



The strength behind your insurance

SHORT FORM MEDICAL REGISTRATION

– FOR GROUP –

Policy Number: _____

Policyholder Name: _____

Insured Person (Last/First/Middle Name): _____

Date of Birth (day/month/year): _____ Height: _____ Weight: _____

Occupation: _____ Male: Female:

Passport or Government ID #: _____

Country of Citizenship: _____

Country of Residence: _____

Insured Person's Email: _____ Mobile phone: _____

Insurance Effective Date (day/month/year): _____

PACIFIC CROSS VIETNAM reserves the right to request additional information based on the responses given in this questionnaire.

Please answer the below questions by answering checking **Yes** or **No**.

- Yes No Have you ever had any medical, disability or life application/policy been declined, rated, restricted, cancelled or withdrawn?
- Yes No Have you ever been diagnosed with, investigated or treated for, cancer, heart, lung, kidney, liver, and brain, orthopedic or psychiatric conditions?
- Yes No Have you been hospitalized or had any inpatient treatment within the last 10-years?
- Yes No Do you have any on-going or planned treatment of any kind?

If you answered "Yes" to any of the above questions 1 to 4, please give complete details including medical history, diagnosis, nature/date of care and treatment received, date of last consultation and related medical reports, etc. (If the space provided is insufficient, please use a separate sheet.)

DECLARATION: I hereby apply for insurance to be based on the above statements and 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.

Signature of Insured Person

Date (day/month/year)

Name of Insured Person (In BLOCK LETTERS)