

## HEALTHCARE INSURANCE APPLICATION FORM For FAMILY

This application form and its contents, as completed by the insured person(s), will form a part of and be attached to the policy package

POLICYHOLDER NAME:								
Tel:	Contact Email:							
		Lillall,						
A-INSURED PERSON DETA								
	INSURED P	PERSON 1	INSURED PERSON 2		INSURED	PERSON 3	INSURED	PERSON 4
Full Name								
Relationship to Policyholder								
Height and Weight		17				. V		
Date of birth (dd/mm/yy)	Cm	Kg	Cm	Kg	Cm	Kg	Cm	Kg
Gender	/	Female	/	Female	/	Female	/	Female
Occupation	Midle	remaie	Maic	remaie	ividic	remaie	Widie	Terriale
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? If you have quit smoking, please state when (mm/yy):	Yes	No	Yes	□ No	Yes	□ No	Yes	□ No
Tel				/				
Contact Email:								
I hereby authorize Pacific Cross Vietnan	n to communicate	with me via my e	mail address. I fu	rther accept email	communication:	s form part of my p	policy.	
For Insured Person under age 03: In which week of pregnancy was this child born? Height and Weight at birth	Cm	Weeks	Cm	Weeks		Weeks	Cm	Weeks
Does this child have twin/triplet brother(s) or/and sister(s)?	Yes	□No	Yes	□No	Yes	□No	Yes	□No
B-PLAN SELECTION								
FOUNDATION	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
Standard - VND 500,000,000						Ш	Ш	
Executive - VND 1,000,000,000								
Premier - VND 2,000,000,000								
Additional Benefit	Dental 1	Dental 2	Dental 1	Dental 2	Dental 1	Dental 2	Dental 1	Dental 2
MASTER						_		_
M1+ - VND 5,000,000,000			L				L	
M2 – VND 10,000,000,000							<u> </u>	
M3 – VND 20,000,000,000				]				
	Dental		Dental		Dental		Dental	
	LifeStyle 1	LifeStyle 2	LifeStyle 1	LifeStyle 2	LifeStyle 1	LifeStyle 2	LifeStyle 1	LifeStyle 2
Additional Benefit	· ·	00,000 Surgeon's e (for M1+ only)	☐ VND1,000,0	000,000 Surgeon's de (for M1+ only)	□VND1.000.0	000,000 Surgeon's le (for M1+ only)	₩VND1,000,0	000,000 Surgeon's de (for M1+ only)
	Personal Ac	cident (PA)	Personal A	ccident (PA)	Personal A	ccident (PA)	Personal A	accident (PA)
Discount Option: Treatment Area Limit (25%) Outpatient Exclusion (30%) 20% Co-payment (25%) VND50,000,000 Inpatient Benefit Deductible (20%)					] [ ]			

HEALTH FIRST	Core Bene	_	enefit	Core Bene	-	tient Medic Benefit	al Core Ber	nefit Out	Benefit	Core Bene		ent Medical enefit
HF1 - VND 150,000,000								<u> </u>				
HF2 - VND 250,000,000 HF3 - VND 450,000,000												
Dental	□HF1	☐HF2	☐HF3	☐HF1	☐HF2	☐HF3	☐HF1	HF	2	☐HF1	HF2	☐HF3
Personal Accident		Amount:			Amount			Amour	nt:		Amount:	
Beneficiary information (for PA only)												
Beneficiary Designation Relationship to Insured Persor	n						_					
PAYMENT OPTION ANNUAL	SEMI-A	NNUAL (S	URCHARGE	IS APPLIE	O) PREF	ERRED CO	VERAGE EF	FECTIVE D	OATE (DD/MM/	YY):	_/	/
C-QUESTIONNAIRES												
Please answer the questions below provided is kept in the strictest co											en). All info	ormation
					JRED PER		NSURED P		INSURED PI		INSURED P	
1 Are you currently covered			(If YES, ple	ase		io ]	YES	NO	YES	NO	YES	NO
provide a copy of the policy a  - Have you had any medical in:			olicy declin	ad								
rated, restricted, or cancelled If YES, please explain:	, at any time i	n the past	?			] 						
2. Have you ever had symptoms of cortreated for any of the following:	or been diagr	nosed with	, investiga	ted								
2.1. Psychological or psychiatric or sleep disorders?	conditions,	drug and	alcohol iss				_		_		_	_
Ex: depression, anxiety, stress and alcohol dependency, etc		mnia, slee <sub>l</sub>	o apnea, dr	ugs								
<b>2.2. Heart or circulatory conditi</b> Ex: high/low blood pressure		st pains, he	eart attacks	s or		7	П	П	П		П	П
heart failure, coronary arter varicose vein, etc.	ies, ischemia	, deep vei	n thrombo	osis,		_	ш					
<b>2.3. Tumors, growths or cancer</b> Ex: polyps, benign growths	or cysts, lym	phomas, a	iny cancers	or								
pre-cancerous conditions, etc  2.4. Brain or nervous system co												
Ex: stroke/transient ischem epilepsy, migraines, multiple				or								
2.5. Diabetes, thyroid, metaboli Ex: diabetes type 1 or type 2	2, hypothyroid	dism or hy										
dyslipidemia, pituitary or adr  3. In the last 5 years, have you se			erienced a	anv								
symptoms, or been admitted to a operation or procedure, or undergo	hospital or	medical	facility for	an								
of the following conditions?  3.1. Eyes, ears, nose or throat?						_				_		
Ex: glaucoma, cataracts, retin hearing difficulties/loss, relap	osed otitis, tor			on,								
<b>3.2. Breathing or respiratory co</b> Ex: asthma, chronic obstructive shortness of breath, pneumoni	pulmonary dis					_						
respiratory allergies, Coronavirus  3.3. Urinary, kidney, ureter, bladde	s infection (incl	uding Covic	l-19), etc.									
Ex: kidney, bladder, urethra ir sexually transmitted infection	nfections or st											
3.4. Stomach, liver, gall-bladd conditions?	er, pancreas	s, or dige	stive syst	em								
Ex: gastritis, gastroesophageal gallstones, pancreatitis, irrita	ble bowels,	colitis, hen	norrhoids/p	iles,								
persistent diarrhea, Crohn's pain, bleeding, all kind of he	rnia, etc.		rs, abdomi	nal								
<b>3.5. Neck, back, joint, muscular</b> Ex: neck, back or joint pain, s gout, joint replacements, fractu	sciatica, arthri	tis, osteoar										
3.6. Auto-immune disorders?  Ex: HIV/AIDS, rheumatoid ar:							П		П		П	П
scleroderma, etc.	anicis, system	ne lupus e	rythemato:	, ,								
3.7. Skin conditions? Ex: eczema, dermatitis, rasho bleed, or all kind of skin allerg			es that itch	or		<b>-</b>						
bieed, or all killu of skill allerg	gi <del>c reactions,</del>	etc.										

<b>3.8. Gynecological or breast conditions?</b> Ex: irregular periods, fibroids, prolapse, endometriosis, abnormal Pap test, cervix, uterus, ovaries or fallopian tube disorders, etc.								
3.9. Any physical defect or congenital condition?								
4. Have you been advised to undergo or have you undergone any medical test, medical check-up, taken medication, or had a procedure not mentioned above?								
D-SUPPLEMENT								
f you answered "YES" to any of the above questions 2, 3, 4 in Part C, pl and treatment received, date of last consultation, related medical repo provided is insufficient, please use a separate sheet for each Insured I NSURED PERSON 1	orts, name	complete and conta	details inclu act details o	ding medi f your pers	ical history, onal physic	diagnosis, ian or doc	, nature/dat tor, etc. (if t	te of care he space
NSURED PERSON 2								
NSURED PERSON 3								
NSURED PERSON 4								

## **E-DECLARATION**

We hereby declare that all information above, including all papers and documents, which were submitted according to the requirements of this Healthcare Insurance Application, are true, accurate and complete. We understand that untruthful information, concealment, or misrepresentation of any significant condition will result in the voiding of all applicable insured's benefits under the plan. We further understand that the premium is based on the Insured Person(s) residency in Vietnam. We 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 our health, to give to Pacific Cross Vietnam any such information. A photographic copy of this authorization shall be valid as the original.

We agree to receive any information relating to the policy and insurance benefits from Hung Vuong Insurance Company and its third party administrator - Pacific Cross Vietnam via Email/ SMS/ MMS/ USSD/ Zalo/ Whatsapp/ Viber and other electronic means.

## **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:	

## 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 Pacific Cross Vietnam in order to receive your official policy package. If the Healthcare insurance application form is not bound at the spine, please sign in each page. Color images and color scanned files for this application are accepted when sending by above registered email of each Insured person.