

APPLICATION FOR POLICY TRANSFER

Policy No.:					
Name of Existing Policyholder:					
Name of New Policyholder:					
Name(s) of Insured Person(s):					
Address:					
Telephone No.:	(H)			(O)	
Fax No.:					
Email:					
Effective Date for Proposed Changes:					
Remarks:					

Pleas	se advise if any person covered by this request:	YES	NO
	has undergone any tests, investigations or taken any medications or received any form of treatment recommended or prescribed during the last 12 months?		
3.	is currently under treatment or observation for any medical condition? has been advised to have any diagnostic test or medical procedure which has not		
	been completed? has incurred any medical expenses which have not yet been fully disclosed to Pacific Cross Vietnam ?		
5.	has exhibited any symptoms in a repeated/persistent way?		

If you answered "Yes" to any of the above questions 1 to 5, please give complete details on a separate sheet.

I/We hereby 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. I/We further declare that all persons covered by this request are in good health except as declared herein.

Signature of Policyholder:	Date (day/month/year):