

## APPLICATION FOR UPGRADE

**IMPORTANT NOTE:** Any condition existing at the time of upgrade shall continue to be covered at the old benefit level.

Policy No.: \_\_\_\_\_

Name of Policyholder: \_\_\_\_\_

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

Name(s) of Insured Person(s): \_\_\_\_\_

Telephone No.: \_\_\_\_\_ (H) \_\_\_\_\_ (O)

Fax No.: \_\_\_\_\_

Email: \_\_\_\_\_

New Plan Requested: \_\_\_\_\_

Option(s): \_\_\_\_\_

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 conditions?   | <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 <b>Pacific Cross Vietnam</b> ?   | <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): \_\_\_\_\_