J&C ELITE CARE

APPLICATION FORM FOR INDIVIDUAL CLIENT OR FAMILY CLIENT

I. *APPLICANT INFORMATION*

Name:	
Occupation:	
Address:	
Email address:	
Phone number:	

II. *DETAILS OF THE INSURED PERSONS*

	Main applicant	*Dependent 1*	*Dependent 2*	*Dependent 3*
Full name				
Relationship				
Nationality				
Passport /ID No.				
Date of Birth				
Gender (F/M)				
Height (m)				
Weight (kg)				
Full-time Education? (Applicable to Children).				
(Occupation of Dependents)				
Chosen plan				

III. ***DESIRED COMMENCEMENT DATE*:**

DD/MM/YY: _____

IV. ***BENEFIT OPTIONS*:**

	Plan 1	**Plan 2**
Hospitalization	○ US$ 100,000	○ US$ 75,000
Out-patient	○ US$ 3,000	○ US$ 1,500
Death by Illness	○ US$ 100,000	○ US$ 75,000
Personal Accident	○ US$ 100,000	○ US$ 75,000

V. **HEALTH DECLARATION**

Important Note about filling in this form:

The answers you give to the questions contained in this Application will form the basis of any insurance Policy issued, and will be incorporated into the contract. It is essential that you give accurate, truthful and complete information for all persons to be insured as inaccuracies may jeopardize coverage or invalidate a claim

1. *Have the Insured and/or any of the Insured's family member had any congenital, acquired physical defect or impairment?*	○ Yes	○ No
2. *In the last five years, have the Insured and/or any of the Insured's family members had any surgical operation, been confined or treated in hospital, sanatorium or other institution or other medical institution; or do any of the persons to be insured know any circumstances for which hospital treatment may be necessary in the next twelve months; or taking any medication or receiving any form of treatment at the present time?*	○ Yes	○ No
3. *In the last five years, have the Insured and/or any of Insured's family members ever suffered from or been treated for:* ***Group I:*** *tuberculosis, diabetes mellitus, hepatitis, lung, heart condition, varicose veins, blood pressure, gall bladder, kidney, pancreas or venereal disease, cancer or tumors, growth hormone disorder, parkinson or psychiatric disorders, bone marrow, diseases related to hematopoietic (blood forming), jaundice, gastritis, sinusitis, fistula, haemorrhoids, prostate, thyroid, eczema, cyst, asthma, cholesterol, circulatory disorder?* ***Group II:*** *respiratory disorder, mental intestinal disorder, genito-urinary system, sexual transmitted diseases, bone, joint, muscle, skin, hernia, gynaecological disease, depression, anxiety, nervous system, stroke, epilepsy, paralysis, spinal condition, slipped disc, complication of pregnancy?*	○ Yes ○ Yes	○ No ○ No
4. *Does the Insured and/or any of the Insured's family member reside outside Laos?*	○ Yes	○ No
5. *Is there any member smoking?*	○ Yes	○ No

If the answer to any of the above is YES, please provide further details about person who suffered/ has been suffering, the number visits for treatment and current condition:

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Name and contact details of the Family doctor (if has):

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Phone number: .....

Please sign and return (by hard copy or scan) this Application Form and pay full premium to the Insurance Company or Authorized Representatives before the cover can be granted.

Declaration: *I and the insured listed above hereby apply to be enrolled in the insurance policy. I declare to the best of my knowledge and belief that the information given in this Application is true and complete. I am on behalf of all persons to be insured, acknowledge that we are fully understand the policy's terms and conditions including but not limited to all benefits and exclusions. I also agree that this declaration and information given in this Application shall form the basis of issuing the contract of insurance.*

	Date:
	Signature and full name of Applicant (*on behalf of all Persons to be insured*)