CUSTOMER INFORMATION

Policyholder name
Nguyễn Văn Huy

Billing Address:
657/5 Ba Đình, P 6, Q 8

Tel:
0365448229

Contact Email:
vanhuy170496@gmail.com

A - INSURED PERSON DETAILS

	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4
Full Name (last/ middle/ first)				
Relationship to Policyholder				
Height and Weight	cm - kg	cm - kg	cm - kg	cm - kg
Date of birth (dd/mm/yy)				
Gender				
Occupation				
Work description (Ex: office/ administration, retail/ trading duties/ light manual labour, etc.)				
Passport/ ID #				
Country of Residence				
Country of Citizenship				

Do you currently smoke or use tobacco product?	No	No	No	No
If you have quit smoking, please state when (mm/yy):	/	/	/	/
Tel				
Email				

FOR INSURED PERSON UNDER AGE 03:

In which week of pregnancy was this child born?	Week	Week	Week	Week
Height and Weight at birth	cm - kg	cm - kg	cm - kg	cm - kg
Does this child have twin/triplet brother(s) or/and sister(s)?				

B-PLAN SELECTION

	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4
Other Plan				
BENEFICIARY INFORMATION (FOR PA ONLY)				
Relationship to Insured Person				
PAYMENT OPTION	☐ Annual ☐ Semi-Annual (surcharge is applied)			

C-QUESTIONNAIRES

Please answer the questions below (if Insured person is under 18 years old, parents are required to complete and sign on behalf of

children). All information provided is kept in the strictest confidentiality. Your complete and accurate responses will assist us to properly underwrite your policy.

	Insured Person 1	Insured Person 2	Insured Person 3	Insured Person 4
1. - Are you currently covered by a medical policy? (If YES, please provide a copy of the policy and benefit schedule)				
- Have you had any medical insurance application or policy declined, rated, restricted, or cancelled, at any time in the past? If YES, please explain:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2.2 Heart or circulatory conditions? Ex: high/low blood pressure, angina/chest pains, heart attacks or heart failure, coronary arteries, ischemia, deep vein thrombosis, varicose vein, etc.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you ever had symptoms of or been diagnosed with, investigated or treated for any of the following:				
2.1 Psychological or psychiatric conditions, drug and alcohol issues or sleep disorders?Ex: depression, anxiety, stress, autism, insomnia, sleep apnea, drugs and alcohol dependency, etc.	☐ Yes ☑ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2.2 Heart or circulatory conditions? Ex: high/low blood pressure, angina/chest pains, heart attacks or heart failure, coronary arteries, ischemia, deep vein thrombosis, varicose vein, etc.	☑ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
2.3 Tumors, growths or cancer? Ex: polyps, benign growths or cysts, lymphomas, any cancers or pre-cancerous conditions, etc.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

2.4 Brain or nervous system conditions? Ex: stroke/transient ischemic attack (TIA), syncope, seizure or epilepsy, migraines, multiple sclerosis, meningitis, neuritis, etc.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2.5 Diabetes, thyroid, metabolic or any other endocrine disorders Ex: diabetes type 1 or type 2, hypothyroidism or hyperthyroidism, dyslipidemia, pituitary or adrenal problems, etc.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2.6. Eyes, ears, nose or throat? Ex: glaucoma, cataracts, retinal detachment, hearing difficulties/loss, tonsillitis, sinusitis, etc.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2.7. Breathing or respiratory conditions? Ex: asthma, chronic obstructive pulmonary disease (COPD), emphysema, shortness of breath, tuberculosis (TB), all kind of respiratory allergies, Coronavirus infection (including Covid-19), etc.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2.8. Urinary, kidney, ureter, bladder, urethral or prostate conditions or STI?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2.9. Stomach, liver, gall-bladder, pancreas, or digestive system conditions?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2.10. Neck, back, joint, muscular or skeletal problems? Ex: sciatica, osteoarthritis of spine, gout, joint replacements, cartilage or ligament problems, etc.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2.11. Auto-immune disorders? Ex: HIV/AIDS, rheumatoid arthritis, systemic lupus erythematosus, scleroderma, etc.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

2.12. Skin conditions? Ex: eczema, rashes, psoriasis, all kind of skin allergic reactions, etc.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2.13. Gynecological or breast conditions? Ex: prolapse, endometriosis, abnormal Pap test, etc.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2.14 Any physical defect or congenital condition?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. In the past 3 years, have you seen a physician, or have you undergone any medical test, medical check-up, taken medication, or had any other procedure not mentioned above?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

D-SUPPLEMENT

If you answered “YES” to any of the above questions 2, 3 in Part C, please give complete the attached "General Question" form.

Insured Person 1

Insured Person 2

Insured Person 3

Insured Person 4

E-DECLARATION

I/We hereby declare that

1. The answers and information which I/ We given to Hung Vuong Insurance Corporation and its third party administrator - Pacific Cross Vietnam (hereinafter referred to as "the Company") are true, complete, and correct. I/ We agree and confirm that the answers/ information provided above shall be the basis of the Insurance Policy between the Company and myself/ ourselves. I/ We understand that untruthful information, concealment, or misrepresentation of any significant condition will result in the voiding the Insurance Policy.
2. I/ We have provided complete and accurate personal information to the Company. I/ We know the type of personal data that will be processed as well as the rights and obligations of the data subject in accordance with the law on protection of personal data. I/ We voluntarily and completely agree and allow the Company to process our personal data for the purposes related to this Insurance Policy.
Regarding the information and personal data of relevant data subject which I/ We provided to the Company. I/ We warrant that I/ We have the full approval and consent of the data subject to provide the Company and are fully responsible for providing this information and personal data.
3. I/ We have received, read, understood, and agreed to the Company's Insurance Policy wordings, including coverage terms, exclusions and related conditions.
I/ We do confirm that I have received a clear and complete explanation of insurance benefits, be aware of the characteristics of the selected product. I/ We further understand that the premium is based on the insured person residency in Vietnam.
4. I do hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health, to give to company any such information. A photographic copy of this authorization shall be valid as the original.

5. I/ We agree to receive any information relating to the Insurance Policy and insurance benefits from Company via Email/SMS/MMS/USSD/Zalo/Whatsapp/Viber and other electronic means.
6. I/ We hereby agree that the Company can:
i. Send information on its products and services as well as other information relating to customer services, to our phone numbers and/or email/mail addresses and
ii. Send and store all information related to this Insurance Policy at relevant third-party vendors that provide data processing, storage and/ or back-up services to the Company.

Please note:

(i) We will not be able to process your application if any sections are left incomplete or any necessary questions left unanswered.
(ii) Please submit the completed Healthcare insurance application form with your original signature to Company. If the Healthcare insurance application form is not bound at the spine, please sign in each page. We accept the submitting of color images and color scanned files of the Healthcare insurance application form sending by above registered email of each Insured person.
(iii) Please submit the copy of the Passport/ ID, this identifying information is the basis for us to issue the insurance policy as well as settle the healthcare insurance benefits to you.

SIGNATURE AND NAME

Policyholder	Date (dd/mm/yy)
Insured Person 1	Date (dd/mm/yy)
Insured Person 2	Date (dd/mm/yy)
Insured Person 3	Date (dd/mm/yy)
Insured Person 4	Date (dd/mm/yy)
Broker	