LUMA
57 Park Ventures Ecoplex 9th Floor,
Unit 912 Wireless Road,
Lumpini, Pathumwan, Bangkok 10330

Tel. +662 494 3600

CONSENT FORM
RELEASE OF MEDICAL INFORMATION

I _____, date of birth ____/_____/_____,
(member's name)

Member ID_____, Passport/ID Number_____,

address _____,

hereby confirms to give consent to LUMA to disclose any medical conditions*, initially declared during the subscription of the policy, as well as which may occur later during policy years,
To the below beneficiaries: (please enter the information of the beneficiaries below)

First & Last Name	Email Address	Mobile Phone	Relation with member (relative, broker…)

Please note that if you wish to amend the above-mentioned agreement you should reach out to the Luma customer service team without any delay by email at CS@lumahealth.com.

* I understand that the medical information may include all information including those related to treatment of drug or alcohol abuse, psychological impairments and sexually transmitted illnesses.

Issuer of the consent (signature + date)

IMPORTANT: Please add to this document a copy of your ID on which you appose your signature and date.