PACIFIC CROSS

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: ______________________________

Billing Address: ______________________________

Tel: ______________ Contact Email: ______________________________

A-INSURED PERSON DETAILS

	INSURED PERSON 1	INSURED PERSON 2	INSURED PERSON 3	INSURED PERSON 4
Full Name				
Relationship to Policyholder				
Height and Weight	____Cm ____Kg	____Cm ____Kg	____Cm ____Kg	____Cm ____Kg
Date of birth (dd/mm/yy)	___/___/___	___/___/___	___/___/___	___/___/___
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Occupation				
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 Vietnam to communicate with me via my email address. I further accept email communications form part of my policy.

For Insured Person under age 03:

	INSURED PERSON 1	INSURED PERSON 2	INSURED PERSON 3	INSURED PERSON 4
In which week of pregnancy was this child born?	____ Weeks	____ Weeks	____ Weeks	____ Weeks
Height and Weight at birth	____Cm ____Kg	____Cm ____Kg	____Cm ____Kg	____Cm ____Kg
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	☐	☐	☐	☐	☐	☐	☐	☐
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	☐	☐	☐	☐
M2 – VND 10,000,000,000	☐	☐	☐	☐
M3 – VND 20,000,000,000	☐	☐	☐	☐
Additional Benefit	☐ Dental ☐ LifeStyle 1 ☐ LifeStyle 2 ☐ VND1,000,000,000 Surgeon's Fee Upgrade (for M1+ only) ☐ Personal Accident (PA) Amount:____	☐ Dental ☐ LifeStyle 1 ☐ LifeStyle 2 ☐ VND1,000,000,000 Surgeon's Fee Upgrade (for M1+ only) ☐ Personal Accident (PA) Amount:____	☐ Dental ☐ LifeStyle 1 ☐ LifeStyle 2 ☐ VND1,000,000,000 Surgeon's Fee Upgrade (for M1+ only) ☐ Personal Accident (PA) Amount:____	☐ Dental ☐ LifeStyle 1 ☐ LifeStyle 2 ☐ VND1,000,000,000 Surgeon's Fee Upgrade (for M1+ only) ☐ Personal Accident (PA) Amount:____

Discount Option:				
Treatment Area Limit (25%)	☐	☐	☐	☐
Outpatient Exclusion (30%)	☐	☐	☐	☐
20% Co-payment (25%)	☐	☐	☐	☐
VND50,000,000 Inpatient Benefit Deductible (20%)	☐	☐	☐	☐

HEALTH FIRST	Core Benefit	Outpatient Medical Benefit	Core Benefit	Outpatient Medical Benefit	Core Benefit	Outpatient Medical Benefit	Core Benefit	Outpatient Medical Benefit
HF1 - VND 150,000,000	☐	☐	☐	☐	☐	☐	☐	☐
HF2 - VND 250,000,000	☐	☐	☐	☐	☐	☐	☐	☐
HF3 - VND 450,000,000	☐	☐	☐	☐	☐	☐	☐	☐
Dental	☐HF1 ☐HF2 ☐HF3		☐HF1 ☐HF2 ☐HF3		☐HF1 ☐HF2 ☐HF3		☐HF1 ☐HF2 ☐HF3	
Personal Accident	Amount:		Amount:		Amount:		Amount:	
Beneficiary information (for PA only)								
Beneficiary Designation								
Relationship to Insured Person								

PAYMENT OPTION ☐ ANNUAL ☐ SEMI-ANNUAL (SURCHARGE IS APPLIED) PREFERRED COVERAGE EFFECTIVE DATE (DD/MM/YY): _____ /_____ /_____

C-QUESTIONNAIRES

Please answer the questions below (if Insured person is under 18 years old, parents are required to complete and sign on behalf of children). All information provided is kept in the strictest confidentiality. Your complete and accurate responses will assist us to properly underwrite your policy.

	INSURED PERSON 1		INSURED PERSON 2		INSURED PERSON 3		INSURED PERSON 4	
	YES	NO	YES	NO	YES	NO	YES	NO
1. - Are you currently covered by a medical policy? (If YES, please provide a copy of the policy and benefit schedule)	☐	☐	☐	☐	☐	☐	☐	☐
- Have you had any medical insurance application or policy declined, rated, restricted, or cancelled, at any time in the past? If YES, please explain:	☐	☐	☐	☐	☐	☐	☐	☐
2. Have you ever had symptoms of or been diagnosed with, investigated or treated for any of the following:								
2.1. Psychological or psychiatric conditions, drug and alcohol issues or sleep disorders? Ex: depression, anxiety, stress, autism, insomnia, sleep apnea, drugs and alcohol dependency, etc.	☐	☐	☐	☐	☐	☐	☐	☐
2.2. Heart or circulatory conditions? Ex: high/low blood pressure, angina/chest pains, heart attacks or heart failure, coronary arteries, ischemia, deep vein thrombosis, varicose vein, etc.	☐	☐	☐	☐	☐	☐	☐	☐
2.3. Tumors, growths or cancer? Ex: polyps, benign growths or cysts, lymphomas, any cancers or pre-cancerous conditions, etc.	☐	☐	☐	☐	☐	☐	☐	☐
2.4. Brain or nervous system conditions? Ex: stroke/transient ischemic attack (TIA), syncope, seizure or epilepsy, migraines, multiple sclerosis, meningitis, neuritis, etc.	☐	☐	☐	☐	☐	☐	☐	☐
2.5. Diabetes, thyroid, metabolic or any other endocrine disorders Ex: diabetes type 1 or type 2, hypothyroidism or hyperthyroidism, dyslipidemia, pituitary or adrenal problems, etc.	☐	☐	☐	☐	☐	☐	☐	☐
3. In the last 5 years, have you seen a physician, or experienced any symptoms, or been admitted to a hospital or medical facility for an operation or procedure, or undergone any test or investigations, for any of the following conditions?								
3.1. Eyes, ears, nose or throat? Ex: glaucoma, cataracts, retinal detachment, macular degeneration, hearing difficulties/loss, relapsed otitis, tonsillitis, sinusitis, etc.	☐	☐	☐	☐	☐	☐	☐	☐
3.2. Breathing or respiratory conditions? Ex: asthma, chronic obstructive pulmonary disease (COPD), emphysema, shortness of breath, pneumonia, bronchitis, tuberculosis (TB), all kind of respiratory allergies, Coronavirus infection (including Covid-19), etc.	☐	☐	☐	☐	☐	☐	☐	☐
3.3. Urinary, kidney, ureter, bladder, urethral or prostate conditions or STI? Ex: kidney, bladder, urethra infections or stones, prostate problems, sexually transmitted infections, etc.	☐	☐	☐	☐	☐	☐	☐	☐
3.4. Stomach, liver, gall-bladder, pancreas, or digestive system conditions? Ex: gastritis, gastroesophageal reflux disease (GERD), hepatitis, cirrhosis, gallstones, pancreatitis, irritable bowels, colitis, hemorrhoids/piles, persistent diarrhea, Crohn's disease, digestive ulcers, abdominal pain, bleeding, all kind of hernia, etc.	☐	☐	☐	☐	☐	☐	☐	☐
3.5. Neck, back, joint, muscular or skeletal problems? Ex: neck, back or joint pain, sciatica, arthritis, osteoarthritis of spine, gout, joint replacements, fracture, cartilage or ligament problems, etc.	☐	☐	☐	☐	☐	☐	☐	☐
3.6. Auto-immune disorders? Ex: HIV/AIDS, rheumatoid arthritis, systemic lupus erythematosus, scleroderma, etc.	☐	☐	☐	☐	☐	☐	☐	☐
3.7. Skin conditions? Ex: eczema, dermatitis, rashes, psoriasis, acne, moles that itch or bleed, or all kind of skin allergic reactions, etc.	☐	☐	☐	☐	☐	☐	☐	☐

3.8. Gynecological or breast conditions? 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

If you answered "YES" to any of the above questions 2, 3, 4 in Part C, please give complete details including medical history, diagnosis, nature/date of care and treatment received, date of last consultation, related medical reports, name and contact details of your personal physician or doctor, etc. (if the space provided is insufficient, please use a separate sheet for each Insured Person.)

INSURED PERSON 1

INSURED PERSON 2

INSURED PERSON 3

INSURED 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.*