



The strength behind your insurance

APPLICATION FOR CHANGE OF BENEFIT

(not applicable for upgrade of benefit)

Policy No.: _____

Name of Policyholder: _____

Address: _____

Name(s) of Insured Person(s): _____

Telephone No.: _____ (H) _____ (O)

Fax No.: _____

Email: _____

New Benefit Requested: _____

Effective Date for Proposed Changes: _____

Remarks: _____

Please advise if any person covered by this request:	YES	NO
1. has undergone any tests, investigations or taken any medications or received any form of treatment recommended or prescribed during the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
2. is currently under treatment or observation for any medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
3. has been advised to have any diagnostic test or medical procedure which has not been completed?	<input type="checkbox"/>	<input type="checkbox"/>
4. has incurred any medical expenses which have not yet been fully disclosed to Pacific Cross Vietnam ?	<input type="checkbox"/>	<input type="checkbox"/>
5. has exhibited any symptoms in a repeated/persistent way?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "Yes" to any of the above questions 1 to 5, please give complete details on a separate sheet.

I/We hereby declare that, to the best of my knowledge and belief, all answers to the foregoing questions are correctly and accurately recorded, and that they are full, complete and true. I/We further declare that all persons covered by this request are in good health except as declared herein.

Signature of Policyholder: _____ Date (day/month/year): _____