Allianz Ayudhya General Insurance Public Company Limited
898 Ploenchit Tower, Ploenchit Road, Khwang Lumpini,
Khet Pathumwan, Bangkok 10330
Tel. +66 2677 0000 Fax. +66 2230 6500

APPLICATION FOR CHANGE BENEFIT PLAN AND COVERAGE

Contract No. : .....Customer Name .....

Payment Method ☐ Yearly ☐ Monthly

Existing Benefit Plan: ..... Plus OPD Benefit: ☐ YES ☐ NO

Other Optional Benefits (If any): .....

Contact Address .....

Telephone No. : .....Mobile .....Fax ..... E-mail : .....

NEW PLAN SELECTED: ..... **Plus OPD Benefit:** ☐ **YES** ☐ **NO**

OTHER OPTIONAL BENEFITS: ..... ◯ **UPGRADE** (Please completed the health questions)

***EFFECTIVE DATE FOR PROPOSED CHANGES:** ..... ◯ **DOWNGRADE**

**New benefit plan will be effective date 30 days in advance after you signed on the document and subject to medical re-underwriting*

PLEASE ANSWER EACH THE FOLLOWING QUESTIONS FULLY AND ACCURATELY (Completed only upgrade case)

1. Please kindly state your underlying diseases or any chronic health sickness (If any) .....
   .....
2. Are you on any on-going medication? ☐ Yes ☐ No
   If yes, please specify .....
3. Please list any hospitals, doctor visit, treatment, test or medicine taken (whether prescribed or not) during the last 24 months:
   .....
4. Please provide full details if any person covered by this request is :
   a) Currently under treatment or observation for any medical condition .....
   b) Has been advised to have any diagnostic test or medical procedure which has not been completed.....
   c) Has incurred any medical expenses which have not yet been fully disclosed to Allianz Ayudhya General Insurance PCL.
   .....
   (If necessary, please attach a separate sheet)

All the above statements are true and complete to the best of my knowledge and belief and I understand that the Company, believing them to be such, will rely on them. I, do hereby, appoint Allianz Ayudhya General Insurance Public Company Limited. As the Attorney-in-fact to request a photocopy or any kinds of information of my health record or health conditions from any physician or health care provider or any organization on my behalf until completion. A photocopy of this statement shall be as effective and valid as the original.

WARNING

By Insurance Department, Ministry of Commerce

The applicant must truthfully answer all questions. Any concealment or misrepresentation of the truth may result in the insurance company refusing to honor insurance claims, as per clause 865 of the Civil and Commercial Code. If you have any queries regarding this Insurance Policy, please contact the office of the Insurance Commissioner Telephone 0-2547-4602-16

NOTE

- **UPGRADE** : - In case of the benefits and/or coverage **increasing**, any conditions existing before and at the time of upgrade shall continue to be covered at the old benefit level
- **DOWNGRADE** :- In case of the benefits and/or coverage **decreasing**, any the claims incurred had been covered under LOWER BENEFIT shall continue to be covered under the new plan or the new benefit whichever is smaller.

.....	.....	.....
Applicant's Signature	Signature of Lawful Representative (in case where the Applicant is a minor)	Apply date (Date/Month/Year)

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