

Insurance Application

Cancer Insurance

Notice

1. In order for you to fully understand the insurance applied for and so as to protect your rights and interests, please ask sales representative/agent/broker for the policy wording and detailed explanations of the policy wording, particularly in terms of important contents such as benefits and exclusions before applying. Before completing this application, please ensure that the sales representative/agent/broker has explained the policy wording; that you have carefully read the relevant insurance contents and policy wording; and that you have fully understood important issues like benefits, exclusions, honest disclosure and contract cancellation.
2. The Application Form, and other files deemed necessary by the Insurer (hereinafter "application files") are the basis for the Insurer to issue the Insurance Contract and will be an important part of the Insurance Contract. The Policyholder and the Insured should disclose honestly, and the Insurer agrees to keep all application files confidential.
3. The application form may only be signed by the policyholder. No other party or person may sign on behalf of the policyholder.
4. By completing and signing the application files, you acknowledge that you have fully read, and understand the policy wording and agree to abide by it.
5. You must reside during the policy period within Laos for at least 8 months. Please inform sales representative/agent/broker and the Insurer if you are unsure or not able to meet the residential requirement.

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

Applicant Signature

Date (DD/MM/YYYY)

1. Applicant Information

First name & Family name (Mr/Ms).....

Current residence address

ID card Passport Family book Number..... (Please attached a copy for evidence)

D-M-Y of Birth.....Age.....Sex.....Height (cm)Weight (Kg)

Occupation.....Brief job description Income/Month Kip

Place of work.....

Beneficiary

First name & Family name Relationship with Applicant.....

2. Coverage Term: Start Date Time.....mn. End Date Time 16:30 mn

The applicant selects the insurance coverage plan 1 2 3 4

1. Has the applicant or his/her family members ever had or died from cancer?

Medical background of the Applicant

	No	Yes	If yes, please indicate the person's name and type of cancer
Applicant	<input type="radio"/>	<input type="radio"/>	
Father - Mother	<input type="radio"/>	<input type="radio"/>	
Brother - Sister	<input type="radio"/>	<input type="radio"/>	
Child	<input type="radio"/>	<input type="radio"/>	



2. During the past five years, have you had any surgery? No Yes
If yes, what is the reason of your surgery Date of your surgery (mm/yyyy).....
Name of Hospital.....
3. Have you had medical treatment for any chronic diseases? No Yes.
Please indicate the diseases.....
Name of Hospital.....Date.....Month.....Year.....
4. At present, do you smoke cigarettes? No Yes,
If yes,Cigarettes per day. I have been smoking for.....Years
5. Has the applicant got sick or been treated by a doctor or been infected by the following diseases?
 Hepatitis B, C (either used to be a carrier or infected) HIV (Aids infected)
 Chronic Lung infected (still under medical treatment) Liver cirrhosis, Hepatitis
 Chronic Colon infected (still under medical treatment) Cancer
 Chronic Cervical infected (still under medical treatment) Chronic Hernia infected
 Tumor, mass or cysts, (please indicate typeand the organs infected)
 At present, still have, no surgery yet
 Already had a surgery to remove it, but less than 2 years before applying for the insurance
 Already had a surgery to remove it, more than 2 years before applying for the insurance
(surgery on (mm/yyyy) at.....(Hospital name)
Tissue examination results: Normal Not normal
 Got appointment with doctor to follow up on tumor, mass or cysts every
 3 months 6 months 1 year more than 1 year
 Never
If you have any diseases above, what is the current condition?
 Normal under medical treatment at.....(Hospital name)
6. Do you have other cancer insurance policy or other insurance policy that covers cancer? If yes, please provide details
 No Yes Insurer.....Sum Insured.....Kip

DECLARATION

- I declare that I have answered all the questions truthfully and to the best of knowledge. If this form has been completed on my behalf, I agree to the truthfulness of the responses given. I understand that any incorrect or incomplete answer or the concealment of any facts relevant to this insurance may invalidate this policy; I also understand that the insurer shall be entitled to retain all premiums paid during the policy year by virtue of breach of this declaration.
- I am also aware that I have to notify the insurer of any fact material to this insurance, which arises between the date of this declaration and the inception of this policy.
- I understand and accept that no benefit will be payable to any pre-existing condition which is not approved by the Insurer.
- I understand and accept all items stated in the policy wording.

Signature of Applicant/Primary Insured

Date (DD/MM/YYYY)

Please return completed and signed Form(s) together with copy ID/passport to J&C Insurance (insurance@jclao.com).