HEALTHCARE INSURANCE APPLICATION FORM FOR FAMILY

PACIFIC CROSS

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/yyyy)	__/__/__	__/__/__	__/__/__	__/__/__
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Occupation				
Work description (Ex: office, trading duties, light manual labour, etc.)				
Passport/ID No.				
Country of Residence				
Country of Citizenship				
Do you currently smoke or use tobacco products? If you have quit smoking, please state when (mm/yy):	☐ Yes ☐ No __/__	☐ Yes ☐ No __/__	☐ Yes ☐ No __/__	☐ Yes ☐ No __/__
Tel				
Contact Email:				

For Insured Person under age 03:

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) and/or sister(s)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

B - PLAN SELECTION

MASTER

M1+ - VND 5,000,000,000	☐	☐	☐	☐
M2 – VND 10,000,000,000	☐	☐	☐	☐
M3 – VND 20,000,000,000	☐	☐	☐	☐
Additional Benefit	☐ Dental ☐ Life Style 1 ☐ Life Style 2 ☐ VND 1,000,000,000 Surgeon's Fee Upgrade (for M1+ only) ☐ Personal Accident (PA) Amount: ____	☐ Dental ☐ Life Style 1 ☐ Life Style 2 ☐ VND 1,000,000,000 Surgeon's Fee Upgrade (for M1+ only) ☐ Personal Accident (PA) Amount: ____	☐ Dental ☐ Life Style 1 ☐ Life Style 2 ☐ VND 1,000,000,000 Surgeon's Fee Upgrade (for M1+ only) ☐ Personal Accident (PA) Amount: ____	☐ Dental ☐ Life Style 1 ☐ Life Style 2 ☐ VND 1,000,000,000 Surgeon's Fee Upgrade (for M1+ only) ☐ Personal Accident (PA) Amount: ____
Discount Options				
Treatment Area Limit (25%)	☐	☐	☐	☐
Outpatient Exclusion (30%)	☐	☐	☐	☐
20% Co-payment (25%)	☐	☐	☐	☐
VND 50,000,000 Inpatient Benefits Deductible (20%)	☐	☐	☐	☐

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
Personal Accident	Amount: ____		Amount: ____		Amount: ____		Amount: ____	

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:	

HEALTHUP	Core Benefit	Additional Medical Benefit	Core Benefit	Additional Medical Benefit	Core Benefit	Additional Medical Benefit	Core Benefit	Additional Medical Benefit
HU1 - VND 650,000,000	☐	☐	☐	☐	☐	☐	☐	☐
HU2 - VND 1,000,000,000	☐	☐	☐	☐	☐	☐	☐	☐
Dental	☐HU1 ☐HU2		☐HU1 ☐HU2		☐HU1 ☐HU2		☐HU1 ☐HU2	
Personal Accident	Amount:		Amount:		Amount:		Amount:	

BENEFICIARY INFORMATION (FOR PERSONAL ACCIDENT BENYFITS ONLY)

	INSURED PERSON 1	INSURED PERSON 2	INSURED PERSON 3	INSURED PERSON 4
Beneficiary Designation:				
Relationship to Insured Person:				

PAYMENT OPTION: ☐ **Annual** ☐ **Semi-Annual (surcharge is applied)**

C - QUESTIONNAIRES

Please answer the questions below (if Insured Person is under 18 years old, parents/ legal guardian are required to complete and sign on behalf of children). Your complete and accurate responses will assist us to underwrite and issue policy.

	INSURED PERSON 1 YES	INSURED PERSON 1 NO	INSURED PERSON 2 YES	INSURED PERSON 2 NO	INSURED PERSON 3 YES	INSURED PERSON 3 NO	INSURED PERSON 4 YES	INSURED PERSON 4 NO
1. Are you currently covered by other 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 state the reason:	☐	☐	☐	☐	☐	☐	☐	☐
2. Have you ever had diseases of or been diagnosed with for any of the following?								
2.1. Psychological or psychiatric conditions, drug and alcohol issues or sleep disorders? Ex: depression, stress, autism, etc.	☐	☐	☐	☐	☐	☐	☐	☐
2.2. Tumors, growths or cancer? Ex: high/low blood pressure, angina/chest pains, coronary arteries, ischemia, deep veins thrombosis, varicose vein, etc.	☐	☐	☐	☐	☐	☐	☐	☐
2.3. Diabetes, thyroid, metabolic or any other endocrine disorders? Ex: benign growths or cysts, lymphomas, 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: dyslipidemia, pituitary or adrenal problems, etc.	☐	☐	☐	☐	☐	☐	☐	☐
2.6. Eyes, ears, nose or throat? Ex: glaucoma, cataracts, retinal detachment, hearing difficulties/loss, tonsillitis, sinusitis, etc.	☐	☐	☐	☐	☐	☐	☐	☐
2.7. Breathing or respiratory conditions? Ex: asthma, chronic obstructive pulmonary disease (COPD), emphysema, shortness of breath,tuberculosis (TB), all kind of respiratory allergies, Coronavirus infection (including Covid-19), etc.	☐	☐	☐	☐	☐	☐	☐	☐
2.8. Urinary, kidney, ureter, bladder, urethral or prostate conditions or STI?	☐	☐	☐	☐	☐	☐	☐	☐
2.9. Stomach, liver, gall-bladder, pancreas, or digestive system conditions?	☐	☐	☐	☐	☐	☐	☐	☐

2.10. Neck, back, joint, muscular or skeletal problems? Ex: sciatica, osteoarthritis of spine, gout, joint replacements, cartilage or ligament problems, etc.	☐	☐	☐	☐	☐	☐	☐	☐
2.11. Auto-immune disorders? Ex: HIV/AIDS, rheumatoid arthritis, systemic lupus erythematosus, scleroderma, etc.	☐	☐	☐	☐	☐	☐	☐	☐
2.12. Skin conditions? Ex: eczema, rashes, psoriasis, all kind of skin allergic reactions, etc.	☐	☐	☐	☐	☐	☐	☐	☐
2.13. Gynecological or breast conditions? Ex: prolapse, endometriosis, abnormal Pap test, etc.	☐	☐	☐	☐	☐	☐	☐	☐
2.14. Any physical defect or congenital condition?	☐	☐	☐	☐	☐	☐	☐	☐
3. In the past 3 year, have you seen a physian, or have you undergone any medical test, medical check-up, taken medication, or had a other procedure not mentioned above?	☐	☐	☐	☐	☐	☐	☐	☐

D - SUPPLEMENT

If you answered "YES" to any of the above questions 2, 3 in Part C, please give complete the attached "General Question" form.

INSURED PERSON 1

INSURED PERSON 2

INSURED PERSON 3

INSURED PERSON 4

E - DECLARATION

I/We hereby declare that

1. The answers and information which I/We given to Hung Vuong Insurance Corporation and its third party administrator - Pacific Cross Vietnam (hereinafter referred to as "the Company") are true, complete, and correct. I/We agree and confirm that the answers/information provided above shall be the basis of the Insurance Policy between the Company and myself/ourselves. I/We understand that untruthful information, concealment, or misrepresentation of any significant condition will result in the voiding the Insurance Policy.

2. I/We have provided complete and accurate personal information to the Company. I/We know the type of personal data that will be processed as well as the rights and obligations of the data subject in accordance with the law on protection of personal data. I/We voluntarily and completely agree and allow the Company to process our personal data for the purposes related to this Insurance Policy.

Regarding the information and personal data of relevant data subject which I/We provided to the Company, I/We warrant that I/We have the full approval and consent of the data subject to provide the Company and are fully responsible for providing this information and personal data.

3. I/We have received, read, understood, and agreed to the Company's Insurance Policy wordings, including coverage terms, exclusions and related conditions.

I/ We do confirm that I have received a clear and complete explanation of insurance benefits, be aware of the characteristics of the selected product. I/We further understand that the premium is based on the Insured Person residency in Vietnam.

4. I 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 my health, to give to the Company any such information. A photographic copy of this authorization shall be valid as the original.

5. I/We agree to receive any information relating to the Insurance Policy and insurance benefits from Company via Email/SMS/MMS/USSD/Zalo/Whatsapp/ Viber and other electronic means.

6. I/We hereby agree that the Company can:

   i. Send information on its products and services as well as other information relating to customer services, to our phone numbers and/or email/mail addresses and

   ii. Send and store all information related to this Insurance Policy at relevant third-party vendors that provide data processing, storage and/or back-up services to the Company.

SIGNATURE AND NAME:

Policyholder:	**Date(dd/mm/yyyy):**
_____	_____ /_____ /_____
Insured Person 1:	**Date(dd/mm/yyyy):**
_____	_____ /_____ /_____
Insured Person 2:	**Date(dd/mm/yyyy):**
_____	_____ /_____ /_____
Insured Person 3:	**Date(dd/mm/yyyy):**
_____	_____ /_____ /_____
Insured Person 4:	**Date(dd/mm/yyyy):**
_____	_____ /_____ /_____
Agent/ 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 Company. If the Healthcare insurance application form is not bound at the spine, please sign in each page. We accept the submitting of color images and color scanned files of the Healthcare insurance application form sending by above registered email of each Insured Person.

(iii) Please submit the copy of the Passport/ID, this identifying information is the basis for us to issue the Insurance Policy as well as settle the healthcare insurance benefits to you.