorize any physician, hospital, clinic, or other organization that has any records or knowledge of me or my health to furnish American International Assurance Company, Limited with information concerning my medical history and physical condition. A photocopy of this authorization shall be effective and valid as the original.

In addition to the above statement, I hereby warrant that I am not aware to, or have never been treated of AIDS or test positive to AIDS virus and I fully understand that if I contact AIDS virus or have a positive blood test, the company may decline my application for insurance.

The statements made on this form are answered correctly to the best of my knowledge and belief.
(Employer's Company Stamp)

Policyholder / Witness .....
By ..... (Signature)
Position .....

..... (Signature of Employee)

( )

..... (Date)

Note from The Department of Insurance

Important Note Pursuant To : Civil & Commercial Codes, Section No. 865, you are required to disclose in this proposal form, fully and faithfully, all the facts which you know or ought to know, otherwise the policy issued here under may be void.