



**ace insurance**

399 อาคารอินเตอร์เซนจ 21  
ชั้น 25 - 30  
ถนนสุขุมวิท  
แขวงคลองเตยเหนือ  
เขตวัฒนา กรุงเทพฯ 10110  
โทร: (66) 0-2611-4040  
โทรสาร: (66) 0-211-4313

Levels 25<sup>th</sup> - 30<sup>th</sup>,  
Interchange 21 Bldg.,  
399 Sukhumvit Rd.,  
Klongtoey Nua,  
Wattana, Bangkok 10110.  
Tel: (66) 0-2611-4040  
Fax: (66) 0-2611-4313

**REGISTRATION FORM**

**Type of Payment**

Month  Semi Annual  Annual

Discount Optional \_\_\_\_\_

**Type of Plan**

Yes, I'd like to enroll for "Personal Accident (PA)"  
 Plan I, Sum Insured 1 ML.  Plan II, Sum Insured 3 ML.  Plan III, Sum Insured 5 ML.  
 Other please specify \_\_\_\_\_

**The applicant information**

Insured Name \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ yrs. (not over 60 yrs.) Sex:  Male  Female

Contact Address: \_\_\_\_\_

Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Tel \_\_\_\_\_ Off \_\_\_\_\_ ext. \_\_\_ mobile \_\_\_\_\_

Occupation \_\_\_\_\_ Description \_\_\_\_\_

Yes, I'd like to cover for my spouse for the same plan.

Spouse's Name \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ yrs. (not over 60 yrs.) Sex:  Male  Female

Occupation \_\_\_\_\_ Description \_\_\_\_\_

Yes, I'd like to cover for my children for the same plan

Children's name 1 \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ yrs. (6 months - 20 yrs.) Sex:  Male  Female

Children's name 2 \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ yrs. (6 months - 20 yrs.) Sex:  Male  Female

**Name of Beneficiary** \_\_\_\_\_

Have you, spouse and children ever been admitted to a hospital, had an operation or had any chronic disease, please provide details

**Insured**  Never / None  Yes / have (please specify) \_\_\_\_\_

**Spouse**  Never / None  Yes / have (please specify) \_\_\_\_\_

**Children 1**  Never / None  Yes / have (please specify) \_\_\_\_\_

**Children 2**  Never / None  Yes / have (please specify) \_\_\_\_\_

**Remark:**

This insurance policy will have an effective since as The Company receives the completed registration form and the premium payment.

I understand that you will send me the Policy as soon as the Acceptance Form is processed and accepted by ACE, stipulating the effective date and condition of coverage.

X \_\_\_\_\_  
Insured's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**Important Note**

Pursuant to Section 865 of the Civil Code, you are to disclose in this proposal (Acceptance Form), fully and faithfully, all the facts you know or ought to know. Otherwise this Policy issued hereunder may be void.