EZY Life Gold/Silver Insurance Application Form

Notice

1. In order for you to fully understand the insurance you are applying and to protect your rights and interests, please ask sales representative/agent/broker for the policy coverage and detailed explanations of the policy coverage particularly on benefits and exclusions before applying.
2. The Application Form, and other supporting documents deemed necessary by Phongsavanh Insurance (APA) Co., Ltd (hereinafter called "the Company") shall be held as promissory and shall be the basis of the contract between you and the Company. You must disclose all information honestly, and the company undertake to keep all application files confidential.
3. The application form must be signed by the both the buyer and insured person and no other party or person may sign on behalf of them.
4. By completing and signing the application form, you acknowledge that you have fully read, and understand the policy and agree to abide by it.
5. The purpose of the medical questionnaire is to evaluate the health conditions of you and therefore, please answer the questions as truthfully and thoroughly as possible. Pre-existing conditions, if any, will not be covered unless approved by the company. For the purpose of your health insurance, pre-existing conditions are defined as "any illness or injury, physical or mental condition, for which an Insured Person received any diagnosis, medical advice or treatment, or had taken any prescribed drug, or where distinct symptoms were evident prior to the effective date".
6. Once the Company have accepted your application and the Company having received your insurance premium, the Company shall issue the policy and you will be given an insurance card. The insurance card can be used at our "network hospitals/clinics" where they send claims to us for direct settlement. However, if you used the card, for any expenses not covered by the policy and not collected by the network hospitals/clinics, you have to pay the expenses to the Company within 30 days from the day of notification by the Company or its representative.

I hereby acknowledge that I have read, understand and agree to the terms and conditions stated above.

.....
Signature of Buyer

Date: (/ /)

.....
Signature of Insured Person

Date: (/ /)

Please complete this form in BLOCK LETTERS, and tick in boxes where applicable.

Checklist:

☐ Application Form ☐ Passport/ID copies of all insured members ☐ Medical Records (if applicable)

SECTION 1. DETAILS OF BUYER

First Name:_____Last Name: _____ ☐ Male ☐ Female

Address:_____

Date of Birth (DD/MM/YYYY):_____Height (m):_____Weight (kg): _____

Nationality:_____ID/Passport No.:_____Marital Status: _____

Phone Number:_____Fax:_____Email:_____

Occupation:_____Employer:_____

Emergency Contact Person:_____Relationship:_____

Phone Number:_____Email: _____

SECTION 2. DETAILS OF INSURED PERSON

First Name:_____Last Name: _____ ☐ Male ☐ Female

Address:_____

Date of Birth (DD/MM/YYYY):_____Height (m):_____Weight (kg): _____

Relationship with buyer:_____

Nationality:_____ID/Passport No.:_____Marital Status: _____

Phone Number:_____Fax:_____Email:_____

Occupation:_____Employer:_____

SECTION 3. Beneficiary information (if not specified, the company will pay to a person with legal family ties)

First Name and Last Name	Date of Birth	Phone No	Relationship	% Share

Cover start date: ……/……/……

(Extra charge of LAK 30,000 if policyholder required plastic medical card)

Are you presently insured with another insurance company ☐ Yes ☐ No If yes, please provide the following details:

Name of Company:_____Plan:_____Expiration Date (DD/MM/YYYY) _____

SECTION 4. MEDICAL QUESTIONNAIRE

- Please tick **"YES"** or **"NO"** to each of the following questions for each person named in your application.

	Insured Person	
	YES	NO
1. For the last 5 years been admitted to a hospital/other medical facility or had surgery?		
2. For the last 5 years been disabled and/or incurred medical costs exceeding USD$3,000?		
3. Been told that there was any abnormality during medical check-up?		
4. Suffered from a disease or an accident requiring 30 days or more sick leave and / or medical treatment?		
5. Received any disability pension or work accident pension?		
6. Been told that it may be necessary to be admitted to the hospital or have surgery in the future?		
7. Within the past 5 years have you ever been infected or have symptoms or have been treated or is currently receiving treatment or has been told by a doctor with the following diseases or medical condition?		
A. Repeated pharyngitis, chronic cough, expectoration, hemoptysis, asthma, difficulty breathing, bronchiectasis, pneumothorax, emphysema, tuberculosis, pleurisy, chronic bronchitis, pneumonia or other diseases of the respiratory system?		
B. Back pain, polyuria,incontinent urination, dysuria, hematuria, proteinuria, anuria, nocturia, facial oedema, Urethral and urolithiasis (Gallstone), nephritis, nephropathy, renal cyst, hydronephrosis, or other urinary system problems?		
C. Palpitation, tachypnea after exercise, hemoptysis, edema or varicose veins of lower extremity, chest discomfort or pressure, syncope, rheumatic fever or heart murmur, arrhythmia, myocarditis, cardiovascular disease, myocardial infarction, stroke, aneurysm, coronary heart disease, hypertension, Dyslipidemia, or other circulatory system disorder?		
D. Fatigue, dizziness, epistaxis, subcutaneous hemorrhage, purpura, pain in bone, anemia, or other blood system disorders?		
E. Arthritis, gout, neck pain, back and lumbar pain, cervical vertebral disease, lumbar vertebral disease, myofascial pain syndrome (MPS), nervous lesion or musculoskeletal / joint problems?		
F. Abnormal appetite, hyperhidrosis, polydipsia, polyuria, tremor on hands, obesity, pigmentation, amenorrhea, diabetes, thyroid diseases, or other metabolism and endocrine system problems?		
G. Dizziness, vertigo, syncope, hypomnesia, disturbance of vision, insomnia, disturbance of consciousness, tremor, convulsions, seizure, paralysis, sensory, abnormality, epilepsy, loss of consciousness or other nerve system disorder?		
H. Prostate disorder, gastralgia, mastitis, irregular menstruation, menorrhagia, dysmenorrhea, endometriosis, fibroma uterine, ovarian cyst, infertility, or other diseases of the male/female reproductive organs including sexual transmitted diseases (STD)?		
I. Cancer, tumor or mass, polyps, cysts, enlarged glands, lymph nodes or organ, disorders of the skin or pigmentation, fibro-cystic breast or any related conditions?		
J. HIV infection, AIDS, AIDS-related complex or other immune deficiency disorders, infection problems or sexual transmitted diseases (STD)?		
K. Alcohol or substance abuse, mental/nervous, behavioral, emotional, or eating disorders?		
L. Cataracts, glaucoma, or any eye disorder, hearing loss, or any ear/nose/throat (ENT) disorder?		
M. Do you or your dependents have any family medical history relating to disabling illness, physical defect, suffers from the consequences of accident, congenital disease, hereditary disease, genetic defect?		
8. Are you or your dependents:		
(a) Currently pregnant?		
(b) Have any complications of pregnancy?		
(c) Expects a child by either natural or artificial means?		
(d) Advised to seek treatment, medication, diagnostic test or surgery for infertility?		
(e) Been treated for infertility?		
9. Other than previously stated:		
(a) Smoke more than 12 cigarettes per day?		
(b) Use tobacco in any form?		
(c) Within the past 5 years, gained or lost more than 12kg in 12 months?		
(d) Any other medical condition that has not been disclosed above? If so, please describe in details below		

Please provide explanation for any YES answers below. Medical report may be required.

No.	Name	Date	Condition	Treatment	Current Status
1					
2					
3					
4					
5					

SECTION 5. DECLARATION

1. I declare that all the information supplied above is true and correct and I hereby agree that this Application and Declaration shall be held as promissory and shall be the basis of the Contract between the me/Applicant and the Company and I understand that any false, incorrect or misleading statements may render this application null and void.
2. I hereby declare that I am in good health and free from any physical defects (except as stated above)
3. I also understand that the Company shall be entitled to retain all premiums paid during the policy year by virtue of breach of this declaration.
4. I am also aware that I have to notify the Company of any fact material to this insurance, which arises between the date of this declaration and the inception of this policy.
5. I understand and accept that, no benefit will be payable to any pre-existing condition which is not approved by the Company.
6. I understand and consent that the Company has full rights to check all Insured medical records and diagnosis records as and when needed. I further authorize any medical organization or person to release information gathered in the course of my examination or treatment to the Company.

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Signature of Buyer

Date: (/ /)

.....
Signature of Insured Person

Date: (/ /)

.....
Signature of Sales Agent

Date: (/ /)