PACIFIC CROSS VIETNAM

The strength behind your insurance

GENERAL QUESTIONNAIRE

IF YOU ANSWERED "YES" TO ANY QUESTIONS 2, 3, 4 IN C-SECTION IN HEALTHCARE INSURANCE APPLICATION, PLEASE PROVIDE BELOW DETAILS

Question No.: _____

1. The first symptom(s) appear: _____ /_____ /_____ (dd/mm/yy)

2. Symptom(s)'s description: _____

3. Part(s) of body affected (please state right/ left) _____

_____

4. The underlying cause: _____

5. The exact diagnosis made by doctor: _____

_____

6. Treatment:

☐ Medication. Name and dosage: _____

_____

☐ Tests/ Radiology. Name and result: _____

_____

☐ Surgery: Pin/ Materials inserted into the body ☐ Yes ☐ No. If Yes, when it removed: _____ /_____ /_____ (dd/mm/yy)

☐ Others. Please state details: _____

_____

7. Frequency of attacks in the last 12 months: _____

8. Date of the last consultation: _____ /_____ /_____ (dd/mm/yy)

9. Currently status: _____

10. Name and address of treating doctor/clinic/hospital: _____

_____

11. (*) For Hypertension/ Dyslipidemia/ Impaired Glucose Tolerance. Please provide these index taken within the last 03 months:

Blood pressure: The highest: _____ The last 03 months: _____

Lipid profiles: Cholesterol: _____ HDL: _____ LDL: _____ Triglyceride: _____

Blood sugar: _____ HbA1c: _____

12. Additional information (if have):

_____

_____

_____

If the space provided is insufficient, please use back of page.

Signature of Insured Person: _____

Name of Insured Person: _____ Date (dd/mm/yy): _____ / _____ / _____

16th Floor | Royal Centre Tower B | 235 Nguyen Van Cu Street | Nguyen Cu Trinh Ward | District 1 | Ho Chi Minh City | Vietnam

Tel: (+84 28) 7306 9669 | Email: inquiry@pacificcross.com.vn