

Proposal Form "PA TOP Shield"

The Proposer's Information

Name-Surname (Mr./Mrs/Miss).....Gender : Male Female

I.D./Passport NoDate of Birth...../...../.....Age.....(16- 60 years old)

Address.....

.....Postal Code Mobile Telephone No.

Home Telephone No.Fax No.E-Mail Address.....

Position.....Job description.....

wage/year(Baht).....Office Telephone No.....Ext.

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

Detail of Proposer's Employer

Employer's Name.....Employer's Business.....

Employer's Address.....

Period of Insurance Required : From...../...../.....athours To...../...../.....
at 16:30 hours

Health Statements and others

1. Do you have had or have proposed for Health Insurance, Accident Insurance or Life Insurance with any other Company or Allianz C.P. ?

Never/No Ever/Yes (please state in detail)

Insurance Company.....Sum Insured.....

2. Have you ever been declined any proposal for Health Insurance, Accident Insurance or Life Insurance, ever been declined for insurance renewal or ever had additional premium imposed for such insurance ?

Never/No Ever/Yes (please state in detail)

Insurance Company.....Sum Insured.....

3. Do you have or have you ever been treated or acknowledged or received any Physician's Recommendation regarding Epilepsy or Convulsion, Heart Disease, Hypertension, Diabetes Meliltus, Cancer, AIDS or HIV positive or any disabled part of your body ?

Never/No Ever/Yes (please state in detail)

Insurance Plan required:

Plan 1 **Plan 2** Total Premium (included SBT and Stamp Duty)Baht

I warrant that the above statements are true and correct and agree that this proposal shall be the basis of the contract between the Company and me

Date/...../..... () Proposer's Signature

Insurance Agent Insurance Broker.....License No.

REMINDER

The proposer shall give the answer to all questions above truthfully otherwise the company may have caused to deny liability under the policy in accordance with section 865 of the Civil & Commercial Code.