PACIFIC CROSS

SHORT FORM MEDICAL REGISTRATION

– FOR GROUP –

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

Policy Number: ____________________

Policyholder Name: ____________________

Insured Person (Last/First/Middle Name): ____________________

Date of Birth (day/month/year): ____________________ Height: __________ Weight: __________

Occupation: ____________________ Male: ❑ Female: ❑

Passport or Government ID #: ____________________

Country of Citizenship: ____________________

Country of Residence: ____________________

Insured Person's Email: ____________________ Mobile phone: ____________________

Insurance Effective Date (day/month/year): ____________________

PACIFIC CROSS VIETNAM reserves the right to request additional information based on the responses given in this questionnaire.

Please answer the below questions by answering checking **Yes** or **No**.

Yes ❑	No ❑	Have you ever had any medical, disability or life application/policy been declined, rated, restricted, cancelled or withdrawn?
Yes ❑	No ❑	Have you ever been diagnosed with, investigated or treated for, cancer, heart, lung, kidney, liver, and brain, orthopedic or psychiatric conditions?
Yes ❑	No ❑	Have you been hospitalized or had any inpatient treatment within the last 10-years?
Yes ❑	No ❑	Do you have any on-going or planned treatment of any kind (including Coronavirus infection (Covid-19))?

If you answered "Yes" to any of the above questions 1 to 4, please give complete details including medical history, diagnosis, nature/date of care and treatment received, date of last consultation and related medical reports, etc. (If the space provided is insufficient, please use a separate sheet.)

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DECLARATION: I hereby apply for insurance to be based on the above statements and 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.

____________________ ____________________

Signature of Insured Person Date (day/month/year)

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Name of Insured Person (In BLOCK LETTERS)