

TRAVEL INSURANCE APPLICATION

Applicant: _____

Residential Address: _____

Country of Origin: _____ Email: _____

Tel: _____ Fax: _____

COVERAGE SELECTED: (please appropriate box)

<input type="checkbox"/> TRAVEL FLEX	<input type="checkbox"/> BON VOYAGE	<input type="checkbox"/> ANNUAL TRAVEL
Area of Coverage: <input type="checkbox"/> South East Asia <input type="checkbox"/> Asia <input type="checkbox"/> Worldwide Fundamental Benefits: 1. Medical Expenses And Emergency Assistance <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C 2. Personal Accident <input type="checkbox"/> VND 400,000,000 <input type="checkbox"/> VND 1,000,000,000 <input type="checkbox"/> VND 2,000,000,000 <input type="checkbox"/> VND 5,000,000,000 Optional Benefits: Incidental Cover <input type="checkbox"/> Yes <input type="checkbox"/> No	Plan: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	Plan: <input type="checkbox"/> Premier Plan <input type="checkbox"/> Executive Plan <input type="checkbox"/> Study abroad country:
Premium Type: <input type="checkbox"/> Individual <input type="checkbox"/> Family		

PERIOD OF INSURANCE: from ____/____/____ for ____ days
day/ month / year

Name of Insured Person	Sex	Date of Birth	Passport No.	Optional Rental Car Protection* <small>Period of Insurance (day/month/year)</small>	Premium (VND)
_____	_____	_____	_____	From / / for days	_____
_____	_____	_____	_____	From / / for days	_____
_____	_____	_____	_____	From / / for days	_____
_____	_____	_____	_____	From / / for days	_____

* Applied for Travel Flex and Bon Voyage only

TOTAL _____

BENEFICIARY INFORMATION (for Personal Accident Benefit only)

Beneficiary Designation: _____ Relationship: _____

PAYMENT BY:

-
- American Express
-
- Master Card
-
-
- Visa
-
- Cash

DECLARATION: I hereby apply for _____ to be based on the above statements, and warrant that to the best of my knowledge and belief that no Insured Person is traveling contrary to the advise of a medical practitioner or for the purpose of obtaining medical treatment and that I understand treatment of any pre-existing, existing, recurring or congenital medical conditions is not insured.

I further warrant that I am not aware of any condition, cause or circumstances that may necessitate the cancellation or curtailment of the journey as planned.

Applicant's signature: _____

Date (day/month/year): _____ Broker: _____

Note: No refund of premium will be made once the Policy has been issued.